

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

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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 07/21/2026
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)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that Resident 1 received treatment and care in accordance with professional standards of practice for one of two sampled residents (Resident 1) by: Failure to follow the physician's order regarding medication parameters for an antiarrhythmic (used to prevent, treat, or stop abnormal and irregular heart rhythms), alpha-beta blocker (used for combined effect on vessels and heart rate), and loop diuretic (increase urine output) when Resident 1's blood pressure reading was too low. Failure to follow the facility's policies and procedures (P&P) for change of condition and care plan revision to timely monitor and document assessments and interventions for Resident 1. These deficient practices had the potential to negatively affect the delivery of care and services for Resident 1. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), essential (primary) hypertension (abnormally high blood pressure), and unspecified atrial flutter (a heart rhythm problem where the upper chambers of the heartbeat too fast). During a review of Resident 1's History and Physical (H&P) dated 6/26/26, the H&P indicated Resident 1 has the capacity to understand and make decisions. During a review of Resident's 1's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 7/2/26, 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 required supervisions with eating, and substantial/maximal assistance with 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 Weights and Vitals Summary for 6/1/26 - 7/31/26, the summary indicated the blood pressure readings were as follows: 6/26/26 at 9:21 a.m., 108/86 mmHg (Sitting, right arm) 6/27/26 at 9:58 a.m., 106/60 mmHg (Sitting, right arm) 6/29/26 at 10:28 a.m., 108/64 mmHg (Sitting, right arm) 7/6/26 at 9:18 a.m., 98/70 mmHg (Sitting, right arm) 7/11/26 at 10:38 a.m., 108/60 mmHg (Sitting, right arm) 7/14/26 at 10:27 a.m., 104/70 mmHg (Sitting, right arm) 7/15/26 at 9:55 a.m., 102/60 mmHg (Sitting, right arm) During a review of Resident 1's Medication Administration (MAR) for the month of June 2026, the MAR indicated Resident 1 was prescribed Amiodarone (antiarrhythmic), Carvedilol (alpha-beta blocker), and Furosemide (loop diuretic); medications to treat irregular heart rhythms and hypertension, and for staff to monitor side effects related to hypotension (low blood pressure). The MAR indicated Amiodarone was not given within parameters/MD orders on 6/29/26. The MAR indicated Carvedilol was not given within parameters/MD orders on 6/26/26, 6/27/26 & 6/29/26. The MAR also indicated Furosemide was not given within parameters/MD orders on 6/26/26, 6/27/26 & 6/29/26. During a review of Resident 1's Medication Review Report for active physician orders for the month of June 2026, the report indicated the following: Amiodarone HCl Tablet (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	200 mg, give 1 tablet by mouth one time a day for A-FIB, hold if SBP <110 or AP <60, Start date 6/26/26.Carvedilol Tablet 6.25 mg, give 1 tablet by mouth two times a day for CHF, hold if SBP <110 or PR <60, take with food, Start date 6/26/26.Furosemide Tablet 40 mg, give 1 tablet by mouth one time a day for HTN, hold if SBP <110 or PR <60, Start date 6/26/26.During a review of Resident 1's Medication Administration (MAR) for the month of July 2026, the MAR indicated Amiodarone was not given within parameters/MD orders on 7/6/26, 7/11/26, 7/14/26 & 7/15/26. The MAR also indicated Furosemide was not given within parameters/MD orders on 7/6/26, 7/11/26, 7/14/26 & 7/15/26.During an interview with the Director of Nursing (DON) on 7/21/26 at 3:30 p.m., the DON stated for Amiodarone and Carvedilol, if parameters are not followed then the risk to Resident 1 was bradycardia or hypotension (which could result in a fall). The DON also stated that if parameters are not followed for Furosemide then the risk to Resident 1 is low blood pressure (which could result in a fall) or dehydration.During a review of the facility's Policy and Procedure (P&P) titled, Specific Medication Administration Procedures, updated, the P&P indicated, Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personal authorized to administer medications do so only after they have familiarized themselves with the medication.Obtain and record any vital signs as necessary, prior to medication administration.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a consistent and accurate account for Ozempic (medication to improve type 2 diabetes glycemic [blood sugar] control and reduce cardiovascular events such as heart attack or stroke) through staff documentation for one of two residents (Resident 1). This deficient practice resulted in the facility not providing Resident 1's scheduled dose on 7/4/26 and placed Resident 1 at risk for blood sugar fluctuations and less control over food cravings. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), essential (primary) hypertension (abnormally high blood pressure), and unspecified atrial flutter (a heart rhythm problem where the upper chambers of the heartbeat too fast). During a review of Resident 1's History and Physical (H&P) dated 6/26/26, the H&P indicated Resident 1 has the capacity to understand and make decisions. During a review of Resident's 1's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 7/2/26, 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 required supervisions with eating, and substantial/maximal assistance with 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 Medication Review Report for active physician orders for the month of June 2026, the report indicated the following: Ozempic (0.25 or 0.5 milligram (mg)/dose), subcutaneous solution pen-injector 2mg/1.5ml (Semaglutide), inject 2 mg subcutaneously one time a day every Saturday for cardiovascular event reduction, diabetes mellitus type 2, and morbid obesity. During a review of Resident 1's Medication Administration (MAR) for the month of July 2026, the MAR indicated Resident 1's Ozempic dose for 7/4/26 was coded 9 (Other/See Progress Notes). During a review of Resident 1's handwritten Nursing Progress Notes, dated 7/4/26 at 9:00 a.m., the note indicated Ozempic is not administered because it was not available. No harm to the resident. Resident 1's Physician was aware and the re-ordered was sent to the pharmacy. During a review of Resident 1's Change of Conditions for the month of July 2026, there was no documentation in Resident 1's medical record indicating Resident 1's Ozempic medication was missing, and Resident 1 did not receive the scheduled dose on 7/4/26. During an interview with Registered Nurse 1 (RN 1) on 7/21/26 at 11:40 a.m., RN 1 stated the facility received Resident 1's Ozempic medication on 6/30/26. During an interview with RN 1 on 7/21/26 at 12:15 p.m., RN 1 stated she had to re-order Resident 1's Ozempic medication because it was missing on 7/4/26. During an interview with RN 1 on 7/21/26 at 2:50 p.m., RN 1 confirmed there was no change of condition for Resident 1 indicating the Ozempic medication dose was not given on 7/4/26. RN 1 stated, The nurse has 72 hours to indicate a change of condition or update the plan of care. RN 1 stated she did not know why there was no updated care plan or change of condition documentation. During an interview with the DON on 7/21/26 at 3:30 p.m., the DON stated there was no change of condition completed for Resident 1 because the change of condition for Resident 1 on 7/4/26 did not fall under the facility's policy items listed on page 1 of the Change of Condition policy. The DON further stated she updated Resident 1's care plan on 7/21/26 with the following: Ozempic medication was missed on 7/4/26. No harm on the part of the resident. During an interview with the Pharmacy Technician 1 (Pharm 1), on 7/21/2026, at 4:45 pm, Pharm 1 stated (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1's Ozempic medication was sent on 6/26/26 to the facility. On 6/30/26, the facility contacted the pharmacy and informed the pharmacy the facility could not find the medication. Pharm 1 stated the pharmacy re-ordered the Ozempic medication (after receiving approval from the facility) and the medication was sent to the facility on 7/7/26. During a review of the facility's Policy and Procedure (P&P) titled, Medication Count Policy, revised October 2017, the P&P indicated, Purpose: To ensure the accurate accountability, security, and documentation of medications, particularly controlled substances, and to promote resident safety and regulatory compliance. The P&P further indicated, Any discrepancy in the medication count must be reported immediately to the charge nurse or supervisor. Medications will be stored in locked medication carts or cabinets with access limited to authorized personnel. Count records must be maintained accurately, legibly and completely. During a review of the facility's Policy and Procedure (P&P) titled, Change of Condition, effective August 2005, the P&P indicated, Objective: To ensure proper assessment and follow through for any resident with a condition change. The P&P further indicated, Procedure: When a resident's condition change for any reason, this facility will insure proper care and follow-up by using a monitoring system using a Nursing 24 Hour Report Form. Each report will have space specifically for condition changes. This will be monitored by the DON. All condition changes will be handled promptly. During a review of the facility's Policy and Procedure (P&P) titled, Care Plan Revision, effective August 2005, the P&P indicated, Policy: Develop and revised by the IDT, with the participation of the resident and/or resident's representative and includes measurable objectives and timetables to meet the resident's medical, nursing, mental, and psycho-social needs that are identified in the comprehensive assessment. Procedure: Care Plan is updated as the resident conditions change and as revision(s) is needed.		