

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 03/20/2026
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interview and record review, the facility failed to provide adequate supervision to prevent falls for one of three sampled residents (Resident 1) who was identified as a high risk (high possibility of happening) for a fall, by failing to monitor Resident 1's location as often as possible. This failure had the potential to result in Resident 1 falling and sustaining injuries. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 3/12/2026, with diagnoses which included dementia (a progressive state of decline in mental abilities), major depressive disorder (a serious mental health condition that causes a persistent feeling of sadness and loss of interest), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 1's untitled care plan (CP), dated 3/12/2026, the CP indicated Resident 1 was at high risk for injury, accidents, and falls related to fall risk. The care plan goal indicated Resident 1 would have no injuries/accidents or falls in the next 3 months. The care plan interventions included maintaining a safe and hazard free environment, placing the bed in low position with bilateral floor mat to reduce the risk of injury related to fall risk, and to monitor residents' location as often as possible. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 3/14/2026, the MDS indicated Resident 1's cognitive skills (mental process of thinking and understanding) for daily decision-making was moderately impaired. The MDS also indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) and required supervision or touching assistance (helper provides verbal cues and/or touching, steadying and/or contact guard assistance as resident completes activity) for transfers and walking. During a review of Resident 1's Fall Risk Evaluation (FRE - tool that predicts the likelihood that a resident will fall), dated 3/12/2026, the FRE indicated Resident 1 had intermittent confusion, had balance problems while standing and while walking, had decreased muscular coordination, had gait problems, and required the use of assistive devices. The FRE also indicated Resident 1 had 3 or more predisposing diseases (diseases that make the resident more likely to fall). The FRE indicated a total score of 10 or above represents high risk for a fall. Resident 1's total FRE score was 20. During a phone interview with Family Member (FM) 1 on 3/20/2026 at 10:10 AM, FM 1 stated when FM 1 visited the facility on 3/14/2026, Resident 1 was walking alone in the hallway without staff supervision and there were no staff (in general) present in the immediate area monitoring Resident 1. FM 1 stated FM 1 attempted to locate staff (in general) and when FM 1 encountered a certified nursing assistant (CNA) (unidentified) and informed the CNA Resident 1 was walking alone, the CNA did not immediately intervene. During an interview on 3/20/2026 at 2:45 PM with CNA2, CNA 2 stated CNA 2 took care of Resident 1 on 3/14/2026. CNA 2 stated CNA 2 was covering the break of the CNA (unidentified) assigned to the dining area during the shift. CNA 2 stated that while covering the dining area, CNA 2 was unable to visually observe all the residents. CNA 2 stated she did not observe Resident 1 when Resident 1 was ambulating in the hallway on 3/14/2026. During an interview on 3/20/2026 at 2:45 PM with Registered Nurse 1 (RN 1), RN 1 stated monitoring of residents was conducted through frequent checks and staff awareness. RN 1 stated monitoring was not continuous. (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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>RN 1 stated RN 1 was on break on 3/14/2026 at the time the concern (Resident 1 walking unsupervised) was reported. RN 1 stated Resident 1 was new to the facility and staff may not have been fully familiar with Resident 1's needs at that time. During an interview on 3/20/2026 at 3:20 PM with Director of Nursing (DON), DON stated staff were expected to follow care plans and provide monitoring. DON stated Resident 1 was alert but confused, ambulatory, and required assistance with walking. During a review of facility's Policy and Procedure (P&P) titled, Fall Prevention Falling Star Program, revised on 9/19, the P&P indicated residents identified as at risk for falls are to be monitored closely. The policy further indicated that staff are to observe residents for ambulation and attempts to transfer and provide supervision and assistance as needed.</p>		