

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Baldwin Gardens Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 follow proper food storage handling practices in accordance with its policy and procedure (P&P) for one of one facility kitchen, as evidenced by: 1. Ground turkey meat bag dated 5/15/25 was placed on top of an ice bag inside the kitchen freezer. 2. Ten (10) fruit cups inside the kitchen refrigerator were expired, dated 1/26/26. 3. Fourteen (14) red pudding cups inside the kitchen refrigerator were expired, dated 1/26/26. 4. [NAME] rice and [NAME] rice inside plastic containers had a best by date of 1/6/26 in the dry storage room. 5. Test strips to measure the concentration of the sanitizer solution inside the Red bucket had an expiration date of 11/1/24. These deficient practices had the potential for food borne illnesses. Findings: During initial kitchen observation and interview with the Director of Nutrition (DN) on 1/27/26 at 8:12 AM, a bag of ground turkey meat dated 5/15/25 was placed on top of an ice bag inside the kitchen freezer. The DN stated the ice machine inside the kitchen broke the night before so ice bags were purchased for residents' use until the ice machine was fixed. The DN stated the bag of ground turkey meat should not have been placed on top of the bag of ice because if the ice bag is not completely sealed, the ground turkey meat could contaminate the ice. The DN stated if contaminated ice is served to the residents it could potentially make them sick. During an observation and interview with the Kitchen [NAME] (C1) on 1/27/26 at 8:18 AM, C1 stated the ground turkey meat should not have been placed directly on top of an ice bag if the meat was raw, but since the meat was frozen then it was ok. During a concurrent observation and interview with C1 on 1/27/26 at 8:20 AM, C1 stated the ground turkey meat was dated 5/15/25 but since it was frozen, the meat could still be used. During the same observation and interview, C1 pointed out a separate date of 11/25/25 that was placed on the bottom of the ground turkey meat bag. C1 stated, I think that's when they opened it. This one has two dates; one is when it was received and the other one is when it was opened. But the date doesn't specify which date is which. C1 stated the ground turkey meat should not be inside the freezer and should have been discarded because it could possible be expired at this time. During a follow up interview with the DN on 1/27/26 at 8:23 AM, the DN stated if the ground turkey meat had no label indicating the use by date or best by date, the food item should be discarded to ensure it was safe to eat and not expired. The DN stated residents could get sick if given expired food, which had a potential to cause harm. During the same kitchen observation and interview with the DN and C1 on 1/27/26 at 8:27 AM, ten (10) fruit cups and fourteen (14) red pudding cups were inside the kitchen refrigerator with a label dated 1/26/26 indicating for today's (1/27/26) lunch. C1 stated the items were dated 1/26/26 because that was when they were made. The DN stated that according to the date on the labels, the food items were expired and should have been thrown away. The DN stated expired items should be discarded to ensure they were not given to the residents by accident causing the residents to get sick. During a concurrent observation and interview with the DN of the kitchen dry storage room on 1/27/26 at 8:33 AM, a plastic container of brown rice and a plastic container of [NAME] rice with a best by date of 1/6/26 was found. The DN stated both types of rice should be discarded since the rice could be expired. During an observation and interview with the facility's kitchen's Dishwasher (DW) on 1/27/26 at 8:37 AM, the DW used test strips to measure 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
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	concentration of the sanitizing solution inside the Red-Bucket with an expiration date of 11/1/24. The DW stated the DW was not aware the test strips were expired. The DW stated it was important to check the concentration of the sanitizing solution inside the red bucket to determine if it was effective to kill bacteria and germs. The DW stated if the solution was not accurately concentrated, bacteria could spread in the kitchen causing contamination and could spread to the residents' food resulting in illness if consumed. The DW stated the sanitizing solution was used on the kitchen countertops where the clean utensils and serving spoons were kept. During an interview with the Dietary Supervisor (DS) on 1/27/26 at 8:45 AM, the DS stated using a sanitizing solution to clean and disinfect the kitchen area and surfaces help prevent cross-contamination and ensure food preparation surfaces, cutting boards, and equipment do not transfer bacteria from raw to cooked foods. The DS stated if expired strips had been used to measure the concentration of the sanitizing solution in the red bucket, more than likely the reading was not accurate. The DS stated using an effective sanitizing solution was critical to eliminate bacteria and to prevent foodborne illnesses. The DS stated most residents at the facility had weak immune system and foodborne illnesses could result in severe illness or hospitalization of residents. During an observation and interview with C2 inside the kitchen on 1/28/26 at 12:15 PM, C2 used a wet towel from the red bucket that contained sanitizing solution to clean the food prep countertop and other kitchen areas. C2 stated the solution used to clean and disinfect the counter tops in the food prep area needed to be checked using non-expired test strips. C2 stated if the solution did not have enough/effective concentration to kill and disinfect germs and bacteria, it could potentially cause cross contamination to other areas of the kitchen. C2 stated if contaminated food was served to the residents, it would make the residents sick. During an interview with the Infection Prevention Nurse (IPN) on 1/28/26 at 1:32 PM, the IPN stated test strips should not be expired. The IPN stated if the testing strips were expired, the result would be inaccurate. The IPN stated using an expired test strip was not allowed because the areas that were cleaned with the sanitizing solution would not be disinfected properly. During an interview with the IPN on 1/28/26 at 1:34 PM, the IPN stated kitchen staff needed to ensure nothing in the kitchen was expired. The IPN stated the kitchen should not have any expired food primarily because residents were highly vulnerable and had low immune system. The IPN stated if residents consume expired food, it would be dangerous because expired food could cause foodborne illnesses. During a review of the facility's P&P titled, Food Receiving and Storage, reviewed 11/2024, the P&P indicated, Food shall be received and stored in a manner that complies with safe food handling practices. All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). Dry foods that are stored in bins are removed from original packaging, labeled and dated (use by date). Refrigerated foods should be labeled, dated and monitored so they are used by their use-by date, frozen, or discarded. During a review of the facility's P&P titled, Kitchen-Sanitation and Infection Control, reviewed 3/20/25, the P&P indicated, The food service area is maintained in a clean and sanitary manner. All equipment, food contact surfaces and utensils were cleaned and sanitized using heat or chemical sanitizing solutions. Service area wiping cloth should be cleaned and dried or placed in a chemical sanitizing solution of appropriate concentration.		

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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 and follow infection prevention procedures to prevent the transmission of infectious organisms for four of eight sampled residents (Residents 1, 27, 43, and 61) by failing to: a. Cover the [NAME] Valve's (a device that controlled fluid flow in medical tubing) port, which had dry brown crust inside on Resident 1's gastrostomy tube (G-tube [GT], a surgical opening fitted with a device to allow feedings/medications to be administered directly to the stomach) and ensure Resident 1's abdominal binder (a wrap that kept the belly secure to stop G-tube pulling) did not have brown stains. b. Ensure the incentive spirometer (IS, a tool that helps lungs breathe better) mouthpiece was not placed on the flat top surface of the nightstand for Resident 27. c. Date the nasal cannula (NC, a small plastic tube that fits into the person's nostrils for providing supplemental oxygen) storage bag for Resident 43. d. Keep the Foley catheter (FC, a soft, plastic or rubber tube inserted into the bladder to drain urine) drainage bag off the floor for Resident 61. These deficient practices had the potential to transmit infectious microorganisms and increase the risk of infection for Residents 1, 27, 43, and 61. Findings: a. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was originally admitted to the facility on [DATE] and re admitted on [DATE] with diagnoses including dysphasia (difficulty swallowing) and aphasia (difficulty speaking or writing) following cerebral infraction (a blood vessel blockage in the brain) and encounter for attention to gastrostomy. During a review of Resident 1's History and Physical (H&P) dated 12/14/2025, the H&P indicated Resident 1 could not make needs known and did not have the capacity to make medical decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment and care screening tool) dated 12/10/2025, the MDS indicated Resident 1 had severely impaired cognition (ability to understand). The MDS indicated Resident 1 was dependent (helper does all of the effort, resident does none) on staff for oral hygiene, toilet hygiene, personal hygiene, shower and bathing, upper and lower body dressing and putting on/taking off footwear. During a review of Resident 1's untitled Care Plan (CP) initiated on 11/21/25, the CP indicated the resident will remain free of side effects of complications related to tube feeding. The CP intervention indicated abdominal binder to be worn at all times to prevent the resident from pulling out the GT. During an observation of Resident 1 on 1/28/26 at 8:37 AM in Resident 1's room, Resident 1's GT line was hanging on the side of the bed, the medication port had dry brown crust inside and was not covered with a cap. During a concurrent observation of Resident 1 on 1/28/26 at 8:38 AM, Resident 1's abdominal binder was observed with brown stains. During an observation and interview inside Resident 1s room with the Wound Care Nurse (WCN) on 1/28/2026 at 8:41 AM, the WCN stated Resident 1's GT port was crusty, dry and it should have a cap to cover it. The WCN stated if bacteria were present in the GT port area, it could cause an infection to Resident 1. The WCN stated the GT port was dirty and bacteria could grow. The WCN stated the facility staff do not want the residents to get sick and staff were supposed to prevent any type of infection by making sure everything was clean in the facility. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 1/28/2026 at 9:09 AM with the WCN at Resident 1's bedside, the WCN stated Resident 1's abdominal binder was dirty with brown stains. The WCN stated the abdominal binder should be kept clean primarily to prevent infection at the stoma site (the opening where the tube enters the skin). The WCN stated a soiled or dirty binder acts as a breeding ground for bacteria causing irritation of the GT site or infection to Resident 1. The WCN stated keeping the abdominal binder clean was essential to prevent infections, skin breakdown and to protect Resident 1 from leakage of the GT formula or stomach contents. During an interview with the facility's Infection Prevention Nurse (IPN) on 1/28/2026 at 1:32 PM, the IPN stated the GT port should be covered with a cap to close the opening when not in use. The IPN stated the charge nurse who last gave Resident 1's medications should close the GT port with a cap. The IPN stated keeping the GT ports clean and covered was critical to prevent serious complications of infection. During a concurrent interview with the IPN on 1/28/26 at 1:35 PM, the IPN stated Resident 1's abdominal binder should be kept clean at all times and it was not acceptable to see old dry stains on the resident's abdominal binder. The IPN stated having a dirty abdominal binder could affect the dignity of the resident and also affect the skin condition of the GT site. During a review of the facility's Policies and Procedures (P&P) titled Enteral Feeding Supplies ([NAME] Valve), Sanitization of Reusable, revised 3/2015, the P&P indicated, The purpose of this procedure was to guide the proper sanitizing of reusable enteral feeding supplies (Lopez valve) and to cover/cap the Lopez valve port after use. During a review of the facility's P&P titled Gastrostomy/Jejunostomy Site Care revised 10/2025, the P&P indicated, The purpose of this procedure was to promote cleanliness and to protect the gastrostomy or jejunostomy sites from irritation, breakdown and infection. During a review of the facility's P&P titled Quality of Life revised 2/2020, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feelings of self-worth and self-esteem. b. During a review of Resident 27's AR, the AR indicated Resident 27 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (sudden decline in brain function caused by chemical imbalance in the body) and dementia (a progressive state of decline in mental abilities). During a review of Resident 27's History and Physical (H&P) dated 1/4/2026, the H&P indicated Resident 27 could make needs known but could not make medical decisions. During a review of Resident 27's MDS dated [DATE], the MDS indicated Resident 27 had severely impaired cognition (ability to understand). The MDS indicated Resident 27 required setup assistance with eating. The MDS indicated Resident 27 required moderate assistance (helper did less than half the effort) with oral hygiene, toilet hygiene, personal hygiene, and bed-to-chair transferring. The MDS indicated Resident 27 required maximal assistance (helper did more than half the effort) with showering/bathing. During a concurrent observation and interview on 1/27/2026 at 9:24 AM with Resident 27, the IS mouthpiece was placed on the flat top surface of the resident's nightstand. Resident 27 stated Resident 27 used the IS for breathing exercises daily. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 1/27/2026 at 12:38 PM, at Resident 27's bedside, the IS mouthpiece was placed on the flat top surface of the resident's nightstand. During a concurrent observation and interview on 1/28/2026 at 1:44 PM with the Infection Preventionist Nurse (IPN) at Resident 27's bedside, the IS mouthpiece was on the flat top surface of the resident's nightstand. The IPN stated Resident 27's IS mouthpiece should be placed in a bag to prevent infection. The IPN stated the licensed nurse was responsible for keeping the IS mouthpiece away from dirty surface. During an interview on 1/30/2026 at 8:46 AM with the Director of Nursing (DON), the DON stated Resident 27's IS mouthpiece should not be touching the top surface of the table or nightstand due to the risk of respiratory infection. The DON stated the IS mouthpiece should be stored in a plastic bag. The DON stated the licensed nurse should change and date the plastic bag every seven days and as needed. During a review of the facility's P&P titled Incentive Spirometer, revised 10/2024, the P&P indicated The incentive spirometer shall be stored in a designated plastic bag when not in use. c. During a review of Resident 43's AR, the AR indicated Resident 43 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including respiratory failure with hypoxia (lungs could not get enough oxygen into the blood) and muscle weakness. During a review of Resident 43's H&P dated 9/20/2025, the H&P indicated Resident 43 had the capacity to understand and make decisions. During a review of Resident 43's MDS dated [DATE], the MDS indicated Resident 43 had moderately impaired cognition. The MDS indicated Resident 43 required maximal assistance with eating, oral hygiene, and personal hygiene. The MDS indicated Resident 43 was dependent (helper did all the effort) on staff with toileting hygiene, showering/bathing, and bed-to-chair transferring. During a review of Resident 43's Order Summary Report (OSR) with active orders as of 1/28/2026, the OSR indicated Resident 43 had an order for continuous oxygen via nasal cannula (NC) for shortness of breath (SOB), starting on 1/6/2026. During an observation on 1/27/2026 at 10:11 AM at Resident 43's bedside, the NC storage bag was not dated. During an observation on 1/27/2026 at 12:43 PM at Resident 43's bedside, the NC storage bag was not dated. During a concurrent observation and interview on 1/28/2026 at 1:44 PM with the IPN at Resident 43's bedside, the NC storage bag was not dated. The IPN stated the designated certified nurse assistant (CNA) should date and change the NC storage bag every seven days or as needed to ensure the NC storage bag was not dirty for infection control. The IPN stated residents could get respiratory infection from contaminated items. During an interview with on 1/30/2026 at 8:46 AM with the DON, the DON stated the designated CNA should have dated the NC storage bag for infection control. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled Oxygen Administration, revised 1/28/2026, the P&P indicated the NC storage plastic bag will be dated. d. During a review of Resident 61's AR, the AR indicated Resident 61 was admitted to the facility on [DATE] with diagnoses including urinary tract infection (UTI- an infection in the bladder/urinary tract) and benign prostatic hyperplasia (BPH, the prostate gland was enlarged but not cancerous, which made it hard to urinate). During a review of Resident 61's H&P dated 1/27/2025, the H&P indicated Resident 61 had the capacity to understand and make decisions. During a review of Resident 61's OSR with active orders as of 1/28/2026, the OSR indicated Resident 61 had an order of FC for obstructive uropathy (urine flow was blocked), starting on 1/26/2026. During a review of Resident 61's Care Plan (CP) for FC initiated on 1/26/2026, the CP goal indicated Resident 61 would not show signs or symptoms of urinary infection. During an observation on 1/27/2026 at 9:40 AM at Resident 61's bedside, the FC drainage bag was touching the floor. During a concurrent interview and picture review on 1/28/2026 at 1:44 PM with the IPN, the picture dated 1/27/2026 at 9:44 AM was reviewed. The IPN stated the picture indicated the FC drainage bag was touching the floor. The IPN stated the FC drainage bag should not be touching the floor for infection control. The IPN stated there should be a basin holding the FC drainage bag. The IPN stated the floor was dirty and bacteria could get into the resident's urinary system causing infection. The IPN stated nursing staff (in general) was responsible for ensuring the FC drainage bag was not touching the floor. During an interview on 1/30/2026 at 8:46 AM with the DON, the DON stated all staff should ensure the FC drainage bag was not touching the floor throughout the shift for infection control. During a review of the facility's P&P titled Catheter Care, Urinary, revised 9/2024, the P&P indicated to keep the catheter drainage bag off the floor.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain a signed Informed Consent (IC-ethical and legal process where a resident voluntarily confirms willingness for a procedure after being informed of relevant risks, benefits, and alternatives) from the resident's responsible party (RP) prior to the administration of Mirtazapine (medication used to treat depression [mood disorder causing persistent sadness]) 7.5 milligram (mg- unit of measurement), for one of one sampled resident (Resident 59). This deficient practice violated Resident 59 and the RP's right and had the potential for Resident 59 to receive medication against Resident 59 or Resident 59's RP's will. Findings: During a review of Resident 59's admission Record (AR), the AR indicated Resident 59 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (lung diseases that block airflow) and depression. During a review of Resident 59's History & Physical (H&P) dated 12/19/2025, the H&P indicated Resident 59 did not have the capacity to make medical decisions. During a record review of Resident 59's Order Summary (OS) dated with active orders as of 12/27/2025, the OS indicated for licensed staff to administer Mirtazapine 7.5mg, one time a day (QD), by mouth (PO), for depression manifested by (m/b) poor PO intake. During a review of Resident 59's Minimum Data Set (MDS, a resident assessment tool) dated 12/29/2025, the MDS indicated Resident 59 had severely impaired cognition (ability to understand and process thoughts) and was dependent on Activities of Daily Living (ADLs). During a review of Resident 59's Care Plan (CP) for antidepressant medication initiated on 12/29/2025, the CP indicated to educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of and to specify anti-depressant drugs being given. During a record review on 1/29/2026 at 12:27 p.m. of Resident 59's IC dated 12/19/2025, the IC for Mirtazapine 7.5 mg was not signed by Resident 59 nor Resident 59's RP. During a concurrent interview and record review on 1/30/2026 at 10:20 a.m. of Resident 59's IC, with Registered Nurse 1 (RN 1), RN 1 stated the IC dated 12/19/2025 was signed with the Nurse's signature who received the order. RN 1 stated the Physician (MD) notifies the family and the family or resident or RP was required to sign the IC. RN 1 stated Resident 59's IC was not complete. During an interview on 1/30/2026 at 10:32 a.m. with the Director of Nursing (DON), the DON stated Resident 59's IC was not signed and the IC was not complete. The DON stated it was important to obtain a signed and complete IC so that the facility's licensed staff could administer medications. During a review of the facility's Policy and Procedure (P&P) titled, Informed Consent for Psychotherapeutic Medications, revised November 2025, the P&P indicated the Physician/Licensed Practitioner is responsible for obtaining informed consent for the use of psychotherapeutic drugs. The Physician or Licensed Practitioner shall examine the resident and obtain informed consent from the resident or the resident's representative.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the notice of discharge to the Ombudsman (an advocate for residents of nursing homes) in a timely manner for one of one sampled resident (Resident 57). This deficient practice increased the risks of unsafe discharge and violation of Resident 57's rights. Findings: During a review of Resident 57's admission Record (AR), the AR indicated Resident 57 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (brain problem caused by body chemistry) and lack of coordination. During a review of Resident 57's Minimum Data Set (MDS, a resident assessment tool) dated 12/24/2025, the MDS indicated Resident 57 had severely impaired cognition (ability to understand). The MDS indicated Resident 57 was dependent (helper did all the effort) on staff with eating, oral hygiene, personal hygiene, toileting hygiene, showering/ bathing, and transferring. During a review of Resident 57's Physician Order (PO) dated 1/4/2026, the PO indicated to transfer Resident 57 to General Acute Care Hospital 2 (GACH 2) on 1/4/2026 for evaluation. During a review of Resident 57's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there was a change of condition among the residents) dated 1/4/2026, the SBAR indicated Resident 57 was transferred to GACH 2 for further evaluation on 1/4/2026 due to congestion and distress. During a review of Resident 57's Notice of Proposed Transfer/Discharge (NPTD) dated 1/4/2026, the NPTD indicated the copy of Resident 57's NPTD was provided to the Ombudsman on 1/13/2026. The NPTD indicated Resident 57's Responsible Party 1(RP 1) was notified on 1/4/2026. During a review of Resident 57's History and Physical (H&P) dated 1/19/2026, the H&P indicated Resident 57 did not have the capacity to understand and make decisions. During an interview on 1/29/2026 at 11:44 AM with Licensed Vocational Nurse 1(LVN 1), LVN 1 stated the social service department would fax the NPTD to the Ombudsman after transferring a resident. LVN 1 stated the purpose was to inform the Ombudsman that the facility transferred out the resident and where the resident was discharged . LVN 1 stated it was important to provide the NPTD to the Ombudsman in a timely manner because the Ombudsman needed to know the transfer reason. LVN 1 stated the Ombudsman protect the residents. LVN 1 stated the Ombudsman should be notified within a day of transfer because the resident sometimes return to the facility within the same day of transfer. LVN 1 stated, for Resident 57, it was late to notify the Ombudsman on 1/13/2026 when Resident 57 was transferred to GACH 2 on 1/4/2026. LVN 1 stated it affected the continuity of Resident 57's care. LVN 1 stated the licensed nurse, who transferred Resident 57 on 1/4/2026 should have faxed the NPTD to the Ombudsman on the day of transfer or the following day if the social service was not available during the weekend. During a concurrent interview and record review on 1/29/2026 at 12:29 PM with Social Service Director (SSD), Resident 57's NPTD dated 1/4/2026 was reviewed. Resident 57's NPTD indicated the copy was provided to the Ombudsman on 1/13/2026. The SSD stated the copy of Resident 57's NPTD was provided late to the Ombudsman on 1/13/2026. The SSD stated the SSD should have faxed the NPTD to the Ombudsman the following business day of the transfer. The SSD stated it was important to fax the NPTD to notify the Ombudsman of the resident's whereabout immediately. The SSD stated the Ombudsman was an advocate for the residents. During an interview on 1/30/2026 at 8:46 AM with the Director of Nursing (DON), the DON stated the SSD should fax the NPTD to the Ombudsman within 24 hours of transferring a resident because it was the regulation to notify the Ombudsman timely. The DON stated it violated the regulation when the NPTD was not faxed to the Ombudsman timely. The DON stated it was not acceptable to fax the NPTD to the Ombudsman on 1/13/2026 when Resident 57 was transferred to GACH 2 on 1/4/2026. During a review of the facility's Policy & Procedure (P&P) titled Transfer or discharge, facility-initiated, dated 2001, the P&P indicated the NPTD should be provided to the Ombudsman when practicable.		

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NAME OF PROVIDER OR SUPPLIER Baldwin Gardens Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 10786 Live Oak Avenue Temple City, CA 91780	
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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete a Significant Change - Minimum Data Set (MDS - a comprehensive assessment and care screening tool) assessment for one of one sampled resident (Resident 51). The resident was readmitted from the hospital with an indwelling catheter (a flexible tube that's put into your bladder to drain urine into an external bag). This failure had the potential to affect the accuracy of the resident's assessment, care planning, and monitoring of the resident's needs. Findings: During a review of Resident 51's admission Record, the admission record indicated Resident 66 was admitted to the facility on [DATE]. Resident 66's diagnoses included but are not limited to polyneuropathy, urinary tract infection (UTI- an infection in the bladder/urinary tract), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), depression (a serious mood disorder that causes persistent sadness and loss of interest in daily activities, affecting how a person thinks, feels, and behaves, and can lead to physical problems), obstructive and reflux uropathy (a blockage in your body that makes it difficult or impossible to pee), and anxiety disorder. During a review of Resident 51's MDS, dated [DATE], the MDS indicated Resident 51 was cognitively intact. Resident 51's was dependent for toileting hygiene, lower body dressing, and chair/bed-to-chair transfer. The MDS indicated Resident 51 did not have an indwelling catheter. During a review of Resident 51's nursing progress notes, dated 05/14/2025, the progress notes indicated Resident 51 was sent to the hospital for abdominal pain. During a review of Resident 51's Admission/Readmission/ Initial Assessment, dated 5/17/2025, the Admission/readmission Initial Assessment indicated Resident 51 was readmitted to the facility from the hospital with an indwelling catheter. During a review of Resident 51's Physician's Orders, dated 5/18/2025, Resident 51 had an order for an indwelling catheter for obstructive uropathy (a blockage in the urinary tract that hinders urine flow, causing urine to back up and potentially damage the kidneys) from 5/18/2025 to 1/22/2026. During a review of Resident 51's Treatment Administration Record (TAR), dated May 2025, the TAR indicated to secure Resident 51's indwelling catheter and monitor the drainage for signs of infection. During a review of Resident 51's MDS, dated [DATE], the MDS indicated Resident 51 had an indwelling catheter. During a review of Resident 51's medical records from May 2025 to January 2026, Resident 51's medical records did not indicate a Significant Change MDS was completed. During a concurrent interview and record review on 1/30/2026 at 9:12 a.m. with the MDS Coordinator, the RAI Manual, dated 10/2024 was reviewed. The RAI Manual indicated, a Significant Change Status Assessment (SCSA) is necessary when, it is determined that there has been a significant change (either improvement or decline) in a resident's condition from their baseline, the resident's condition is not expected to return to baseline within two weeks, and for a resident who frequently leaves and reenters the facility, and reentry is anticipated within the next 30 days. The MDS Coordinator stated, she thought a significant change MDS assessment was not completed for Resident 51 because the indwelling catheter did not impact Resident 51's activity of daily living. The MDS Coordinator stated, after reviewing the RAI Manual guidelines, a significant change in status assessment should have been made because Resident 51 came back with a significant condition that was a decline from the baseline. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated 2001, indicated, A significant change of condition is a major decline or improvement in the resident's status that: Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (in not self-limiting); Impacts more than one area of the resident's health status; Requires interdisciplinary review and/or revision to the care plan; and Ultimately is based on the judgement of the clinical staff and guidelines outlined in the Resident Assessment Instrument. During a review of the facility's P&P titled, Resident Assessment Instrument, dated 2001, indicated, the Assessment Coordinator must ensure that the Interdisciplinary (continued on next page)		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assessment Team conducts timely resident assessments and reviews on the following schedule within 14 days of the resident's admission to the facility and when there has been a significant change in the resident's condition.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set (MDS - a comprehensive assessment and care screening too) reflected the presence of an indwelling urinary catheter for one of one sampled resident (Resident 51). This failure had the potential to negatively affect the resident's care planning and clinical decision-making. Findings: During a review of Resident 51's admission Record, the admission record indicated Resident 66 was admitted to the facility on [DATE]. Resident 66's diagnoses included but are not limited to polyneuropathy, urinary tract infection (UTI- an infection in the bladder/urinary tract), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), depression (a serious mood disorder that causes persistent sadness and loss of interest in daily activities, affecting how a person thinks, feels, and behaves, and can lead to physical problems), obstructive and reflux uropathy (a blockage in your body that makes it difficult or impossible to pee), and anxiety disorder. During a review of Resident 51's MDS, dated [DATE], the MDS indicated Resident 51 was cognitively intact. Resident 51's was dependent for toileting hygiene, lower body dressing, and chair/bed-to-chair transfer. The MDS did not indicate the resident had an indwelling catheter. During a review of Resident 51's Physician's Orders, dated 5/18/2025, the Physician's Orders indicated the resident had an indwelling catheter from 5/18/2025 to 1/22/2026. During a review of Resident 51's MDS, dated [DATE], the MDS indicated Resident 51 had an indwelling catheter. During a review of Resident 51's MDS, dated [DATE], the MDS indicated Resident 51 had did not have indwelling catheter. During a review of the Admission/readmission Initial Assessment, dated 6/27/2025, the Admission/readmission Initial Assessment indicated that Resident 51 had an indwelling catheter present on assessment for obstructive uropathy (a condition in which the flow of urine is blocked). During a review of Resident 51's MDS, dated [DATE], the MDS indicated Resident 51 had an indwelling catheter. During a concurrent interview and record review on 1/30/2026 at 9:12 a.m. with MDS Coordinator (MDS), Resident 51's Treatment Administration Record (TAR), dated June 2026 was reviewed. The TAR indicated, Resident 51 had an indwelling catheter on 6/24/2025. The MDS Coordinator stated that the MDS for 6/24/2025 for Resident 51 was not properly documented and no modification to the MDS was submitted or done. During a review of the of the facility's policy and procedure (P&P) titled, MDS Error Calculation, revised 9/2010, the P&P indicated if an error is found in a record that has already been accepted by the internet-based charting system, procedures must be implemented to either modify or deactivate the information in the system within 14 days from the discovery of the error.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain a physician's order regarding the use of incentive spirometer (IS, a tool that helped lungs breathe better) for one of one sampled resident (Resident 27). This violation had the potential to compromise Resident 27's health and safety. Findings: During a review of Resident 27's admission Record (AR), the AR indicated Resident 27 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (brain problem caused by body chemistry, often linked to respiratory infection [an illness affecting breathing]) and dementia (a progressive state of decline in mental abilities). During a review of Resident 27's History and Physical (H&P) dated 1/4/2026, the H&P indicated Resident 27 could make needs known but could not make medical decisions. During a review of Resident 27's Minimum Data Set (MDS, a resident assessment and care screening tool) dated 1/6/2026, the MDS indicated Resident 27 had severely impaired cognition (ability to understand). The MDS indicated Resident 27 required setup assistance with eating. The MDS indicated Resident 27 required moderate assistance (helper did less than half the effort) with oral hygiene, toilet hygiene, personal hygiene, and bed-to-chair transferring. The MDS indicated Resident 27 required maximal assistance (helper did more than half the effort) with showering/bathing. During a concurrent observation and interview on 1/27/2026 at 9:24 AM with Resident 27 at bedside, the IS mouthpiece was placed on the flat top surface of the nightstand. Resident 27 stated Resident 27 used the IS for breathing exercises daily. During an observation on 1/27/2026 at 12:38 PM at Resident 27's bedside, the IS mouthpiece was placed on the flat top surface of the nightstand. During a concurrent observation and interview on 1/28/2026 at 1:44 PM with the Infection Preventionist Nurse (IPN) at Resident 27's bedside, the IS mouthpiece was placed on the flat top surface of the nightstand. The IPN stated the IS was for Resident 27 to exercise breathing. During a concurrent interview and record review on 1/29/2026 at 3:35 PM with the IPN, Resident 27's active Order Summary Report (OSR) was reviewed. There was no physician's order for the use of IS. The IPN stated there should be a physician's order for the use of the IS prior to providing the IS to Resident 27. The IPN stated it was not acceptable to have the IS at Resident 27's bedside without a physician's order. The IPN stated the licensed nurse should follow up with the physician for the IS order for Resident 27. The IPN stated the licensed nurse should assess Resident 27 for any cough, respiratory distress, lung sounds, breathing, and oxygen saturation (the amount of oxygen in the blood). The IPN stated the licensed nurse should inform the physician about Resident 27's assessment and have the physician decide whether to continue the IS or not. During an interview on 1/30/2026 at 8:46 AM with the Director of Nursing (DON), the DON stated the licensed nurse should have obtained the physician's order prior to starting the IS treatment because it was the standard of nursing practice. The DON stated the licensed nurse should check the physician's order to ensure the order was current and active. During a review of the facility's Policy and Procedure (P&P) titled Incentive Spirometer, revised 10/2024, the P&P indicated to obtain a physician's order as needed for the IS. During a review of the facility's P&P titled Professional Standard of Care, revised 1/2025, the P&P indicated all employees should perform services in accordance with the accepted professional standard of care, ensuring competence, safety, and regulatory compliance.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review for one of three sampled residents (Resident 3), the facility failed to: a. Ensure the low air loss mattress (LALM - a specialty bed that alternates pressure to help heal and prevent pressure ulcers (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) was set accurately for Resident 3. b. Obtain a physician order for the use of LALM for Resident 3. These failures had the potential to impede healing and worsen Resident 3's wounds and cause further skin injuries. Findings: a. During a review of Resident 3's admission Record (AR), the AR indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) and dementia (a progressive state of decline in mental abilities). During a review of Resident 3's History and Physical (H&P) dated 6/28/2025, the H&P indicated Resident 3 did not have the capacity to make decisions. During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool) dated 12/22/2025, the MDS indicated Resident 3 had severely impaired cognition (ability to understand). The MDS indicated Resident 3 was dependent (helper did all the effort) on staff with oral hygiene, toileting hygiene, showering/ bathing, personal hygiene, and transferring. The MDS further indicated Resident 3 had eight pressure ulcers and was using a pressure reducing device for bed. During a review of Resident 3's Monthly Weight Report (MWR) dated 1/1/2026, the MWR indicated Resident 3 weighed 134 pounds (lbs.- unit of measurement to measure body mass). During a review of Resident 3's untiled Care Plan (CP) for skin impairment dated 1/26/2026, the CP indicated Resident 3 had LALM for skin management and the CP goal indicated Resident 3 would be free from skin injury. During a review of Resident 3's Order Summary Report (OSR) with active orders as of 1/29/2026, the OSR indicated a physician's order for licensed staff to monitor the LALM function and setting every shift starting on 1/28/2026. During an observation on 1/27/2026 at 9:53 AM in Resident 3's room, Resident 3 was lying on a LALM. The LALM weight setting was set at 200 lbs. During an observation on 1/27/2026 at 12:40 PM in Resident 3's room, Resident 3 was lying on a LALM. The LALM weight setting was set at 200 lbs. During a concurrent review and interview on 1/29/2026 at 10:19 AM with the facility's Wound Care Nurse 1 (WCN1), the pictures taken dated 1/27/2026 at 9:54 AM and 12:40 PM were reviewed. The pictures indicated Resident 3's LALM setting was set at 200 lbs. WCN 1 stated the LALM setting in the pictures was not the appropriate LALM setting according to Resident 3's weight of 134 lbs. WCN 1 stated the LALM would help with wound healing and should be set up according to resident's weight or preference. WCN 1 stated the LALM was firm when the setting was high, and would lose its purpose. WCN 1 stated WCN 1 would check with the responsible party (RP)'s preference for non-alert residents (in general). WCN 1 stated if the RP preferred the LALM to be firmer with the higher setting, WCN 1 would educate the risk and benefit and document on the nursing progress note as needed. WCN 1 stated there was no documentation indicating RP 2 preferred to have Resident 3's LALM setting at 200 lbs. WCN 1 stated the licensed nurse should monitor the resident's weight and the setting of LALM to ensure the resident's wound and skin integrity was not worsening. WCN 1 stated WCN1 checked the LALM setting during treatment. During an interview with the Director of Nursing (DON) on 1/30/2026 at 8:46 AM, the DON stated the LALM should be set according to the resident's weights when there was no documentation indicating the resident or the RP's preferences. During a review of the facility's Policy and Procedure (P&P), titled Specialty Mattress - Pressure Relieving Devices, revised on 1/2024, the P&P indicated staff were to follow the LALM manufacturer's user instructions for setup. During a review of Proactive medical products: Operator's Manual Item for Protekt Aire 4000DX/5000Dx, (undated), the LALM manual indicated the system was designed for prevention, treatment and management of pressure ulcers. The manual indicated to press the up or down buttons to select the correct patient weight. The manual indicated users could adjust air mattress to a desired (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	firmness according to patient's weight or the suggestion for a health care professional. b. During a concurrent record review and interview on 1/29/2026 at 10:19 AM with WCN 1, Resident 3's OSR with active orders as of 1/29/2026, were reviewed. The OSR indicated a physician's order for licensed staff to monitor the LALM function and setting every shift starting on 1/28/2026. WCN 1 stated there should be a physician order for the use of LALM before 1/28/2026 for Resident 3. WCN 1 stated the admission nurse or WCN 1 should have obtained a LALM order before placing Resident 3 on the LALM. During an interview with the DON on 1/30/2026 at 8:46 AM, the DON stated the licensed nurse should have obtained the physician's order prior to starting the LAL, because it was the standard of nursing practice. The DON stated the licensed nurse should check the physician's order to ensure the order was current and active. During a concurrent record review and interview with the DON on 1/30/2026 at 12 PM, the facility's P&P titled Pressure Ulcers/Skin Breakdown -Clinical Protocol, revised on 11/2025, was reviewed. The DON stated the P&P indicated staff were to obtain the physician order for the use of LALM.		