STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555088	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fidelity Health Care	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 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 observation, interview, and record review, the facility failed to protect the residents' right to be free from verbal, mental(emotional) and physical abuse for two of three sampled residents (Residents 1 and 2).This deficient practice resulted in Resident 1 being subjected to physical abuse and Resident 2 being subjected to verbal and mental abuse. Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), Chronic atrial fibrillation (AFib- a condition where the upper chambers of the heart (atria) beat irregularly and rapidly), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control). During a review of Resident 1's Nursing admission Assessment (NAA) dated 1/17/25, the NAA indicated Resident 1had clear speech, normal hearing, and level of consciousness was oriented, awake/alert and confused. During a review of Resident 1's History and Physical (H&P) dated 1/18/25, the H&P indicated Resident 1 had the capacity to understand and make medical decisions. During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 7/28/25, the MDS indicated Resident 1 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 1 was independent in eating, oral hygiene, toileting hygiene, shower/bathe self, upper/lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 1's Physician Orders (POs), the POs indicated the following orders:1. Monitor behavior manifested by verbally abusive to staff every shift and tally by hashmark (Order date: 4/8/25).2. Monitor any signs of emotional or psychological distress every shift (Start date: 9/5/25).3. Scratch on neck - Cleanse with Normal Saline. Pat dry, apply bacitracin ointment every day shift for 14 days (Start date: 9/5/25). During a review of Resident 2's AR, the AR indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included other intervertebral disc degeneration, thoracic region and primary osteoarthritis, right hand (two separate conditions: degenerative disc disease in the mid-back (thoracic region) and primary osteoarthritis in the right hand which are both age-related wear and tear conditions), COPD and DM. During a review of Resident 2's NAA dated 3/9/23, the NAA indicated Resident 2 had clear speech, normal hearing, and level of consciousness was oriented, and awake/alert. During a review of Resident 2's H&P dated 2/28/25, the H&P indicated Resident 2 had the capacity to understand and make medical decisions. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had intact cognition for daily decision making. The MDS indicated Resident 2 was independent with eating and required set-up or clean-up assistance with oral hygiene, toileting hygiene, upper/lower body dressing, putting on/taking off footwear and personal hygiene; supervision was required for shower/bathe self. During a review of Resident 2's Physician Orders (POs), the POs indicated the following orders:1. Monitor behavior manifested by verbally abusive to staff every shift, tally by hash marks (Start date: 12/1/24).2. Monitor episodes of hallucination (seeing, hearing, smelling, tasting, feeling things that are not present), memory loss, aggressiveness, violent behavior, dizziness, headache, shortness of breath, restlessness every shift, tally by hash marks (Start date: 12/1/24).3. Monitor episodes of hitting another resident every shift, tally by hash marks (Start date: 12/1/24).4. Monitor behavior m/b yelling and screaming at staff every shift Tally by hash marks (Start date: 12/1/24). During a review of Resident 1's Change of Condition (COC)/Interact Assessment Form (SBAR, a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains) dated 9/5/25, the COC indicated on 9/5/25 Resident 1 stated, I was leaving Nursing Station 2 from signing out for OOP (temporarily absent from the facility, or Out on Pass), then I was coming back to my room down the hallway, I saw [former resident's name], the ex-patient, was in Resident 2's room when he exited, I said, Hello [former resident's name] , how are you doing? and then Resident 2 stated, He needs to put some [f-king] socks in his mouth so he can shut up. Resident 2 was in the wheelchair, in the middle of the hallway with [former resident's name], so I passed her [Resident 2] up cause she was cursing me out and taking long to move out of the way, so I turned around and she [Resident 2] got up from her wheelchair, and put both hands behind my back and she [Resident 2] grabbed by my neck and choked me, and then she socked me on the right cheek, and she punched me in my stomach too. She [Resident 2] then said, I don't give a damn. then I walked away towards my room. The COC further indicated the charge nurse (CN) was sitting at Nursing Station 2 and heard yelling down the hallway and CN