

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025
NAME OF PROVIDER OR SUPPLIER Fidelity Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 11210 Lower Azusa Rd. El Monte, CA 91731	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of nine sampled residents (Resident 1) was free from verbal and physical abuse (willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) according to the facility's policy and procedure (P&P) titled, Abuse Prevention. Resident 1 was yelled and scratched on the right hand by Resident 2, resulting in an open cut on Resident 1's right hand.</p> <p>This deficient practice resulted in Residents 1 to experience physical and verbal abuse from Resident 2.</p> <p>Findings:</p> <p>a. During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was readmitted to facility on 4/25/2024, with multiple diagnoses including osteoarthritis (joint disease) of both knees and anxiety (a feeling of worry, nervousness, or unease).</p> <p>During a review of Resident 1's History and Physical (H&P), dated 1/7/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 1/29/2025, the MDS indicated Resident 1 was moderate cognitive impairment (noticeable decline in thinking) and needed moderate assistance (helper did half the work) wit toilet and personal hygiene, upper and lower body dressing and transfer from chair/bed-to-chair.</p> <p>A review of Resident 1's Care Plan (CP) titled, Resident Care Plan, dated 3/4/2025, the CP indicated Resident 1 had an Allegation of Resident-to-Resident Altercation (with Resident 2).</p> <p>During a review of Resident 1's Physician Order (PO), dated 3/4/2025 at 9 am, the PO indicated to cleanse Resident 1's right hand with normal saline, pat dry, apply bacitracin (an antibiotic) ointment, cover with dry dressing every shift for 21 days.</p> <p>During a review of Resident 1's Progress Notes (PN), dated 3/4/2025 at 3:47 pm, the PN indicated Resident 1 was noted with 0.1 centimeter (cm- unit of measurement) by 0.1 cm scratch on Resident 1's right hand.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 3/6/2025 at 12:15 pm, with Resident 1, Resident 1 had an open wound with exposed pink tissue on the top portion of Resident 1's right hand. Resident 1 stated on 3/4/2025, at around 3 am (could not remember exact time), Resident 1 and Resident 2 had a verbal disagreement regarding having the room light on. Resident 1 stated later that day at around 8 am, while the housekeeper was cleaning the room, Resident 2 approached Resident 1. Resident 1 stated Resident 2 screamed and yelled and hit me on the hand.</p> <p>b. During a review of Resident 2's AR, the AR indicated Resident 2 was admitted to the facility on [DATE], and was readmitted on [DATE], with diagnoses that included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and depression (causes feelings of sadness and/or a loss of interest in activities once enjoyed).</p> <p>During a review of Resident 2's physician order (PO), dated 2/2/2025, the PO indicated for staff to monitor Resident 2 for aggressive behavior manifested by hitting and pinching staff.</p> <p>During a review of another PO for Resident 2, dated 2/2/2025, the PO indicated for staff to place Resident 2 on one-to-one (1:1 - one staff member continuously observes and is immediately available to one patient) monitoring (indication not specified).</p> <p>During a review of Resident 2's MDS, dated [DATE], the MDS indicated the resident was cognitively intact, had clear speech, and the ability to understand and be understood. The MDS indicated Resident 2 needed maximal assistance with chair/bed- to- chair transfers.</p> <p>During a review of Resident 2's H&P, dated 2/27/2025, indicated Resident 2 had the capacity to make medical decisions.</p> <p>A review of Resident 2's CP titled, Resident Care Plan, dated 3/4/2025, the CP indicated the resident had an Allegation of resident (Resident 2) scratching another resident (Resident 1).</p> <p>During a review of Resident 2's 1:1 Monitoring Log (ML), dated 3/4/2025, indicated at 8 am, Resident 2's observation on resident's activity indicated Resident 2 went to the room, having conversation with Resident 1. The ML indicated no nurses initial was documented between the hours of 7:30 am to 8 am.</p> <p>During a concurrent observation and interview on 3/6/2025 at 12:32 pm, with Resident 2, Resident 2 was sitting in Resident 2's wheelchair, moving around the room independently. Resident 2 stated on 3/4/2024 at around 8 am while housekeeping was cleaning the room, Resident 2 told Resident 1 to stay in bed and (Resident 1) cannot use the restroom because the lady was cleaning. Resident 2 stated Resident 1 was sitting in the wheelchair next to her (Resident 2's) bed. Resident 2 stated Resident 2 told Resident 1 to move because they are going to mop the room. Resident 2 stated Resident 1 went to the restroom. Resident 2 stated Resident 2 did not touch Resident 1.</p> <p>During an interview on 3/6/2025 at 12:49 pm, with Resident 3, Resident 3 stated on 3/4/2025 (unable to recall time), while waiting for housekeeping to finish cleaning the room, Resident 3 was in the hallway and heard Resident 2 yell at Resident 1 inside the room. Resident 3 stated no staff was around to monitor the residents.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/6/2025 at 1:39 pm with CNA 3, CNA 3 stated CNA 3 was responsible for the one-to-one monitoring of Resident 2. CNA 3 stated on 3/4/2025, around 8 am, CNA 3 went and used the restroom without informing another staff member. CNA 3 stated CNA 3 should have informed the nurse in charge that CNA 3 had to use the restroom and not leave Resident 2 unattended.</p> <p>During an interview on 3/6/2025 at 2 pm with the Director of Nursing (DON), the DON stated Resident 1 had orders for one-to-one monitoring. The DON stated CNA 3 was the staff member assigned to (1:1) monitor Resident 2 and needed to inform another staff member prior to leaving Resident 2 unattended for safety concerns.</p> <p>During a review of the facility's P&P titled, Abuse Prevention, revised on 3/15/2018, the P&P indicated the facility shall upload resident rights to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntarily seclusion.</p> <p>During a review of the facility's P&P titled, One-on-One Monitoring Policy, dated 3/2018, the P&P indicated, the policy aims to ensure the safety, well-being, and quality of care for residents requiring individualized monitoring within the facility. The P&P indicated, Assigned staff: Designated staff members such as CNAs, shall be assigned to provide one-on-one monitoring to residents as ordered by healthcare providers . Continuous Supervision: Staff providing one-on-one monitoring shall maintain continuous visual supervision of the resident, remaining within close proximity to intervene promptly in the event of a safe concern or medical emergency.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>40913</p> <p>Based on interview and record review, the facility failed to implement its written policies and procedures for screening potential employees for a history of abuse, neglect, exploitation or misappropriation of property by failing to:</p> <ol style="list-style-type: none"> 1. Obtain information from previous employers and/or current employers for four out of four sampled employees (Certified Nursing Assistants [CNA] 1, 2, 3, and 4). 2. Inform the previous employer and/or current employer of facility's intention to make reasonable efforts to uncover information about any past criminal prosecutions, allegations of abuse, etc. <p>These deficient practices had the potential for residents to be exposed to abuse, neglect, exploitation or misappropriation of property from staff.</p> <p>Findings:</p> <p>During an interview on 3/7/2025 at 10:03 AM, with the Director of Staff Development (DSD), the DSD stated when completing reference checks, the DSD would ask the previous employer of the applicant/potential employee if the potential employee would be hireable or not and the DSD would write hireable or not hireable on the applicant's reference checks.</p> <p>During a concurrent interview and record review on 3/7/25 from 9:52 AM to 2:30 PM, with the DSD, five (5) employee files were reviewed. The employee files indicated the following:</p> <ol style="list-style-type: none"> a. Certified Nursing Assistant (CNA) 1 had one (1) reference check from the most current employer and the DSD had written on the Telephone Reference Check Form (TRCF) the DSD's name as the second reference. The DSD stated the DSD would only usually call for reference from the most recent employer. The DSD stated the DSD was the second reference because the DSD worked briefly with CNA 1 and CNA 1 had no performance issues at that time. b. CNA 2 had one reference check from Facility 1. The DSD stated the DSD would be the second reference because the DSD used to work with CNA 2 from Facility 1. The DSD did not call the past employer where CNA 2 worked from 2020 to 2021. CNA 2's TRCF did not indicate CNA 2's reason for separation from Facility 1, the most recent employer and did not indicate if CNA 2 was eligible for rehire. c. CNA 3 had one reference check. CNA 3's TRCF only had a written note hire. CNA 3's TRCF did not indicate if the second reference was contacted. The DSD stated the DSD wrote hire on one of the references and did not remember if the DSD called the second reference. d. CNA 4 had one reference check. The DSD stated CNA 4's TRCF only had a written note hire from one reference check. There was no second reference documented. The DSD stated the DSD wrote hire on one of the references and could not remember if she called the second reference. The DSD stated it was important to document any attempts to contact references for it would be hard to remember a few weeks or few months after. <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/7/2025 at 2:40 PM with the DSD, the DSD stated the facility needed more than one reference to verify and to find out how the potential employee performed as a CNA.</p> <p>During a concurrent interview and record review on 3/7/2025 at 3 PM, with the Administrator, the facility's policy and procedure (P&P) titled, Patient Abuse and Prevention was reviewed. The Administrator stated based on the facility's P&P, there needed to be at least two reference checks from the current and from the previous employer. The Administrator stated the DSD was responsible for screening potential employees. The Administrator stated the DSD needed to ask the previous employer for any allegations of abuse while working at the previous employer/facility.</p> <p>During a review of the facility's P&P titled Patient Abuse Prevention, dated 3/15/2018, the P&P indicated, it is the responsibility of the facility staff (i.e. Administrator, Department Supervisors, etc.) to call at least one of the previous employers and current employers and inform them of the potential hiring of the employee. The P&P indicated, .c. Inform the previous employer and/or current employer of facility's intention to make reasonable efforts to uncover information about any past criminal prosecutions, allegations of abuse, etc .</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108</p> <p>Based on observation, interview, and record review, the facility failed to report an allegation of abuse to the California Department of Public Health (CDPH- a government agency that promotes and protects the health of all people and their communities), the police department and the Ombudsman (advocates for residents of nursing homes) within the two-hour time frame as indicated in the facility's policy and procedure (P&P) titled, Abuse Prevention. On 3/6/2025, Resident 5 reported to the Social Services Assistant (SSA) that Resident 6 hit Resident 5.</p> <p>This deficient practice had the potential to compromise the safety of Resident 5 and exposed Resident 5 to further physical, mental, and emotional abuse.</p> <p>Findings:</p> <p>a. During a review of Resident 5's Admission Record (AR), the AR indicated Resident 5 was readmitted to the facility on [DATE], with diagnoses that included diabetes (elevated blood sugar in the blood), hypertension (elevated blood pressure), and abnormalities in gait and mobility (walking).</p> <p>During a review of Resident 5's History and Physical (H&P), dated 2/10/2025, the H&P indicated Resident 5 had the capacity to understand and make decisions.</p> <p>During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 2/6/2025, the MDS indicated Resident 5 was cognitively (intellectual activity such as thinking, reasoning, or remembering) intact, had clear speech, had the ability to express ideas and wants, and had the ability to understand others. The MDS indicated Resident 5 required partial/moderate assistance (helper does less than half the effort) with oral, toileting, and personal hygiene, lower/upper body dressing, and putting on/taking off footwear. The MDS indicated Resident 5 required supervision/touching assistance with walking.</p> <p>b. During a review of Resident 6's AR, the AR indicated Resident 6 was readmitted to the facility on [DATE], with diagnoses that included schizophrenia (a mental disorder effecting how a person thinks and feels) and diabetes (elevated blood sugar).</p> <p>During a review of Resident 6's H&P, dated 11/11/2024, the H&P indicated Resident 6 had the capacity to make medical decisions.</p> <p>During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 2 was moderately cognitively impaired, had clear speech, usually had the ability to express ideas and wants and usually had the ability to understand others. The MDS indicated Resident 6 was independent (no assistance) with eating, toileting hygiene, dressing, transfers (ability to get in and out of a chair), and walking.</p> <p>During an interview on 3/6/2025 at 1:10 pm with Resident 5, Resident 5 stated about two to three weeks ago, Resident 6 hit Resident 5 in the arm. Resident 5 stated she reported the incident to the Social Services Assistant (SSA).</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the on 3/7/2025 at 1:22 pm with the SSA, the SSA stated on 3/6/2025 in the morning (could not remember exact time), Resident 5 was screaming, Get away from me! to Resident 6. Resident 5 was yelling, I don't like to see him (Resident 6) because he hit me 2-3 weeks ago. The SSA stated Resident 6 often swung Resident 6's arms when walking and Resident 6 did not intentionally hit Resident 5. The SSA stated Resident 5 often overreacts and calls 911 for every little thing. The SSA stated the SSA did not tell anyone about Resident 5's allegation of Resident 6 hitting Resident 5. The SSA stated it was important to report any alleged abuse to determine what really happened and for it (abuse) not to happen again and to find a solution to not to let it happen again.</p> <p>During an interview on 3/7/2025 at 3:37 pm, with the Director of Staff Development (DSD), the DSD stated reporting allegations of abuse was very important because it could help the resident and could further prevent abuse. The DSD stated abuse did not have to be witnessed and could be alleged (hear say). The DSD stated reporting abuse to the Administrator (ADM, the facility's abuse coordinator) within two hours was important because we were all (staff) mandated (legally required to report suspected or known cases of abuse) reporters.</p> <p>During an interview on 3/6/2025 at 4:49 pm with Licensed Vocational Nurse (LVN) 1, LVN 1 stated abuse needed to be reported within two hours to the physician and the ADM to prevent further abuse.</p> <p>During an interview on 3/6/2025 at 5:25 pm with the ADM, the ADM stated all staff were mandated reporters and any allegation of abuse needed to be reported within two hours. The ADM stated it was the facility's policy and the law (custom or practice of a community) to report any allegation of abuse to protect the residents.</p> <p>During a review of the facility's P&P titled, Abuse Prevention, revised on 3/15/2018, the P&P indicated, The facility shall upload resident rights to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntarily seclusion. The P&P indicated, Facility shall ensure reporting of all alleged and/or substantiated violation to the stated agency and all other agencies as required necessary corrective actions based on the result of the investigation. The facility shall report the incident by following the mandated reporter grid. The Administrator and Director of Nurses, in the order written, shall report incidents of suspected abuse to the following agencies within two (2) hours of occurrence:</p> <ul style="list-style-type: none"> - Department of Health - Licensing and Certification - LTC (Long-Term Care) Ombudsman or designee . <p>During a review of the facility's Lesson Plan (LP) titled Reporting Abuse - Altercation Resident to Resident, an in-service attended by SSA, dated 3/4/2025, the LP indicated all staff were mandated reporters and to report abuse right away- within two hours.</p>		