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	06/05/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure call lights were within reach and appropriate to the resident's physical ability for two of two sampled residents (Residents 13 and 56). These failures had the potential for Residents 13 and 56 not to receive necessary care or receive delayed services to meet their needs. Findings: a. During a review of Resident 13's admission Record (AR), the AR indicated the facility initially admitted Resident 13 on 2/7/2023 and readmitted on [DATE] with diagnoses including osteoporosis (weak and brittle bones), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) and diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 13's Minimum Data Set (MDS, a resident assessment tool), dated 3/19/2026, the MDS indicated Resident 13 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 13 required partial/moderate assistance (helper did less than half the effort) with eating and oral hygiene. The MDS indicated Resident 13 required substantial/maximal assistance (helper did more than half the effort) with toileting, shower, upper/lower body dressing and personal hygiene. During a concurrent observation inside Resident 13's room and interview on 6/3/2026 at 10:54 am with Certified Nurse Assistant 2 (CNA 2), Resident 13 was lying in bed with push button call light at the back of Resident 13's headboard. CNA 2 stated Resident 13 was confused. CNA 2 stated Resident 13 could not reach the push button call light and did not know and understand how to use the push button call light. CNA 2 stated call lights should be placed next to the resident to call staff for assistance. During an interview on 6/4/2026 at 11:47 am with the Director of Nursing (DON), the DON stated Resident 13 was confused and could not follow and understand simple commands like pressing the call light. The DON stated a sensor pad call light (flat call light activated by gross movement) was more appropriate for Resident 13's physical and functional ability to call and alert the staff when the resident needed help. 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, the purpose of the P&P was to assure that residents receive assistance promptly and to assure that the staff know how to place and use the call cord system. The P&P indicated assure that the call light is within the resident's reach when in their room or on the toilet. (continued on next page)

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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Meeting Residents Need According to Functional Ability and Capability, dated 7/2018, the P&P indicated, Adaptive equipment and assistive devices shall be utilized when appropriate to maximize independence. b. During a review of Resident 56's AR, the AR indicated the facility admitted Resident 56 on 12/13/2021 and readmitted on [DATE] with diagnoses including weakness, overactive bladder (the bladder muscles contracted involuntarily and caused a sudden, uncontrollable urge to urinate), and psychosis (a severe mental condition in which thought, and emotions were affected that contact was lost with reality). During a review of Resident 56's History and Physical (H&P) dated 12/6/2025, the H&P indicated Resident 56 did not have the capacity to understand and make decisions due to psychosis. During a review of Resident 56's ADL (Activities of Daily Living) Maintenance/ Pattern Care Plan (CP) dated 12/8/2025, the CP indicated Resident 56 required assistance with ADL due to muscular weakness. The CP indicated a goal to meet all of Resident 56's needs daily. The CP intervention indicated for nursing staff keep the call light within Resident 56's reach. During a review of Resident 56's MDS dated [DATE], the MDS indicated Resident 56 had severely impaired cognition. The MDS indicated Resident 56 required setup assistance from staff with eating. The MDS indicated Resident 56 required supervision from staff with bed-to-chair transferring. The MDS indicated Resident 56 required moderate assistance (helper did less than half the effort) from staff with oral hygiene, toileting hygiene, personal hygiene, and toilet transferring. The MDS indicated Resident 56 needed maximum assistance (helper did more than half the effort) from staff with showering/ bathing. During a concurrent observation and interview on 6/2/2026 at 9:23 am with Resident 56 inside Resident 56's room, Resident 56 was awake and lying in bed. The call light was not within Resident 56's reach. Resident 56's call light was on Bed A (empty bed next to Resident 56). Resident 56 stated Resident 56 could not reach the call light. During an observation on 6/2/2026 at 11:25 am inside Resident 56's room, Resident 56 was sitting in the wheelchair at bedside with the call light not within Resident 56's reach. Resident 56's call light was on Bed A. During a concurrent picture review and interview on 6/3/2026 at 11:50 am with Certified Nurse Assistant 1 (CNA 1), the picture dated 6/2/2026 at 9:23 am was reviewed, CNA 1 stated the picture indicated the call light was not within Resident 56's reach. CNA 1 stated the call light should be placed on the bed by Resident 56. During a concurrent picture review and interview on 6/3/2026 at 11:50 am with CNA 1, the picture dated 6/2/2026 at 11:25 am was reviewed, CNA 1 stated the picture indicated the call light was not within Resident 56's reach. CNA 1 stated the call light should be placed with the resident on the wheelchair for safety. CNA 1 stated the CNA should ensure the call light was within reach for residents during rounds (nurses went room to room to check on the residents to ensure the residents were safe and cared for). CNA 1 stated the CNA (in general) should put the call light in the resident's hand or clip the call light on the bed when the resident was in bed. CNA 1 stated residents use the call light to call for help when assistance was needed. CNA 1 stated it was important to keep the call light within resident's reach. CNA 1 stated Resident 56 had behavior of throwing the call light on the floor. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA 1 stated everyone in the facility should ensure the call light was within Resident 56's reach regardless of behavior. During an interview on 6/4/2026 at 1:23 pm with the Director of Nursing (DON), the DON stated Resident 56 was at risk of falling. The DON stated Resident 56 could not call for help when needed if the call light was not within reach. The DON stated the resident was at risk of injury, harm, and accident. During a review of Resident 56's Fall Risk Evaluation (FRE- method of assessing a patient's likelihood of falling) dated 6/5/2026, the FRE indicated Resident 56 was assessed as high risk for falls because Resident 56 was chairbound, had intermittent confusion and balance problem while standing and walking, and required the use of assistive devices. During a review of the facility's P&P titled, Call Lights and Use Of the Call Cord System, dated 8/2005, the P&P indicated the facility should ensure the call light was within the resident's reach when in their room or on the toilet.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement its policy and procedures (P&P) titled, Resident Assessment Instrument, and Minimum Data Set (MDS- a resident assessment tool) for three of three sampled residents (Residents 6, 56, and 83) by failing to ensure the MDS assessment was coded accurately for: a. Resident 6's fall on 4/10/2026.b. Resident 56's psychotic disorder and behavior.c. Resident 83's discharge home from the facility. These failures resulted in inaccurate reporting to the Centers for Medicare and Medicaid Services (CMS, a federal agency that administers the Medicare program and works with state governments to administer the Medicaid and health insurance portability standards) agency and had the potential for Residents 6, 56, and 83 not to receive interventions to address their specific care concerns. Findings: a. During a review of Resident 6's admission Record (AR), the AR indicated the facility admitted Resident 6 on 1/12/2026 and re-admitted on [DATE] with diagnoses including Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control) without complications, weakness, and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 6's Incident Note (IN) dated 4/10/2026, the IN indicated Resident 6 stumbled backwards and fell while ambulating (walking) in the facility hallway. During a review of Resident 6's Change in Condition Evaluation (CIC), dated 4/10/2026, the CIC indicated Resident 6 had a fall and the physician was notified. During a review of Resident 6's History & Physical (H&P) dated 4/25/2026, the H&P indicated Resident 6 had a recent fall. During a review of Resident 6's Minimum Data Set (MDS) dated [DATE], the MDS indicated Resident 6 did not have a fall any time in the last month and in the last two to six months prior to admission or reentry. During an observation on 6/4/2026 at 8:37 am, Res 6 was walking inside Resident 6's room. During an interview on 6/4/2026 at 2:06 pm with Registered Nurse 1 (RN 1), RN 1 stated Resident 6 was a fall risk with an unsteady gait and had last fallen in the facility on 4/10/2026. During a concurrent interview and record review on 6/4/2026 at 2:24 pm with Minimum Data Set Director (MDSD), Resident 6's MDS dated [DATE] was reviewed. The MDS indicated Resident 6 did not have a fall any time in the last month or last two to six months prior to admission or reentry to the facility. The MDSD stated the MDS was inaccurate because Resident 6 had a fall on 4/10/2026. The MDSD stated that it was important that the MDS was accurate because it reflected the resident's care and condition. During an interview on 6/5/2026 at 9:22 am with the Director of Nursing (DON), the DON stated Resident 6 had a recent fall. The DON stated the MDS needed to be accurately documented because it was the resident's data set that allowed the facility to determine that appropriate care was provided to the resident. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Resident Assessment Instrument, dated 5/2017, the P&P indicated, the MDS Coordinator shall oversee the completion of all required assessments. The MDS assessments shall be accurate. During a review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1, dated 10/2025, the manual indicated the RAI process had multiple regulatory requirements. The manual indicated, federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) required that the assessment accurately reflected the resident's status. b. During a review of Resident 56's AR, the AR indicated the facility admitted Resident 56 on 12/13/2021 and readmitted on [DATE] with diagnoses including overactive bladder (the bladder muscles contract involuntarily and cause a sudden, uncontrollable urge to urinate) and psychosis (mental condition in which thought and emotions were affected that contact with reality is lost). During a review of Resident 56's H&P dated 12/6/2025, the H&P indicated Resident 56 did not have the capacity to understand and make decisions due to psychosis. During a review of Resident 56's Psychiatric Progress Note (PPN) dated 2/28/2026, the PPN indicated Resident 56 had a psychotic disorder (a condition where a person lost touch with reality). During a review of Resident 56's Social Service Quarterly Note (SSQN) dated 3/9/2026, the SSQN indicated Resident 56 had a period of screaming without reason, striking out, and hitting staff. During a review of Resident 56's MDS dated [DATE], the MDS indicated Resident 56 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 56 required setup assistance from staff with eating. The MDS indicated Resident 56 required supervision from staff with bed-to-chair transferring. The MDS indicated Resident 56 required moderate assistance (helper did less than half the effort) from staff with oral hygiene, toileting hygiene, personal hygiene, and toilet transferring. The MDS indicated Resident 56 needed maximum assistance (helper did more than half the effort) from staff with showering/ bathing. During a concurrent record review and interview on 6/3/2026 at 2:23 pm, with the MDS Coordinator (MDSC), Resident 56's MDS dated [DATE] was reviewed. The MDSC stated the MDS dated [DATE] did not indicate Resident 56 had a diagnosis of psychotic disorder and should have been documented. The MDSC stated the MDSC should review the resident's whole medical records including MAR, physician orders, physician progress notes, resident's diagnosis list, and resident's medication list when completing the MDS. During a concurrent record review and interview on 6/3/2026 at 2:23 pm, with the MDSC, Resident 56's Medication Administration Record (MAR) for 3/2026 was reviewed. The MAR indicated Resident 56 had behavior of striking out on 3/12/2026, 3/14/2026, and 3/15/2026. The MAR indicated Resident 56 had daily behavior yelling. The MAR indicated Resident 56 had behavior of hitting staff on 3/12/2026 and 3/14/2026. The MDSC stated Resident 56's MAR indicated Resident 56 had behaviors of striking out, yelling, and hitting staff before 3/17/2026. During a concurrent record review and interview on 6/3/2026 at 2:23 pm, with the MDSC, Resident 56's MDS dated [DATE] was reviewed. The MDSC stated the MDS indicated Resident 56 did not have physical behavior symptoms directed toward others or other behavior symptoms not directed toward (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	others. The MDSC stated the MDSC should review Resident 56's medical record before 3/17/2026 because the MDS assessment's completion date was 3/17/2026. The MDSC stated the MDS assessment was not an accurate assessment. The MDSC stated the MDS should have coded physical behavior symptoms directed toward others occurred one to three days. The MDSC stated the MDS should have coded other behavior symptoms not directed toward others occurred daily. The MDSC stated the MDS assessment should reflect the resident's condition. The MDSC stated the facility interdisciplinary team (IDT, a team that worked together to plan a resident's care) members completed the MDS assessment. The MDSC stated the social service department was responsible for completing the behavior section in the MDS assessment. The MDSC stated the designated staff should review the resident's entire medical record to obtain necessary information to complete the MDS assessment. The MDSC stated it was important to submit an accurate MDS assessment to CMS so that CMS would have the correct resident assessment. The MDSC stated CMS did not receive the correct resident information and affected the residents' care. The MDSC stated that the MDSC's signature verified the MDS assessment's accuracy and completion. During an interview on 6/4/2026 at 1:23 pm with the Director of Nursing (DON), the DON stated the MDS assessment was a snapshot of the resident's overall condition, change of condition, and how to manage the resident's needs including mental, physical, and activities of daily living. The DON stated the DON signed the MDS assessment to acknowledge and verify assessment accuracy. During a review of the facility's P&P titled, Minimum Data Set (MDS) dated 5/2017, the P&P indicated that MDS coding should accurately reflect the resident's status during the assessment reference period. The P&P further indicated the MDSC was responsible for reviewing assessments for accuracy. c. During a review of Resident 83's AR, the AR indicated the facility admitted Resident 83 on 3/12/2026 with diagnoses including osteoporosis (weak and brittle bones), major depressive disorder (a mood disorder 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 83's MDS dated [DATE], the MDS indicated Resident 83 was admitted from a short-term general hospital (acute hospital) and discharged back to the acute hospital. During a review of Resident 83's Physician Order (PO) dated 3/14/2026, the PO indicated Resident 83 was discharged home against medical advice (AMA, occurs when a resident chooses to depart before treatment team recommends discharge). During a review of Resident 83's Discharge Summary (DS) dated 3/14/2026, the DS indicated Resident 83 was discharged to home AMA as requested by Resident 83's daughter. During a concurrent interview and record review on 6/3/2026 at 2:44 pm with the MDSC, Resident 83's MDS dated [DATE] was reviewed. The MDSC stated the MDS was incorrectly coded with Resident 83's discharge destination to the acute hospital. The MDSC stated Resident 83 was discharged home on 3/14/2026. The MDS C stated the MDS assessment should be coded accurately to reflect Resident 83's current assessment and for accurate reporting to CMS. During an interview on 6/4/2026 at 11:47 am with the DON, the DON stated the MDS assessment should be coded correctly to reflect the resident's overall current health condition and to report accurate information to CMS. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Minimum Data Set (MDS) Accuracy, dated 5/2017, the P&P indicated, The Nursing Home shall maintain an MDS process that ensures resident assessments accurately reflect each resident's condition, strengths, needs, services provided, and functional status. MDS assessments shall be completed using current clinical documentation and interdisciplinary input and shall be submitted within required timeframes.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to meet professional standards of care by not rotating the insulin (a hormone that helps a resident's body use sugar for energy) administration site for three of three sampled residents (Residents 3, 8, and 53). These failures had the potential to compromise Residents 3, 8, and 53's health and safety.Findings: a. During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 1/9/2026 and readmitted on [DATE] with diagnoses including type 2 diabetes mellitus (type 2 DM, a disorder characterized by difficulty in blood sugar control) and legal blindness. During a review of Resident 3's History and Physical (H&P) dated 3/26/2026, the H&P indicated Resident 3 could make needs known but could not make medical decisions. During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool) dated 4/6/2026, the MDS indicated Resident 3 had intact cognition (ability to understand and process information). The MDS indicated Resident 3 required supervision from staff with eating. The MDS indicated Resident 3 required maximum assistance (helper did more than half the effort) from staff with oral hygiene, toileting hygiene, showering/ bathing, personal hygiene, and bed-to-chair transferring. The MDS indicated Resident 3 received insulin injection daily. During a review of Resident 3's Physician Order (PO) dated 4/19/2026, the PO indicated Resident 3 had an active order for licensed staff to administer HumuLIN R insulin (a shortˆacting insulin that helps a resident control blood sugar) 100 unit/milliliter (ml- unit of measurement) and inject as per sliding scale (a way to give insulin based on a resident's blood sugar level) subcutaneously (the fatty tissue area located just beneath the skin) before meals and at bedtime. During an interview on 6/3/2026 at 11:13 am with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated the licensed nurse should rotate the insulin injection site for each injection to minimize pain, bleeding, redness, and discoloration. During a concurrent record review and interview on 6/4/2026 at 1:23 pm with the Director of Nursing (DON), Resident 3's Medication Administration Record (MAR) dated 5/1/2026 to 5/31/2026 was reviewed. The MAR indicated the licensed nurses administered HumuLIN R insulin to Resident 3 at the same injection sites and did not rotate the injection site on the following dates: 5/1/2026, 5/2/2026, 5/4/2026, 5/5/2026, 5/6/2026, 5/7/2026, 5/17/2026, 5/18/2026, 5/19/2026, 5/20/2026, and 5/31/2026. The DON stated the MAR indicated the licensed nurse did not rotate the insulin injection site and should have. The DON stated the resident would have skin hardening and pain with the same insulin injection site. The DON stated the licensed nurse should check the last insulin injection site and rotate the site each time. During a concurrent record review and interview on 6/4/2026 at 1:23 pm with the DON, Resident 3's MAR dated 6/1/2026 to 6/30/2026 was reviewed. The MAR indicated the licensed nurse administered HumuLIN R insulin to Resident 3 at the same injection sites and did not rotate the injection site on the following dates: 6/1/2026, 6/2/2026, and 6/3/2026. The DON stated the MAR indicated the licensed nurse did not rotate the insulin injection site and should have. b. During a review of Resident 8's AR, the AR indicated the facility admitted Resident 8 on 5/5/2026 with diagnoses including type 2 DM and hypertension (HTN, high blood pressure). During a review of Resident 8's H&P dated 5/6/2026, the H&P indicated Resident 8 did not have the capacity to understand and make decisions. During a review of Resident 8's MDS dated [DATE], the MDS indicated Resident 8 had severely impaired cognition. The MDS indicated Resident 8 required supervision from staff with eating. The MDS indicated Resident 8 required moderate assistance (helper did less than half the effort) from staff with oral hygiene. The MDS indicated Resident 8 required maximal assistant from staff with toileting hygiene, showering/bathing, and personal hygiene. The MDS indicated Resident 8 was dependent (helper did all the effort) on staff with toilet transferring, tub/ shower transferring, and car transferring. During a review of Resident 8's PO dated 5/22/2026, the PO indicated Resident 8 had an active order for licensed staff to administer HumuLIN R insulin 100 unit/ml and inject as per sliding scale before meals and at bedtime. During a concurrent (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	record review and interview on 6/4/2026 at 1:23 pm with the DON, Resident 8's MAR dated 5/1/2026 to 5/31/2026 was reviewed. The MAR indicated the licensed nurse administered HumuLIN R insulin to Resident 8 at the same injection sites and did not rotate the injection site on the following dates: 5/24/2026, 5/25/2026, 5/26/2026, 5/27/2026, 5/28/2026, 5/29/2026, 5/30/2026, and 5/31/2026. The DON stated the MAR indicated the licensed nurse did not rotate the insulin injection site and should have. During a concurrent record review and interview on 6/4/2026 at 1:23 pm with the DON, Resident 8's MAR dated 6/1/2026 to 6/30/2026 was reviewed. The MAR indicated the licensed nurse administered HumuLIN R insulin to Resident 8 at the same injection sites and did not rotate the injection site on the following dates: 6/1/2026 and 6/2/2026. The DON stated the MAR indicated the licensed nurse did not rotate the insulin injection site and should have. c. During a review of Resident 53's AR, the AR indicated the facility admitted Resident 53 on 2/14/2017 and readmitted on [DATE] with diagnoses including type 2 DM and HTN During a review of Resident 53's PO dated 12/7/2023, the PO indicated Resident 53 had an active order for licensed staff to administer insulin Aspart (rapid-acting insulin) 100 unit/ml and inject per sliding scale subcutaneously before meals and at bedtime. During a review of Resident 53's PO dated 8/21/2025, the PO indicated Resident 53 had an active order for licensed staff to administer insulin Glarigine (long-acting insulin) 100 unit/ml and inject 16 units subcutaneously at bedtime. During a review of Resident 53's H&P dated 11/30/2025, the H&P indicated Resident 53 could not make decisions. During a review of Resident 53's MDS dated [DATE], the MDS indicated Resident 53 had severely impaired cognition. The MDS indicated Resident 53 required setup assistance from staff with eating. The MDS indicated Resident 53 required supervision from staff with toileting hygiene. The MDS indicated Resident 53 required moderate assistance from staff with oral hygiene and bed-to-chair transferring. The MDS indicated Resident 53 required maximal assistant from staff with showering/bathing and personal hygiene. The MDS indicated Resident 53 received insulin injection daily. During a concurrent record review and interview on 6/4/2026 at 1:23 pm with the DON, Resident 53's MAR dated 5/1/2026 to 5/31/2026 was reviewed. The MAR indicated the licensed nurse administered insulin Aspart to Resident 53 at the same injection sites and did not rotate the injection site on the following dates: 5/14/2026, 5/15/2026, 5/18/2026, 5/19/2026, 5/25/2026, and 5/26/2026. The MAR indicated the licensed nurse administered insulin Glargine to Resident 53 at the same injection site and did not rotate the injection site on the following dates: 5/5/2026, 5/6/2026, 5/7/2026, 5/17/2026, 5/18/2026, and 5/19/2026. The DON stated the MAR indicated the licensed nurse did not rotate the insulin injection site and should have. During a concurrent record review and interview on 6/4/2026 at 1:23 pm with the DON, Resident 53's MAR dated 6/1/2026 to 6/30/2026 was reviewed. The MAR indicated the licensed nurse administered insulin Aspart to Resident 53 at the same injection sites and did not rotate the injection site on the following dates: 6/1/2026, 6/2/2026, and 6/3/2026. The DON stated the MAR indicated the licensed nurse did not rotate the insulin injection site and should have. During a review of the facility's Policy and Procedure (P&P) titled Insulin Administration, dated 9/2018, the P&P indicated the facility should administer insulin in accordance with accepted nursing standards to ensure safe insulin administration to minimize the risk of adverse events. The P&P indicated the licensed nurse should rotate the insulin injection sites according to accepted nursing practice.

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	06/05/2026

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a safe environment for two of two sampled residents (Residents 3 and 28) in accordance with the facility's policy and procedure (P&P) when: a. The facility did not provide Resident 3 who was on hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) had failed) an emergency kit (E-kit, containing the main items needed in an emergency) at bedside.b. The facility did not properly dispose of a shaver, leaving the shaver unattended on top of the hand soap dispenser inside Room A's restroom.c. Resident 28 who required supervision while smoking (breathing in smoke from cigarettes [tobacco wrapped in paper]) had a lighter in possession. These deficient practices had the potential to increase the risk of injury, accidental fire and harm for the residents, staff and visitors in the facility. Findings: a. During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 1/9/2026 and readmitted on [DATE] with diagnoses including acute kidney failure (kidneys suddenly stopped working), dependence on renal dialysis (treatment for kidney failure that removes unwanted toxins, waste products and excess fluids by filtering the blood), and legal blindness. During a review of Resident 3's History and Physical (H&P) dated 3/26/2026, the H&P indicated Resident 3 could make needs known but could not make medical decisions, During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool) dated 4/6/2026, the MDS indicated Resident 3 had intact cognition (ability to understand and process information). The MDS indicated Resident 3 required supervision from staff with eating. The MDS indicated Resident 3 required maximum assistance (helper did more than half the effort) from staff with oral hygiene, toileting hygiene, showering/ bathing, personal hygiene, and bed-to-chair transferring. During a review of Resident 3's care plan (CP) for hemodialysis, revised 6/2026, the CP indicated Resident 3 was at risk of bleeding secondary to the Perma catheter (a tube placed into a large vein so the resident could get dialysis) on Resident 3's left upper chest. The CP goal was for Resident 3 to not have complications related to hemodialysis. The CP intervention indicated to monitor Resident 3's skin condition daily. During a concurrent observation and interview on 6/3/2026 at 11:13 am with Licensed Vocational Nurse 1 (LVN 1) inside Resident 3's room, Resident 3 was awake, lying in bed with Perma catheter on Resident 3's left upper chest. LVN 1 stated Resident 3 did not have a dialysis E-kit at bedside. LVN 1 stated it was important to have a dialysis E-kit at bedside for emergencies such as active bleeding at the resident's Perma catheter site. During an interview on 6/4/2026 at 1:23 pm with the Director of Nursing (DON), the DON stated the purpose of the dialysis E-kit was to apply pressure in the event of bleeding during an emergency. The DON stated the facility should have the dialysis E-kit available for Resident 3 who had a Perma catheter. The DON stated the DON forgot to place the dialysis E-kit inside Resident 3's bedside (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	06/05/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	drawer. The DON stated the dialysis E-kit included gauze, tape, and bandage. During a review of the facility's undated Policy and Procedure (P&P) titled, Hemodialysis, Care of Resident, dated 5/2016, the P&P indicated the facility should ensure safe and effective care for residents receiving hemodialysis and to promote their health, safety, comfort, and quality of life. b. During an observation on 6/2/2026 at 9:14 am inside Room A's restroom, a blue shaver was on top of the hand soap dispenser unattended by staff. During an observation on 6/2/2026 at 11:25 am, inside Room A's restroom, a blue shaver was on top of the hand soap dispenser unattended by staff. During an observation on 6/2/2026 at 1:00 pm, inside Room A's restroom, a blue shaver was on top of the hand soap dispenser unattended by staff. During an observation on 6/3/2026 at 9:21 am, inside Room A's restroom, a blue shaver was on top of the hand soap dispenser unattended by staff. During a concurrent observation and interview on 6/3/2026 at 11:13 am with LVN 1, inside Room A's restroom, LVN 1 stated there was a shaver on top of the hand soap dispenser without any staff supervision. LVN 1 stated the shaver should never be in a resident's restroom. LVN 1 stated staff should dispose of the shaver into the sharp disposal container (a tough, hard plastic box used to safely throw away sharp medical objects) for safety and prevent the residents from injury/cutting themselves. During an interview on 6/4/2026 at 1:23 pm with the DON, the DON stated the shaver should not be placed unattended in the resident's restroom for safety. The DON stated the certified nurse assistant was responsible for assisting residents to shave in the restroom. The DON stated the facility should ensure environmental safety. During a review of the facility's undated Policy and Procedure (P&P) titled, Resident Safety, dated 1/2019, the P&P indicated the facility should provide a safe and secure environment for residents through ongoing assessment, supervision, staff education, environmental safety measures, and prompt response to identified risks. The P&P indicated the facility should take reasonable precautions to prevent accidents and injuries while encouraging residents to maintain their highest practicable level of independence. The P&P indicated that the staff should implement appropriate interventions to minimize the risk of accidents and injuries. c. During a review of Resident 28's AR, the AR indicated the facility admitted Resident 28 on 9/30/2019 and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD- type of obstructive lung disease characterized by long-term poor airflow), hyperlipidemia (high level of fats in the blood), and hypertension (high blood pressure). During a review of Resident 28's untitled Care Plan (CP) dated 2/3/2026, the CP indicated Resident 28 was at risk for injury due to smoking and the resident was capable of smoking in a designated area with supervision only. The CP intervention indicated for nursing staff to monitor Resident 28's whereabouts, especially during smoking time. During a review of Resident 28's Smoking Safety Assessment (SSA) dated 2/3/2026, the SSA (continued on next page)

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	555088	A. Building B. Wing	06/05/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated Resident 28 was independent for decision making and interventions included smoking safely with minimal supervision and supervised smoking by staff. During a review of Resident 28's MDS dated [DATE], the MDS indicated Resident 28 had intact cognition. The MDS indicated Resident 28 was independent for eating and needed moderate assistance (helper does less than half the effort) from staff for oral hygiene, toileting hygiene, shower, lower body dressing, putting on/taking off footwear and personal hygiene. During a concurrent observation and interview on 6/2/2026 at 9:08 am, inside Resident 28's room, Resident 28 was awake, lying in bed and stated Resident 28 had smoked 2 weeks ago and kept a lighter in Resident 28's possession. Resident 28 stated Resident 28 had the lighter and took the lighter from Resident 28's left pocket. During a concurrent observation and interview on 6/2/2026 at 9:08 am, inside Resident 28's room together with Registered Nurse 1 (RN 1), RN 1 stated, lighters and smoking paraphernalia should not be in Resident 28's possession and should be kept in a box in the Activity Department for safety of the residents and prevent potential fire. During an interview on 6/3/2026 at 1:28 pm, with the Activity Director (AD), the AD stated Resident 28 smoked once a week at night and AD did not know Resident 28 had a lighter in possession. The AD stated residents who smoke were not allowed to keep cigarettes and lighters in their possession to prevent the residents from lighting up cigarettes. During an interview on 6/4/2026 at 11:47 am with the facility's Director of Nursing (DON), the DON stated, residents were not allowed to keep lighters in their possession due to risk of fire. The DON stated, smoking paraphernalia should be secured in the AD's office during daytime and handed over to the licensed nurse in the afternoon for safety. During a review of the facility's P&P titled, Smoking Policy, updated 2/16/2022, the P&P indicated All cigarettes and lighters will be kept at the Activities office from 8am to 3pm and the Nursing Stations from 3pm to 8pm. Smoking in bed shall not be permitted.

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	555088	A. Building B. Wing	06/05/2026

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents' weights were documented accurately on the residents' medical record (chart) and electronic medical record (EMR) for two of two sampled residents (Residents 2 and 4). These failures resulted in inaccurate information for Residents 2 and 4 and had the potential to negatively affect Residents 2 and 4's care and treatment received from the facility. Findings: a. During a review of Resident 4's admission Record (AR), the AR indicated the facility admitted Resident 4 on 9/26/2023 and readmitted on [DATE] with diagnoses including anemia (a condition where the body does not have enough healthy red blood cells), gastroesophageal reflux disease (GERD, a chronic digestive disorder occurring when stomach acid repeatedly flows back into the esophagus), and diverticulosis (presence of small, bulging pouches in the lining of the large intestine). During a review of Resident 4's untitled Care Plan (CP) dated 12/26/2025, the CP indicated Resident 4 was on pureed (foods blended to a smooth, pudding-like texture that requires no chewing) and therapeutic diet (specialized meal plan to manage, treat, or prevent a specific medical condition). The CP interventions included monitoring weight and reporting weight loss or gain and significant weight changes to the medical doctor (MD). During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool) dated 4/1/2026, the MDS indicated Resident 4 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 4 was independent with eating and setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with oral hygiene and upper body dressing. The MDS indicated Resident 4 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with toileting and lower body dressing. The MDS indicated Resident 4 required partial/moderate assistance (helper did less than half the effort) with shower and personal hygiene. During a review of Resident 4's Order Summary Report (OSR) dated 5/7/2026, the OSR indicated Resident 4 had an order for staff to monitor the resident's weight weekly for four weeks. During a review of Resident 4's Weekly Weights Monitoring (WWM) in Resident 4's chart, the WWM indicated Resident 4 weighed 99 pounds (lbs.) on 5/8/2026, 97 lbs. on 5/15/2026, 97 lbs. on 5/23/2026 and 97 lbs. on 5/29/2026. During a review of Resident 4's Weights and Vital Summary (WVS) in Resident 4's EMR from 2/19/2026 to 5/14/2026, the WVS indicated Resident 4 weighed 113 lbs. during each measurement. During a concurrent interview and record review on 6/3/2026 at 9:13 am with Licensed Vocational Nurse 3 (LVN 3), Resident 4's WWM in the chart dated 12/26/2025, 1/2/2026, 1/9/2026, 1/16/2026, 5/8/2026, 5/15/2026, 5/23/2026, 5/29/2026 and Resident 4's WVS in the EMR from 2/19/2026 to 5/14/2026 were reviewed and compared. LVN 3 stated the correct weights of Resident 4 were the weights documented in the WWM in the chart. LVN 3 stated the weights were incorrectly documented in the EMR. LVN 3 stated Resident 4's weights should have been documented accurately to properly (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	06/05/2026

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care for and manage Resident 4's changes in weights. During an interview on 6/5/2026 at 9:15 am with the Director of Nursing (DON), the DON stated nursing staff were incorrectly copying and entering historical weight into the residents' EMR. The DON stated documenting incorrect weights could cause confusion and problems in managing the residents' weights. During a review of the facility's undated Policy and Procedure (P&P) titled, Documentation, the P&P indicated, It is the policy of the facility to document in the medical record any changes in the resident's medical or mental condition and all services provided. All observations, medications administered services performed, etc. must be documented in the resident's clinical record. b. 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 including muscle wasting and atrophy (shrinkage) and dementia (a progressive state of decline in mental abilities) with mood disturbance. During a review of 2's OSR dated 4/8/2026, the OSR indicated an active order for Resident 2 to have weekly weights taken for four weeks and then monthly. During a review of Resident 2's History and Physical (H&P), dated 4/9/2026, the H&P indicated Resident 2 did not have the capacity to understand and make decisions and was at risk for malnutrition, weight variance, and dehydration. During a review of Resident 2's untitled CP dated 4/9/2026, the CP indicated Resident 2 had potential for excessive weight loss with a plan to continue to monitor weight weekly for four weeks, then monthly and report continued weight loss to the physician and dietitian promptly. During a review of Resident 2's Dietary Profile (DP) dated 4/13/2026, the DP indicated Resident 2 was readmitted with a weight of 136 pounds (lbs.), below the ideal body weight (IBW - optimal or healthy weight for a person based primarily on their height and gender) range of 139 lbs. to 169 lbs. and to continue with the plan of care. During a review of Resident 2's Weekly Weights Monitoring (WWM) in the paper medical record, the WWM indicated Resident 2 weighed: 135 lbs. on 4/17/2026, 136 lbs. on 4/24/2026, 136 lbs. on 5/1/2026, and 136 lbs. on 5/8/2026. During a review of Resident 2's Weights and Vitals Summary from 1/8/2026 to 5/25/2026 in the electronic medical record, Resident 2 weighed 132 lbs. during each measurement. During an interview on 6/4/2026 at 1:47 pm with Licensed Vocations Nurse 2 (LVN 2), LVN 2 stated LVN 2 checked resident weights in both the paper and electronic medical records. During a concurrent interview and record review on 6/5/2026 at 9:15 am with the DON, the WWM dated 4/17/2026 to 5/8/2026, and WVS dated 1/8/2026 to 5/25/2026, the DON stated staff were incorrectly copying and entering a previous weight into the electronic medical record. The DON stated the incorrect weights could cause confusion and problems with monitoring the resident's weights correctly. During a review of the facility's undated P&P titled, Documentation, the P&P indicated it was the (continued on next page)

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	555088	A. Building B. Wing	06/05/2026

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	policy of the facility to document any changes in the resident's medical or mental condition and all services provided in the medical record. The P&P indicated all observations, medications administered, services performed, etc. must be documented in the resident's medical record. During a review of the facility's P&P titled, Nutrition and Hydration, dated 10/2017, the P&P indicated nursing staff shall monitor residents for weight loss or gain and staff shall document weight monitoring.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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** Based on observation, interview, and record review, the facility failed to provide residents on Enhanced Barrier Precaution (EBP, a set of infection control practices that use personal protective equipment [PPE, clothing and equipment used to provide protection] to reduce the spread of multi-drug resistant organisms [MDRO, a bacteria that is resistant to antibiotics]) a safe and sanitary environment to help prevent the development and transmission of communicable diseases for two of eight sampled residents (Residents 13 and 36) by failing to: a. Ensure the Minimum Data Set Coordinator (MDS C) wore the required PPE when touching Resident 13's gastrostomy tube (GT, a medical device inserted through the abdomen directly into the stomach).b. Ensure Restorative Nurse Assistant 1 (RNA 1) wore the required PPE while transferring Resident 36 from the wheelchair to the bed. These failures had the potential to expose Resident 13, Resident 36 and other residents in the facility to infection.Findings: a. During a review of Resident 13's admission Record (AR), the AR indicated the facility initially admitted Resident 13 on 2/7/2023 and readmitted on [DATE] with diagnoses including gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach), history of urinary tract infections (UTI, an infection in the bladder/urinary tract)), and diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control). During a review of Resident 13's Minimum Data Set (MDS, a resident assessment tool) dated 3/19/2026, the MDS indicated Resident 13 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 13 required partial/moderate assistance (helper did less than half the effort) with eating and oral hygiene. The MDS indicated Resident 13 required substantial/maximal assistance (helper did more than half the effort) with toileting, shower, upper/lower body dressing and personal hygiene. The MDS indicated Resident 13 was on feeding tube for nutrition. During a review of Resident 13's untitled Care Plan (CP) dated 5/28/2026, the CP indicated Resident 13 was at risk for MDRO related to GT feeding. The CP approach included placing Resident 13 on EBP and wearing gloves, gown and hand hygiene during high contact resident care activity (dressing, showering, transferring, providing hand hygiene, changing briefs with toileting, device care and wound care). During a review of Resident 13's Order Summary Report (OSR) dated 5/29/2026, the OSR indicated Resident 13 was placed on EBP related to GT feeding and pressure injury (PU, localized damage to the skin and/or underlying tissue usually over a bony prominence). During a concurrent observation inside Resident 13's room and interview on 6/2/2026 at 9:06 am with MDS C, Resident 13 was lying in bed. The MDS C checked and touched Resident 13's G-tube catheter and site. The MDS C was wearing only gloves and not wearing a gown. The MDS C stated the MDS C needed to wear gown and gloves before checking and touching Resident 13's GT catheter and site to prevent the spread of infection. b. During a review of Resident 36's AR, the AR indicated the facility initially admitted Resident 36 on 2/3/2024 and readmitted on [DATE] with diagnoses including open wound on the right thigh, history of UTI, and stage 3 pressure ulcer (full-thickness loss of skin. Dead and black tissue may be visible) on the upper left back. During a review of Resident 36's untitled CP dated 3/19/2026, the CP indicated Resident 36 had a right thigh wound and stage 3 pressure injury on the left deltoid (large, triangular muscle that covers the shoulder). The CP approach included placing Resident 36 on EBP during high contact resident care activity. During a review of Resident 36's MDS dated [DATE], the MDS indicated Resident 36 had moderately impaired cognition. The MDS indicated Resident 36 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity) with eating. The MDS indicated Resident 36 required substantial/maximal assistance with oral hygiene, toileting, shower, upper/lower body dressing and personal hygiene. During a review of Resident 36's OSR dated 3/26/2026, the OSR indicated Resident 36 was placed on EBP related to right thigh wound and left deltoid with stage 3 pressure injury. During a concurrent observation inside Resident 36's room and (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	06/05/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 6/3/2026 at 10:15 am with Restorative Nurse Assistant 1 (RNA 1), RNA 1 transferred Resident 36 from the wheelchair to Resident 36's bed. RNA 1 was only wearing gloves and not wearing a gown. RNA 1 stated Resident 36 was on EBP and RNA 1 should have worn a gown and gloves before transferring Resident 36 from the wheelchair to the bed for infection control. During an interview on 6/4/2026 at 8:50 am with the Infection Prevention Nurse (IPN), the IPN stated all staff should wear gowns and gloves during high-contact care activities including transferring and touching of feeding tubes of residents placed on EBP to avoid contamination and spread of infection. During an interview on 6/4/2026 at 11:47 am with the Director of Nursing (DON), the DON stated staff must wear proper/necessary PPE when touching, transferring and caring to residents on EBP to prevent the spread of infection. During a review of the facility's Policy and Procedure (P&P) titled, Enhanced Barrier Precaution. dated 6/2021, the P&P indicated, EBP may be implemented for residents who: have wounds requiring ongoing treatment or dressing changes; have indwelling medical devices, including: urinary catheters, central venous catheters, tracheostomies, feeding tubes and other devices as identified by the IP or physician. Staff shall wear gloves and gown during high-contact resident care activities - dressing residents, bathing or showering, transferring residents, changing linens, wound care, device care, assisting with toileting and other activities involving extensive physical contact.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for one of one sampled resident (Resident 5) to address the resident's refusal for podiatry care. This deficient practice had the potential to negatively affect the delivery of necessary care and services for Resident 5. Findings: During a review of Resident 5's admission Record (AR) the AR indicated Resident 5 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included muscle weakness and lack of coordination. During a review of Resident 5's Order Summary Report (OSR) dated 2/6/2026, the OSR indicated an active order for Resident 5 to have podiatry care every two months and as needed for hypertrophic or mycotic nails (thick, discolored, brittle nails). During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool) dated 3/19/2026, the MDS indicated Resident 5 had severely impaired cognition (ability to understand) for daily decision making and needed partial/moderate assistance (helper does less than half the effort) for putting on or taking off footwear. During a review of Resident 5's Podiatry Evaluation and Treatment (PET), dated 4/16/2026, the PET indicated Resident 5 refused treatment. During a concurrent observation and interview on 6/2/2026 at 9:39 am with Certified Nurse Assistant 2 (CNA 2) in Resident 5's room, Resident 5 was awake in bed and had long toenails on all five toes of the right foot and the first, second and third toe of the left foot. CNA 2 stated, Resident 5 was confused and had long toenails. During a concurrent observation and interview on 6/2/2026 at 9:49 am with Registered Nurse 1 (RN 1) in Resident 5's room, Resident 5 was awake in bed and had long toenails. RN 1 stated Resident 5's toenails on both feet were long. RN 1 stated toenails should not be kept long to avoid anything getting caught on them and to prevent dirt from getting under the nails. During a review of Resident 5's entire Care Plans (CP), there was no CP developed to address Resident 5's podiatry care or refusal. During an interview on 6/3/2026 at 3:09 pm with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated a care plan should have been developed for Resident 5's refusal of podiatry care, grooming, and Activities of Daily Living (ADL). During a concurrent interview and record review on 6/3/2026 at 3:12 pm with Registered Nurse 1 (RN 1), Resident 5's entire current care plans were reviewed. RN 1 stated there was no CP developed for Resident 5's podiatry refusal in the medical record. During an interview on 6/3/2026 at 3:15 pm with the Director of Nursing (DON), the DON stated Resident 5 did not have a CP for non-compliance for podiatry care. The DON stated CPs were created to meet the residents' needs and provide necessary care. The DON stated Resident 5 had a risk for infection with long toenails, and a CP should have been developed. During a review of the facility's policy and procedure (P&P) titled, Care Plan Revision, dated August 2005, the P&P indicated the CP included measurable objectives and timetables to meet the resident's medical, nursing, mental, and psycho-social needs. The P&P indicated, the CP was updated as the resident's conditions changed and was revised as needed.