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	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fidelity Health Care	11210 Lower Azusa Rd. El Monte, CA 91731

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307 Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Residents 4 and 34) were treated with dignity when Certified Nursing Assistant 2 (CNA 2) and CNA 4 stood over Residents 4 and 34 while assisting Residents 4 and 34 to eat. This deficient practice had the potential to result in psychosocial (mental and emotional well-being) decline and lowered self-esteem and self-worth for Residents 4 and 34. Findings: a. During a review of Resident 4's Admission Record (AR), the AR indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) without dyskinesia (uncontrolled, involuntary muscle movement), without mention of fluctuations and unspecified dementia (a progressive state of decline in mental abilities), mild, without behavioral disturbance, psychotic disturbance (a mental health condition characterized by a loss of contact with reality), mood disturbance (a significant change in a person's emotional state that persists for an extended period), and anxiety (a mental health condition characterized by persistent, excessive fear or worry that significantly interferes with daily life). During a review of Resident 4's History and Physical Examinations (H&P) dated 7/24/24, the H&P indicated Resident 4 did not have the capacity to understand and make decisions. During a review of Resident 4's Care Plan (CP, provides direction on the type of nursing care an individual needs that include goals of treatment, specific nursing interventions and evaluation plan), titled, Weight (Wt.) loss of 7 pounds (lbs.) for 30 days, dated 9/15/24, the CP interventions included for staff to provide assistance with meals as needed. During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool) dated 2/18/25, the MDS indicated Resident 4's cognitive skills (ability to think and process information) for daily decision making was severely impaired. The MDS indicated Resident 4 required set up or clean-up assistance (helper sets up or cleans up) with eating (the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident). (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation in Resident 4's room and interview on 4/1/25 at 12:16 p.m. with Certified Nursing Assistant (CNA) 7, Resident 4 was in bed at a high fowler's position (bed is elevated 60-90 degrees) while being fed lunch by CNA 2. CNA 2 was feeding Resident 4 while CNA 2 was standing over Resident 4 on the left side of Resident 4's bed. Resident 4's head was at CNA 2's waist level. CNA 7 stated staff needed to sit down while feeding residents (in general) at eye level of the resident for staff to be engaging and make residents feel comfortable. During an interview on 4/2/25 at 8:08 a.m. with the Director of Nursing (DON), the DON stated, staff should be sitting down when feeding residents for body mechanics (coordinated movement to maintain balance and posture) for the staff and to be able to feed the residents correctly. During a review of the facility's Policy and Procedure (P&P) titled, Feeding Program Policy, effective 2/2018, the P&P indicated the purpose of the policy was to establish guidelines for the feeding program at the facility to ensure that all residents received proper nutrition, hydration, and individualized feeding assistance in a safe and dignified manner. The P&P indicated, proper feeding assistance should be provided to residents who required help with eating and drinking to maintain their health and quality of life. The P&P indicated, staff should assist residents who required help with feeding in a patient, respectful, and dignified manner. 40438 b. During a review of Resident 34's AR, the AR indicated Resident 34 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial weakness on one side of the body). During a review of Resident 34's MDS dated [DATE], the MDS indicated Resident 34 had severely impaired cognition. The MDS indicated Resident 34 required partial/moderate assistance (helper did less than half the effort) with eating and dependent (helper did all of the effort, resident did none of the effort to complete the activity) with oral and toileting hygiene, shower, upper and lower body dressing and personal hygiene. During an observation inside Resident 34's room on 4/1/2025 at 10:41 am, Resident 34 was in bed on her back and the head of the bed was elevated. CNA 4 was standing on the left side of Resident 34. CNA 4 was feeding Resident 34 with vanilla pudding. During an interview on 4/2/2025 ay 9:53 am with CNA 2, CNA 2 stated residents should be fed with the staff sitting next to resident and at eye level of the resident for the resident be able to eat comfortably and in a relaxed pace. During an interview on 4/4/2025 at 9:44 am with the Director of Nursing (DON), the DON stated, staff feeding a resident should be sitting at an eye level of the resident for the health, safety and dignity of the resident. During a review of the facility's policy and procedure (P&P) titled, Feeding Assistance Procedures, dated 5/2017, the P&P indicated, Sit at eye level with the resident to encourage engagement. Avoid rushing and maintain a calm, pleasant dining environment.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to ensure the call light was within reach for one of three sampled residents (Resident 47). This failure had the potential for Resident 47 not to receive necessary care or receive delayed services, placing the resident at risk for falls or injury. Findings: During a review of Resident 47's Admission Record (AR), the AR indicated Resident 47 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), dementia (a progressive state of decline of mental abilities), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 47's Fall Risk Assessment (FRA) dated 1/31/2025, the FRA indicated Resident 47 was assessed as high risk for fall. During a review of Resident 47's Minimum Data Set (MDS, a resident assessment tool) dated 2/26/2025, the MDS indicated Resident 47 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 47 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral hygiene and lower body dressing and substantial/maximal assistance (helper did more than half the effort) with shower. During a review of Resident 47's untitled Care Plan (CP), dated 2/25/2025, the CP indicated, Resident 47 was high risk for injury /accident and falls related to episode of getting out of bed unassisted. The CP interventions included for staff to ensure the call light was within reach and to answer promptly. During a concurrent observation inside Resident 47's room and interview on 4/1/2025 at 11:17 am with Certified Nurse Assistant 3 (CNA 3), Resident 47 was in bed on her back with call light stuck behind Resident 47's personal belongings. CNA 3 stated Resident 47 would not be able to find and reach the call light. CNA 3 stated the resident's call light should be placed next to the resident and within the reach of the resident to be able to call staff when help was needed. During an interview on 4/4/2025 at 9:53 am with the Director of Nursing (DON), the DON stated the resident's call light should be placed next to the resident's strong arm and hand so that the resident could call for assistance and staff could address the resident's needs timely. During a review of the facility's Policy and Procedure (P&P) titled, Call Lights and Use of the Call Cord System, dated 8/2005, the P&P indicated, Assure that the call light is within the resident's reach when in their room or on the toilet. Placement of the call cord within the resident's reach.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on interview and record review, the facility failed to implement its Policy and Procedure (P&P) on Advance Directives (AD, a legal document indicating resident preference on end-of-life treatment decisions) for one of one sampled resident (Resident 76) by failing to ensure the Advance Directive Acknowledge (ADA) Form was completed on admission for Resident 76. This failure had the potential risk for facility staff to provide medical treatment and services against the will of Resident 76. Findings: During a review of Resident 76's Admission Record (AR), the AR indicated Resident 76 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing) and Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control). During a review of Resident 76's Minimum Data Set (MDS, a resident assessment tool) dated 1/29/2025, the MDS indicated Resident 76 had an intact cognition (ability to understand) and required setup or clean-up assistance (helper sets up or clean up, resident completes activity) with toileting hygiene and upper and lower body dressing. During a review of Resident 76's ADA, the ADA did not indicate if Resident 76 had or had not executed an ADA. The ADA was not dated when it was signed by Resident 76. The ADA had missing signature from the facility. During an interview on 4/1/2025 at 1:03 pm with Social Service Director (SSD), the SSD stated Resident 76's ADA form was considered incomplete because there was no indication if Resident 76 executed an AD. The SSD stated Resident 76 did not execute an AD. The SSD stated, an AD indicated the resident's care and treatment choices, and it was important to follow the residents' wishes. The SSD stated, if the ADA form was incorrectly completed, the nurses would not know the resident's choices during an emergency. During a review of the facility's undated P&P titled Advanced Directives Policy and Procedure, the P&P indicated Advanced Directive acknowledgement forms must be completed within 7 days from admission by Social Services director or designee.

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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. 42307 Based on observation, interview, and record review, the facility failed to follow safe food handling and proper storage practices for one of one facility kitchen in accordance with professional standards of food service safety and the facility's Policy and Procedure (P&P) by failing to: 1. Label/date food items. 2. Store dishware and kitchenware under sanitary conditions. 3. Wear hair restraints in the kitchen food preparation area. These deficient practices could result in a risk for serious complications from food borne illness (illness caused by the ingestion of contaminated food or beverage) and/or affect the quality and palatability (taste) of food for the residents. Findings: During a concurrent observation and interview on 4/1/25 at 9:22 a.m. with the Dietary Supervisor (DS), during the initial tour of the kitchen, Freezer 2 had a signage posted on the door indicating a Reminder: . Observed inside Freezer 2 were: 1. One opened box of 24 count of individual three oz (ounce, a unit of weight) cups of frozen pineapple sherbet and one three oz cup of frozen pineapple sherbet outside of the box on the shelf. The box was marked with a black marker indicating, R 3.24.25 and was not labeled with an opened date. 2. One opened box of 24 count of individual three oz cups of frozen strawberry ice cream. The box was marked with a black marker indicating, R 3.31.25 and was not labeled with an opened date The DS stated, the R on the boxes meant received. The DS stated the boxes should have been labeled with an opened date. During a concurrent observation inside the walk-in refrigerator and interview on 4/1/25 at 9:40 a.m. with the DS and [NAME] 1 (CK 1), CK 1 was asked what kind of eggs to use if a resident wanted either a soft boiled egg or over easy, CK 1 showed a 36-count of white eggs stored on top of a box of 150 count of eggs that had no indication or label that the eggs were pasteurized. The DS stated, staff should use pasteurized eggs to prevent food borne illness. The DS stated, the facility catered to the elderly who were easy to get infection (the invasion and growth of germs in the body) and bacteria. During a concurrent observation in the kitchen and interview with the DS on 4/1/25 at 9:42 a.m. the following were observed: 1. Three stacks of clean white colored dinner plates stored on the shelf above the tray line (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Six stacks of clean maroon colored and clean blue colored plastic plate covers stored on the shelf above the tray line 3. Three stacks of clean cream colored plastic compartment plates stored on the shelf above the tray line 4. One stack of clean stainless steel colander and two stainless steel mixing bowls stored on the bottom shelf of a utility cart. The dishware and kitchenware were stored face up and not covered. The DS stated, dishware and kitchenware should be stored upside down to avoid contamination that could cause food borne illness. During an observation in the kitchen and interview on 4/4/25 at 7:34 a.m. with CK 1, CK 1 was inside the kitchen without a hair restraint. CK 1 stated, it was important to wear a hairnet for sanitization and to maintain cleanliness. CK 1 stated, a hair could fall into the food and contaminate the food and could get the residents sick. During a concurrent observation in the kitchen and interview on 4/4/25 at 10:20 a.m. with the DS, the Dishwasher (DW) was in the dishwashing station without a hair restraint and was tossing and fixing her long, thick hair. The DS stated, staff should wear a hair restraint once staff entered the kitchen to prevent contamination. The DS stated, the facility provided staff with hair net located by the kitchen door. During a record review of the facility's signage posted (SP) on the door of Freezer 2 titled, Reminder:, the SP indicated, to label with the date the package or container was opened. During a record review of the facility's P&P titled, Food Storage, Handling, Dishwashing, Shelf Life, and Hair Restraint Policy, dated 4/16, the P&P indicated, the P&P ensured all food stored, handled, prepared, and served within the facility was safe and sanitary and included measures to prevent contamination, including proper use of hairnets and other restraints in food service areas. The P&P indicated, the P&P applied to all employees involved in food service operations, including procurement, preparation, dishwashing, serving, and storage. The P&P indicated, the facility would enforce hygiene standards, including the mandatory use of hairnet or head coverings to prevent hair contamination in food preparation and storage areas. Staff would follow food safety procedures and maintained a clean, safe environment. The P&P indicated, one of the procedures was to label and seal opened packages and use the FIFO (first-in, first-out) method. The P&P indicated, all staff must wear hairnets or approved hair restraints (e.g., caps) when in food prep, dishwashing, or storage areas. The P&P indicated, under the Kitchenware Storage section, to store clean dishes in dry, covered, clean areas. During a record review of the facility's P&P titled, Policy on Pasteurized Eggs, dated 3/17, the P&P indicated, to minimize the risk of Salmonella (type of bacteria) and other foodborne illnesses, the facility should only use pasteurized eggs or pasteurized egg products in any dish requiring raw or undercooked eggs. The P&P indicated, only commercially pasteurized eggs or egg products should be purchased and stored in the facility.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on interview and record review, the facility failed to designate a member of the facility's Interdisciplinary Team (IDT- a group of health care professionals who work together toward the goals of their patients) who was responsible for working with Hospice (a program designed to provide comfort care and emotional support to the terminally ill) representatives to coordinate care for one of one sampled resident (Resident 3). This deficient practice had the potential to affect Resident 3's quality of while on Hospice Care. Findings: During a review of Resident 3's Admission Record (AR), the AR indicated Resident 3 was readmitted to the facility on [DATE] with diagnoses including adult failure to thrive (a decline in physical and cognitive function) and rhabdomyolysis (a medical condition characterized by the breakdown of muscle tissue, leading to the release of harmful substances into the bloodstream). During a review of Resident 3's active Physician Order (PO) dated 3/19/2025, the PO indicated Resident 3 was admitted under Hospice Service (H 1). During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool) dated 3/30/2025, the MDS indicated Resident 3 had unclear speech, rarely/never understood others and made self-understood. The MDS indicated Resident 3 required substantial/maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) for personal hygiene and upper and lower body dressing. During a review of H1's visitation calendar for 3/2025, the visitation calendar indicated H1's Certified Home Health Aid (CHHA) was scheduled to visit Resident 3 on 3/26/2025 and 4/2/2025. During a review of H1's Staff Sign in Log (SSIL) from 3/19/2025 to 4/2/2025, the sign in log indicated there was no CHHA who signed in on 3/26/2025 and 4/2/2025. During an interview and concurrent record review on 4/2/2025 at 3:10 pm with the Director of Nursing (DON), the DON stated the facility did not have a designated staff who was responsible to work with H1 and coordinate care to Resident 3, provided by the facility staff and H1 staff. The DON stated, the facility had a binder for H1 for Resident 3. The DON stated there was monthly calendar in hospice binder with H1's visitation schedules. The DON stated CHHA was scheduled to visit Resident 3 on 3/26/2025 and 4/2/2025 according to H1's March 2025 schedule. The DON stated hospice staff should sign in on the SSIL every time they come and provide care to Resident 3. The DON stated there was no sign in by CHHA for 3/26/2025 and 4/2/2025. The DON stated the facility cannot verify if CHHA came on 3/26/2025 and 4/2/2025 to provide necessary care to Resident 3 because the facility did not have a designated person to monitor and follow up with H1's scheduled visit. The DON stated it was important to have a designated staff for hospice residents to ensure no missed visitations from hospice staff and ensure Resident 3's hospice care was provided in order to maintain Resident 3's quality of life. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 4/3/2025 at 10:55 am, the DON stated the facility did not have a policy and procedure indicating the facility assigning a designated staff to coordinate with hospice services.

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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** 40037 Based on observation, interview, and record review, the facility failed to implement infection control guidelines by failing to: a. Ensure to change the nasal canula (NC, a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) weekly for one of one sampled resident (Resident 76). b. Ensure personal toiletry was labeled and not stored inside the [NAME] and [NAME] restroom (a restroom that has two doors and is sandwiched between two bedrooms and is accessible by both bedrooms) of Residents 65, 48, 30, 78, 43 and 23. These failures had the potential to result in the spread of infection in the facility. Findings: a. During a review of Resident 76's Admission Record (AR), the AR indicated Resident 76 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing) and Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control). During a review of Resident 76's Minimum Data Set (MDS, a resident assessment tool) dated 1/29/2025, the MDS indicated Resident 76 had an intact cognition (ability to understand) and required setup or clean-up assistance (helper sets up or clean up, resident completes activity) with toileting hygiene and upper and lower body dressing. During an observation on 4/1/2025 at 10:45 am, in Resident 76's room, Resident 76 was sitting at bedside. Resident 76 had NC in the nostrils, receiving 2 liters of oxygen per minute. Resident 76's NC bag was dated 3/8/2025. During a concurrent interview, Licensed Vocational Nurse 3 (LVN 3) stated, resident's NC should be changed weekly and as needed for infection control purposes. During an interview on 4/2/2025 at 9:33 am with the Infection Preventionist Nurse (IPN), the IPN stated the resident's NC should be changed weekly to prevent bacteria accumulating and for infection control. During a review of Resident 76's Order Summary Report (OSR) dated 4/1/2025, the OSR indicated Resident 76 had an active order for oxygen inhalation 2 liters per minute via (through) NC as needed for shortness of breath (SOB), congestion (an excessive accumulation of blood or mucus), wheezing (abnormal lung sound) and comfort needs. During a review of the facility's Policy and Procedure tilted Oxygen Use of, dated 8/2025, the P&P indicated Oxygen equipment will be maintained in the following manner: humidifier bottle will be changed every 7 days (s) and PRN. Equipment will be changed as needed. 42307 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 65's AR, the AR indicated Resident 65 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including unspecified dementia (a progressive state of decline in mental abilities), mild, without behavioral disturbance, psychotic disturbance (a mental health condition characterized by a loss of contact with reality, leading to distorted perceptions, thoughts, and behaviors), mood disturbance (a significant change in a person's emotional state that persists for an extended period), and anxiety (persistent, excessive fear or worry that significantly interferes with daily life) and personal history of urinary (tract) infections (UTI, an infection in the bladder/urinary tract). During a review of Resident 65's History and Physical (H&P) dated 12/25/24, the H&P indicated Resident 65 did not have the capacity to understand and make decisions. During a review of Resident 65's MDS dated [DATE], the MDS indicated, Resident 65 had severely impaired cognition. The MDS indicated Resident 65 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self and personal hygiene. During a review of Resident 48's AR, the AR indicated Resident 48 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including COPD, unspecified and schizophrenia (a mental illness that is characterized by disturbances in thought), unspecified. During a review of Resident 48's H&P dated 10/20/24, the H&P indicated Resident 48 could make needs known but could not make medical decisions. During a review of Resident 48's MDS dated [DATE], the MDS indicated Resident 48's had severely impaired cognition. The MDS indicated Resident 48 required substantial/maximal assistance with toileting hygiene and shower/bathe self. During a review of Resident 30's AR, the AR indicated Resident 30 was originally admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), bipolar type (mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 30's H&P dated 11/28/24, the H&P indicated Resident 30 had the capacity to understand and make decisions. During a review of Resident 30's MDS dated [DATE], the MDS indicated Resident 30's had intact condition. The MDS indicated Resident 30 required setup or clean-up assistance with toileting hygiene and shower/bathe self. During a review of Resident 78's AR, the AR indicated Resident 78 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a brain dysfunction leading to symptoms like confusion, altered consciousness) and type 2 diabetes mellitus (DM) with diabetic neuropathy (a type of nerve damage that can occur with DM), unspecified. During a review of Resident 78's H&P dated 2/17/25, the H&P indicated Resident 78 had the capacity to understand and make decisions. (continued on next page)

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	04/04/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 78's MDS dated [DATE], the MDS indicated Resident 78 had intact cognition. The MDS indicated Resident 78 required substantial/maximal assistance with toileting hygiene and shower/bathe self. During a review of Resident 43's AR, the AR indicated Resident 43 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including unspecified dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety disorder, unspecified. During a review of Resident 43's H&P dated 11/12/24, 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 intact cognition. The MDS indicated Resident 43 required substantial/maximal assistance with toileting hygiene and shower/bathe self. During a review of Resident 23's AR, the AR indicated Resident 23 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including essential (primary) hypertension (HTN, high blood pressure) and anxiety disorder, unspecified. During a review of Resident 23's H&P dated 1/7/25, the H&P indicated Resident 23 did not have the capacity to understand and make decisions. During a review of Resident 23's MDS dated [DATE], the MDS indicated Resident 23 had moderately impaired cognition. The MDS indicated Resident 23 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene and shower/bathe self. During a concurrent observation and interview on 4/1/25 at 11:20 a.m. with Certified Nursing Assistant 7 (CNA 7), inside the [NAME] and [NAME] restroom shared by Residents 65, 48, 30, 78,43 and 23, there was an opened, unlabeled 8 fl. oz. (fluid ounce, a unit of volume) of moisturizing shampoo & body wash stored on the window sill. CNA 7 stated, resident's personal toiletries should not be stored inside the restroom and should be labeled with the resident's name and kept at the bedside for resident's personal use. CNA 7 stated the moisturizing shampoo & body wash shouldn't be in the restroom for safety reasons and to prevent cross contamination among residents. During an interview on 4/1/25 at 11:29 a.m. with the Infection Preventionist Nurse (IPN), the IPN stated personal toiletries were supposed to be labeled with resident's name and stored in the resident's drawer because other residents might use it (personal toiletry) to prevent cross contamination, for infection control. During a record review of the facility's Policy and Procedure (P&P) titled, Personal Hygiene Items, dated 4/16, the P&P indicated each resident would have their own toothbrush, toothpaste, comb, and other personal hygiene items to prevent cross-contamination. During a record review of the facility's undated P&P titled, Infection Control Program, the P&P indicated the facility should establish an infection control program designed to provide a safe, sanitary and comfortable environment for residents and staff to help prevent the development and transmission of disease and infection.

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	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fidelity Health Care	11210 Lower Azusa Rd. El Monte, CA 91731

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to keep an electric fan (a powered machine used to create a flow of air to cool and ventilate rooms and control humidity) in a safe, operating, and sanitary condition for one of one sampled resident (Resident 17). This failure had the potential to affect Resident 17's quality of life and health. Findings: During a review of Resident 17's Admission Record (AR), the AR indicated Resident 17 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hypertension (HTN, high blood pressure), anxiety (intense, excessive, and persistent worry and fear), and osteoarthritis (a progressive disorder of the joints). During a review of Resident 17's Minimum Data Set (MDS, a resident assessment tool) dated 2/5/2025, the MDS indicated Resident 17 had moderately impaired cognition (ability to understand and process information). The MDS indicated Resident 17 required setup or clean-up assistance (helper sets up or cleans up; resident completes the activity) with shower and personal hygiene. During a concurrent observation inside Resident 17's room and interview on 4/1/2025 at 10:22 am with Licensed Vocational Nurse 2 (LVN 2), a black standing fan was at Resident 17's bedside. LVN 2 stated the electric fan blades had dust, and the cover was full of lint. LVN 2 stated Resident 17 could inhale the dust and the lint and cause respiratory problems. During an interview on 4/4/2025 at 9:51 am with the Director of Nursing (DON), the DON stated, the housekeeping staff should keep all equipment in the resident's room clean and in good working condition to prevent respiratory related illnesses. During a review of the facility's Policy and Procedure (P&P) titled, Homelike Environment Policy, dated 4/2018, the P&P indicated, Regular housekeeping and maintenance will be provided while preserving resident's personal touches.