

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555199	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/02/2026
NAME OF PROVIDER OR SUPPLIER Coast Care Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE 14518 E. Los Angeles St. Baldwin Park, CA 91706	
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on interview and record review, the facility failed to ensure policies and procedures (P&P) on Advance Directive (AD, a legal document indicating resident preference on end-of-life treatment decisions) and Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) were implemented for three of three sampled residents (Residents 5, 8, and 41) by failing to:a. Ensure Resident 8's POLST was updated to reflect the resident did not have an AD.b. Ensure Resident 41's AD was in the medical record.c. Ensure Resident 5's Advance Directive Acknowledgement Form (ADAF) was updated to reflect the resident did not have an AD. These failures had the potential for the facility staff to provide medical treatment and services against the will of the residents.Findings: a. During a review of Resident 8's admission Record (AR), the AR indicated Resident 8 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach). During a review of Resident 8's History & Physical (H&P) dated 6/27/2025, the H&P indicated the resident did not have the capacity to understand and make decisions and had a surrogate decisionmaker. During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool) dated 10/23/2025, the MDS indicated Resident 8 was rarely or never understood. During a review of Resident 8's untitled Care Plan (CP), the CP indicated: a. Resident 8 had a communication deficit related to being nonverbal with the inability to make self understood as well as the inability to understand. The CP was revised on 10/13/2025. b. Resident 8's discharge plan was to remain in the facility for long-term care and interventions included to review the plan of care quarterly or as needed. The CP was revised on 1/2/2026 During a concurrent interview and record review on 12/30/2025 at 3:15 pm with the Director of Nursing (DON), Resident 8's POLST dated 11/25/2019, and ADAF dated 7/3/2023 were reviewed. The POLST indicated Resident 8 had an AD, while the ADAF indicated Resident 8 did not have an AD. The DON stated there was no AD in the medical chart and the POLST and ADAF contradicted. The DON stated the POLST should be updated to reflect Resident 8 did not have an AD. The DON stated, this was important to carry out the wishes of the residents during an emergency and prevent confusion for (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	health care workers. During an interview on 12/31/2025 at 1:41 pm with Social Services Director (SSD), the SSD stated the SSD did not know why Resident 8's ADAF stated Resident 8 did not have an AD and stated it could be an error. The SSD stated the POLST and ADAF information was confusing and should match to indicate whether Resident 8 had an AD or not. b. During a review of Resident 41's AR, the AR indicated Resident 41 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 41's MDS dated [DATE], the MDS indicated Resident 41 had intact cognition (ability to understand), had shortness of breath when lying flat, and used tobacco. During a review of Resident 41's POLST dated 11/14/2025, the POLST indicated Resident 41 had an AD dated 8/5/2013 that was available and reviewed. During a review of Resident 41's ADAF dated 11/14/2025, the ADAF indicated Resident 41 had an AD and it was attached in the medical records. During a review of Resident 41's Social Service Assessment (SSA) dated 11/24/2025, the SSA indicated Resident 41's AD was completed and witnessed by the former Social Services Director on 8/5/2013. During a review of Resident 41's H&P dated 12/6/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During an interview on 12/30/2025 at 3:08 pm with the Director of Nursing (DON), the DON stated Resident 41's AD was not in the medical record and it should be available in the chart. The DON stated the purpose of an AD was to allow staff to carry out the residents' wishes during emergency care. During an interview on 12/31/2025 at 1:46 pm with SSD, the SSD confirmed Resident 41's ADAF and POLST indicated an AD was completed. The SSD stated, the AD was not in Resident 41's medical chart and it was important to have the AD to follow the wishes of Resident 41. During a review of the facility's P&P titled, POLST, revised 1/25/2024, the P&P indicated the SSD would update the POLST on a quarterly basis, upon readmission and/or as needed. During a review of the facility's P&P titled, Advance Directives, revised 10/25/2024, the P&P indicated copies of any AD were maintained in the resident's clinical record and the facility must have documented in a prominent part of the resident's clinical record whether the resident issued an AD. c. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE] with a diagnosis of but not limited to encephalopathy (any disease or injury that causes temporary or permanent brain dysfunction including confusion, memory loss, and/or personality changes) and diabetes mellitus type 2 (a chronic condition in which the body does not produce enough of the hormone insulin or becomes resistant to it leading to high blood sugar (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	levels in the body). During a review of Resident 5's History and Physical (H&P), dated 7/29/2025, the H&P indicated, Resident 5 had the capacity to make medical decisions and is on DNR [Do Not Resuscitate] status. During a review of Resident 5's Minimum Data Set (MDS, a resident assessment and care screening tool), dated 10/19/2025 indicated Resident 5's ability to make self-understood and ability to understand others. During a review of Residents 5's medical record, the medical record indicated Resident 5 had an AHCD, dated 8/15/2022. During a review of Resident 5's AHCD Acknowledgement Form, dated 7/28/2025, the form indicated Resident 5 did not have an AHCD. During a review of Resident's 5 Social Service Assessment (SSA), dated 10/20/2025, the SSA indicated Resident 5 did not have an AHCD. During an interview on 12/30/2025 at 2:22 PM with Director of Nursing (DON), DON stated the AHCD Acknowledgement Form should have been updated to indicate Resident 5 did have an AHCD on file. During a review of the facility's policy and procedure (P&P) titled, Advance Directives, last revised 10/25/2024, the P&P indicated if the resident has executed an AHCD the facility must obtain a copy from the resident or legal representative and the facility must have documentation in a prominent part of the resident's clinical record whether the resident issued an AHCD.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review, the facility failed to develop and implement an individualized, comprehensive plan of care for three of three sampled residents (Residents 34, 40 and 41). These failures had the potential to result in the residents not receiving individualized care, affecting their quality of life. Findings: a. During a review of Resident 40's admission Record (AR), the AR indicated Resident 40 was readmitted to the facility on [DATE] with diagnoses including anxiety disorder (mental health conditions causing intense, excessive, and persistent fear affecting daily life) and major depressive disorder (a serious mood disorder causing persistent sadness and loss of interest affecting daily life). During a review of Resident 40's History & Physical (H&P) dated 5/15/25, the H&P indicated Resident 40 did not have the capacity to make medical decisions. During a review of Resident 40's Minimum Data Set (MDS, a resident assessment tool) dated 9/25/25, the MDS indicated Resident 40 had moderate cognitive (ability to understand and process thoughts) impairment, anxiety disorder, and was receiving antipsychotic (a class of drugs primarily used to manage symptoms of psychosis) medication. During a concurrent interview and record review on 1/2/26 at 1:24 p.m. of Resident 40's Care Plans, there was no Care Plan created/implemented for anxiety disorder found in Resident 40's clinical record. The Infection Preventionist Nurse 1 (IPN 1) stated Resident 40 had a diagnosis of anxiety. During an interview on 1/2/26 at 1:31 p.m. with IPN 1, IPN 1 stated an individualized care plan needed to be developed upon admission, licensed nursing staff would initiate the care plan and the MDS staff would complete the Care Area Assessment (CAA- resident specific assessment). During an interview on 1/2/26 at 1:34 p.m., IPN 1 stated the purpose of developing an individualized care plan was to address specific concerns for the resident and the interventions serve as a guideline on how to take care of the resident. IPN 1 stated the facility's policy was to develop a care plan based on resident's diagnoses. During an interview on 1/2/26, at 2:13 p.m., with the Director of Nursing (DON), the DON stated it was important to develop a care plan for patient centered care, for facility staff to know the interventions specific for the resident and to revise the care plan for any change in condition. The DON stated it was important to update the care plan and implement new interventions if the original interventions were not effective, if there was a change in the physician's order or if the care plan or medication was discontinued. The DON stated if a resident was prescribed new medication, the new medication should be incorporated in the current/active care plan. The DON stated it was the policy of the facility to develop an individualized care plan for a diagnosis (anxiety disorder) even if the resident was not receiving medication for that diagnosis. b. During a review of Resident 34's AR, the AR indicated Resident 34 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD- a lung condition restricting breathing due to damaged lung), muscle weakness and paranoid schizophrenia (a type of schizophrenia [mental disorder] associated with (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	feelings of being persecuted or plotted against). During a review of Resident 34's Health and History (H&P) dated 10/26/2025, the H&P indicated Resident 34 had fluctuating capacity to understand and make decisions. During a review of Resident 34's MDS dated [DATE], the MDS indicated Resident 34 required partial/moderate assistance (helper does less than half the effort) for oral, toileting and personal hygiene, shower, upper and lower body dressing and putting on/taking off footwear. During a complete review of Resident 34's paper and electronic Medical Record (MR) on 12/31/2025 at 11:06 AM in the presence of License Vocational Nurse (LVN1), there was no Smoking Care Plan (CP) created for Resident 34. During an interview with LVN1 on 12/31/2025 at 11:06 AM, LVN1 stated a smoking CP was important as a guide for staff to follow and know how to keep Resident 34 safe. LVN 1 stated the primary purpose of the smoking CP was to identify residents at risk of causing a fire, harm to themselves or others due to physical or cognitive limitations while smoking. LVN1 stated nursing staff should have created a smoking care plan for Resident 34 as part of the medical records including smoking interventions. LVN 1 stated, the purpose of initiating a CP for Resident 34 who smokes was for the safety of the resident and other residents in the facility. During an interview with the Director of Nursing (DON) on 12/31/2025 at 11:25 AM, the DON stated when a resident is admitted to the facility and the resident is a smoker, the Activity Director (AD) should complete a smoking assessment and the smoking care plan should be initiated by nursing staff. The DON stated, it was important to have a care plan for the resident who smoke because if there was no care plan then there were no interventions in place to keep the resident safe. The DON stated a smoking care plan provides safe smoking protocols and offer cessation support and interventions for the resident. The DON stated the smoking assessment should have been completed by the AD to confirm that Resident 34 could be offered smoking privileges. The DON stated in Resident 34's case, the AD did not complete the smoking assessment and there was no smoking care plan or interventions initiated by nursing staff. During a review of the facility's P&P titled, Quality of Care, revised 1/25/2024, the P&P indicated, Each resident shall be cared of in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being. c. During a review of Resident 41's AR, the AR indicated Resident 41 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 41's MDS dated [DATE], the MDS indicated Resident 41 had intact cognition (ability to understand), had shortness of breath when lying flat, and used tobacco. During a review of Resident 41's Resident Smoking assessment dated [DATE], the Smoking Assessment indicated Resident 41 smoked. During a review of Resident 41's H&P dated 12/6/2025, the H&P indicated Resident 41 had chronic (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and did not have the capacity to understand and make decisions. During a concurrent observation and interview on 12/30/2025 at 10:31 am with Resident 41 in his room, Resident 41 was sitting on his bed. Resident 41 stated Resident 41 smoked cigarettes four times a day and needed to leave the room to smoke. During an observation on 12/31/2025 at 8:30 am in the smoking patio, Resident 41 was observed smoking a cigarette. During an interview on 12/31/2025 at 2:38 pm with the AD, the AD stated Resident 41 did not have a Care Plan (CP) for smoking. The AD stated, the smoking CP was important to know whether the resident could handle smoking, the resident's mental capacity to handle smoking, and for health reasons. During an interview on 1/2/2026 at 12:56 pm with the Director of Nursing (DON), the DON stated CPs were person-centered for the residents and were used to ensure staff provided appropriate care and interventions for the residents. The DON stated Resident 41 was a smoker and should have a smoking CP to provide interventions for safety and to prevent respiratory problems or other conditions from smoking. During a review of the facility's P&P titled, Care Plans, revised 1/25/2024, the P&P indicated, it was the policy of the facility to develop a comprehensive care plan for each resident that included measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs. The P&P indicated the resident's comprehensive CP was developed within seven days of the completion of the resident assessment or within 21 days after the resident's admission, whichever occurred first.		

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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. Based on observation, interview, and record review, the facility failed to follow proper food storage handling practices in accordance with its policy and procedure (P&P) for one of one facility kitchen, as evidenced by:1. Four boxes of expired donuts were observed in the refrigerator with use by date of 12/16/25.2. One pack of expired sliced ham was observed in the freezer, with sell by date of 11/10/25.3. Two packs of expired roast beef were observed in the freezer, with sell by date of 10/30/25.4. One container of whole egg mayonnaise was observed in the refrigerator with incomplete open date.5. A sliced watermelon was observed in the refrigerator dated 12/18/25.6. Multiple and undated, brown-colored lettuce heads were observed in the refrigerator. These deficient practices had the potential to cause food-borne illnesses to the residents.Findings: During a concurrent observation of the facility's kitchen Refrigerator 1 and interview on 12/30/25, at 9:03 a.m., with the Dietary/Environmental Supervisor (DS), four expired boxes of variety pack donuts were observed with used by date of 12/16/25. During an interview on 12/30/25, at 9:07 a.m., with Dietary Aide (DA 1), DA 1 stated the date on the donuts meant the donuts were expired and cannot be served to the residents. The DS stated it was important not to serve expired food to the residents because the residents could get sick if served with expired food. During a concurrent observation and interview on 12/30/25, at 9:29 a.m., with DA 2, DA 2 stated DA 2 forgot to check the date of the donuts. DA 2's initials were observed on the Dietary Department Equipment Maintenance Schedule and checklist for Cleaning and Sanitizing (DDEMSCCS) dated 12/29/25 and 12/30/25. During an interview on 12/30/25, at 9:33 a.m., with DA 1, DA 1 stated the initials on the DDEMSCCS indicated the refrigerator contents and dates were checked. During a concurrent observation of the deep freezer and interview on 12/30/25, 9:38 a.m., with the DS, one pack of sliced ham with sell by date of 11/10/25 and two packs of premium roast beef with sell by date of 10/30/25 were observed in the freezer. The DS stated the sell by date was the date the manufacturer indicated on the ham and roast beef. The DS declined to state what the sell by date indicated by the manufacturer meant. During a concurrent observation on 12/30/25 at 9:43 a.m. with the DS of the kitchen Refrigerator 2, a yellow, plastic container of whole egg mayonnaise was observed with an incomplete open date. A sliced watermelon was observed in the refrigerator dated 12/18/25. The DS and DA 2 were not able to state what the dates indicated. There were also multiple, brown-colored lettuce heads observed in the refrigerator and were undated. The DS could not state the facility's policy regarding perishable food shelf life. During a review of the facility's P&P titled, Produce Storage Guidelines dated 2018, the P&P indicated melons are stored in refrigerator for 5-7 days. During a review of the facility's P&P titled, Food Storage, revised 7/25/2019, the P&P indicated food items will be stored, thawed, and prepared in accordance with good sanitary practice. All items will be correctly labeled and dated.		

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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 interview and record review, the facility failed to ensure policies and procedures (P&P) on Respiratory Syncytial Virus (RSV, a common respiratory virus that infects the nose, throat, respiratory tract, and lungs) were implemented for two of five sampled residents (Residents 5 and 6) by failing to: a. Ensure Resident 5 was administered the RSV vaccination after it was consented for by Resident 5's responsible party on 7/28/2025. b. Ensure the RSV vaccination was offered to Resident 6 nor Resident 6's responsible party. These failures had the potential to result in respiratory infections that could lead to severe illness and hospitalization. Findings: a. During a review of Resident 5's admission Record (AR), the AR indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including encephalopathy (a disease of the brain that alters brain function or structure), Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control) and immunodeficiency (a weakened immune system that makes it difficult for the body to fight infections and diseases). During a review of Resident 5's History & Physical (H&P) dated 7/29/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool) dated 10/19/2025, the MDS indicated Resident 5's cognition (ability to think) was severely impaired and the resident used a wheelchair. During a review of Resident 5's progress notes (PN) dated 1/1/2026 at 2:47 pm, the PN indicated Resident 5 was on monitoring for episodes of coughing and congestion and was being administered breathing treatments and cough syrup yet still experienced persistent coughing episodes. During a concurrent interview and record review on 1/2/2026 at 10:35 am with Infection Preventionist Nurse 1 (IPN 1), Resident 5's Vaccine Consent Form (VCF) dated 7/28/2025 and Resident Immunization Record (RIR) were reviewed. The VCF indicated Resident 5's responsible party consented for Resident 5 to receive RSV vaccination on 7/28/2025. The RIR did not indicate RSV vaccination was administered to Resident 5. IPN 1 stated Resident 5 was [AGE] years old and should have been vaccinated. IPN 1 stated, as soon as a vaccination was consented for, the licensed nurse should order the medication and administer the RSV vaccine. IPN 1 stated, the RSV vaccination was important for residents 75 years and older to protect them from RSV. b. During a review of Resident 6's AR, the AR indicated Resident 6 was admitted to the facility on [DATE] with diagnoses including pleural effusion (a fluid collection around the lungs), immunodeficiency and respiratory disorders. During a review of Resident 6's H&P dated 4/26/2025, the H&P indicated the resident did not have the capacity to understand and make decisions due to dementia (a progressive state of decline in mental abilities). During a review of Resident 6's untitled Care Plan (CP) dated 4/28/2025, the CP indicated Resident 6 had respiratory disorder and pleural effusion that placed the resident at risk for shortness of breath and respiratory distress. During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6 had moderately impaired cognition. During a concurrent interview and record review on 1/2/2026 at 10:35 am with Infection Preventionist Nurse 1 (IPN 1), Resident 6's RIR was reviewed. The RIR did not indicate RSV vaccination was administered to Resident 6. IPN 1 stated Resident 6 was [AGE] years old and was admitted on [DATE]. IPN 1 stated there was no documentation that the RSV vaccination was offered and it should have been given to Resident 6 due to Resident 6's higher risk for respiratory infections. During an interview on 1/2/2026 at 12:59 pm with the Director of Nursing (DON), the DON stated the facility offer the RSV vaccination to new admissions who were eligible and it was the resident's/responsible party's right to be offered the vaccination. The DON stated, offering the RSV vaccination was important for patient safety. The DON stated, if eligible residents were not given the vaccination, they were at an increased risk for respiratory illnesses and infections. During a review of the CDC Vaccine Information Statement (VIS) for RSV: What You Need to Know, dated 10/17/2024, the VIS indicated the CDC recommended a onetime dose of RSV vaccine for everyone 75 years and older and for adults 60 through [AGE] years of age who are increased risk of severe RSV disease. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The VIS indicated those adults 60 to [AGE] years old who were at increased risk included those with chronic heart or lung disease, a weakened immune system, or certain other chronic medical conditions, and those who are residents of nursing homes. During a review of the facility's P&P titled, Respiratory Syncytial Virus (RSV), revised 1/25/2025, the P&P indicated the facility supported the prevention of RSV through appropriate vaccination of eligible residents in accordance with CDC recommendations, provider orders, and resident consent. The P&P indicated, RSV vaccination was offered to reduce the risk of severe respiratory illness, hospitalization, and complications in older adults and other eligible populations.		

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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** Based on observation, interview, and record review, the facility failed to ensure that the call light (a device used by residents to call for assistance from facility staff) was within reach (an arm's length) for one of one sampled resident (Resident 43). This deficient practice had the potential to result in delayed provision of services, delays in care and Resident 43 not receiving assistance with activities of daily living (ADL- activities related to personal care including bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating). Findings: During a review of Resident 43's admission Record (AR), the AR indicated Resident 43 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including sequela cerebral infarction (type of ischemic [deficient supply of blood] stroke [sudden death of brain cells in a localized area due to inadequate blood flow] resulting from a blockage in the blood vessels supplying blood to the brain) and dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning). During a review of Resident 43's Fall Risk Assessment (FRA) dated 12/12/2025 at 10:52 PM, the FRA indicated Resident 43 was at a high risk for falls. During a review of Resident 43's Minimum Data Set (MDS- a resident assessment tool) dated 12/18/2025, the MDS indicated Resident 43 was dependent (helper does all of the effort) from the staff for eating, oral hygiene, upper and lower body dressing, personal hygiene, toileting hygiene, shower, and putting off footwear. During a review of Resident 43's Health and History (H&P) dated 12/22/2025, the H&P indicated Resident 43 did not have the capacity to understand and make decisions. During a review of Resident 43's untitled Care Plan (CP) initiated on 12/15/2025 and revised on 12/30/2025, the CP indicated Resident 43 was at risk for falls related to unsteady or impaired balance. The CP intervention indicated to keep the call light within reach. During an observation of Resident 43 on 12/30/2025 at 9:27 AM in Resident 43's room, Resident 43 was resting in bed and the call light was not placed within Resident 43's reach. Resident 43's call light cord was hanging at the back of Resident 43's bed. During an observation and interview inside Resident 43's room with the Director of Nursing (DON) on 12/30/2025 at 9:30 AM, the DON stated the call light for Resident 43 was not within reach since it was behind the resident's bed. The DON stated it was important to keep the call light within arm's reach so that Resident 43 could call if help was needed or if the resident needed assistance. The DON stated, if the call light was not within reach, Resident 43 could potentially suffer a fall and get injured. The DON stated having the call light within reach could prevent harm to the residents. During an observation and interview inside Resident 43's room with Certified Nursing Assistant 1 (CNA1) on 12/30/2025 at 9:36 AM, CNA1 stated the call light was important to be within Resident 43's reach to prevent a fall and the resident could call staff for assistance, if needed. During an interview with License Vocational Nurse 1 (LVN1) on 12/31/2025 at 11:13 AM, LVN1 stated the call light should be within the resident's reach for safety and for fall prevention. LVN1 stated staff should answer the call lights as soon as possible to attend to the residents' needs and to prevent injuries. LVN1 stated, if the call light was behind Resident 43's bed, then the resident could not reach it and not able to call for help in case of an emergency. LVN1 stated having the call light within reach was crucial for the residents' safety and well-being. During a review of the facility's Policy and Procedure (P&Ps) titled Call Lights, revised 10/25/2024 the P&P indicated, When providing care to residents, be sure to position the call light conveniently and within reach for the resident to use. Be sure all call light cords are placed on the bed at all times, never on the floor or bedside stand.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an accurate assessment was conducted for one of two sampled residents (Resident 34) who smoked. Resident 34 did not have a smoking assessment completed. This deficient practice had the potential to negatively affect Resident 34's safety and plan of care. Findings: During a review of Resident 34's admission Record (AR), the AR indicated Resident 34 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease with exacerbation (COPD- a lung condition restricting breathing due to damaged lung), muscle weakness, major depressive disorder (persistent feelings of sadness, loss of interest, and a reduced ability to function in daily life) and paranoid schizophrenia (a type of schizophrenia [mental disorder] associated with feelings of being persecuted or plotted against). During a review of Resident 34's admission Checklist (AC) dated 10/24/25, the AC did not indicate a Smoking Assessment was completed for Resident 34. During a review of Resident 34's History and History (H&P) dated 10/26/2025, the H&P indicated Resident 34 had fluctuating capacity to understand and make decisions. During a review of Resident 34's Minimum Data Set (MDS- a resident assessment tool) dated 10/30/2025, the MDS indicated Resident 34 required partial/moderate assistance (helper does less than half the effort) for oral, toileting and personal hygiene, shower, upper and lower body dressing and putting on/taking off footwear. During a review of Resident 34's paper and electronic Medical Record (MR) on 12/31/2025 at 11:06 AM, in the presence of License Vocational Nurse (LVN1), there was no Smoking Assessment completed. During an interview with LVN1 on 12/31/2025 at 11:06 AM, LVN1 stated a Smoking Assessment was important as a guide for staff to follow to keep Resident 34 safe. LVN 1 stated, the purpose of a Smoking Assessment was for the safety of Resident 34 and other residents in the facility. LVN 1 stated the Smoking Assessment would determine if residents were safe to smoke and point out any hazards that could cause harm to the residents such as burns or fire. LVN 1 stated, the primary purpose of the Smoking Assessment was to identify residents at risk of causing fire to themselves or others due to physical or cognitive limitations. During an interview with the Activity Director (AD) on 12/31/2025 11:23 AM, the AD stated Resident 34 was a smoker and had smoking privileges. The AD stated, upon admission to the facility, a resident (in general) who is a smoker is provided with a smoking assessment and a smoking policy. The AD stated, the purpose of the smoking assessment was to ensure the safety and well-being of the residents by identifying potential fire hazards and health risks. The AD stated that a resident who smokes can burn themselves or others while smoking and even start a fire. The AD stated the smoking assessment for Resident 34 was not completed and should have been done. During an interview with the facility's Director of Nursing (DON) on 12/31/2025 at 1:25 PM, the DON stated when a resident is admitted to the facility and the resident is a smoker, the AD should complete a smoking assessment, and a care plan should be initiated by nursing staff. The DON stated that the smoking assessment would help the interdisciplinary team (IDT- a group of health care professionals who work together toward the goals of their patients) create an individualized, person-centered care plan to provide safe smoking protocol and offer cessation support and interventions for the residents. The DON stated, the smoking assessment should have been completed by the AD to validate that Resident 34 could be offered smoking privileges. The DON stated the AD did not complete the smoking assessment for Resident 34 and there was no care plan initiated by nursing staff to address Resident 34's smoking. During a review of the facility's Policy and Procedures (P&Ps) titled Resident Smoking Policy and Procedures, revised 1/30/2024, the P&P indicated, The facility provides a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents. Residents who smoke will be further assessed, using the Resident Safe Smoking Assessment for safety. During a review of the facility's P&P titled, Quality of Care, revised (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/25/2024, the P&P indicated, Each resident shall be cared of in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise the Comprehensive Care Plan following the discontinuation of an antidepressant medication (treats depression [mood disorder causing persistent sadness and loss of interest affecting daily life]) Remeron 7.5 milligrams (mg- unit of measurement), for one of one sampled resident (Resident 40). This failure had the potential to result in a delay in care and services in response to a change in Resident 40's needs and goals. Findings: During a review of Resident 40's admission Record (AR), the AR indicated Resident 40 was readmitted to the facility on [DATE] with diagnoses including anxiety disorder (mental health conditions causing intense, excessive, and persistent fear affecting daily life) and major depressive disorder (a serious mood disorder causing persistent sadness and loss of interest affecting daily life). During a review of Resident 40's History & Physical (H&P) dated 5/15/25, the H&P indicated Resident 40 did not have the capacity to make medical decisions. During a review of Resident 40's Minimum Data Set (MDS, a resident assessment tool) dated 9/25/25, the MDS indicated Resident 40 had moderate cognitive (ability to understand and process thoughts). impairment, anxiety disorder, and was receiving antipsychotic (a class of drugs primarily used to manage symptoms of psychosis). During a record review of Resident 40's Physician's Order (PO) dated 10/9/25, the PO indicated Remeron 7.5 mg, by mouth (PO), at bedtime (QHS), was discontinued. During a concurrent interview and record review on 1/2/26 at 1:03 p.m., with the Infection Preventionist Nurse (IPN), Resident 40's electronic Medication Administration Record (eMAR) and Care Plans (CP) were reviewed. The eMAR indicated Remeron 7.5 mg was discontinued on 10/9/25 and Resident 40 was no longer receiving antidepressant medication. Resident 40's CP was not revised following the discontinuation of Remeron 7.5 mg. The IPN stated Resident 40's CP should have been revised. The IPN stated revising the CP would update the CP of necessary care needed for the resident. During an interview on 1/2/26, at 2:13 p.m., with the Director of Nursing (DON), the DON stated it was important to develop a care plan for patient centered care, for facility staff to know the interventions specific for the resident and to revise the care plan for any change in condition. The DON stated it was important to update the care plan and implement new interventions if the original interventions were not effective, if there was a change in the physician's order or if the care plan or medication was discontinued. The DON stated if a resident was prescribed new medication, the new medication should be incorporated in the current/active care plan. During a review of the facility's Policy and Procedure (P&P), titled, Care Plans, revised January 2024, the P&P indicated Care Plans are revised as changes in the resident's condition dictate. Reviews are made at least quarterly.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 8), who was immobile (unable to move) and had limited range of motion (ROM - the extent of movement of a joint) received restorative nursing (a program that helps residents maintain any progress they've made during therapy treatments, enabling them to function at a high capacity) care and the RNA (Restorative Nursing Assistant- an aid who provides restorative and rehabilitation care to residents) documented the services provided five times a week as indicated in the physician's order. This deficient practice had the potential to place Resident 8 at risk for further decline in ROM and further contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints). Findings: During a review of Resident 8's admission Record (AR), the AR indicated Resident 8 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach) and contractures of the right and left ankles. During a review of Resident 8's History & Physical (H&P) dated 6/27/2025, the H&P indicated the resident did not have the capacity to understand and make decisions and had a surrogate decisionmaker. During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool) dated 10/23/2025, the MDS indicated Resident 8 was rarely or never understood. During a review of Resident 8's Order Summary Report (OSR), the OSR indicated the following active orders for:a. RNA to apply bilateral upper extremity resting hand splint every Monday, Tuesday, Wednesday, Thursday, Friday for 3-4 hours or as tolerated. Monitor skin checks before and after splinting (use of rigid material to support and/or immobilize a broken bone), ordered 8/29/2025.b. RNA to apply bilateral upper extremity elbow extension splints for 3-4 hours or as tolerated every Monday, Tuesday, Wednesday, Thursday, Friday, ordered 8/29/2025.c. RNA to apply left knee splint for 2-4 hours as tolerated every Monday, Tuesday, Wednesday, Thursday, Friday, ordered 8/29/2025.d. RNA for gentle passive range of motion on bilateral upper extremities in all appropriate planes, 10 repetitions, two sets as tolerated, every Monday, Tuesday, Wednesday, Thursday, Friday, ordered 9/5/2025.e. RNA for passive range of motion to bilateral lower extremities times 10 repetitions, one set five times a week as tolerated in all planes, every Monday, Tuesday, Wednesday, Thursday, Friday, ordered 9/8/2025. During an observation on 12/30/2025 at 12:05 pm in Resident 8's room, Resident 8 was non-verbal and lying in bed with contracted hands and legs. During an interview 1/2/2026 at 9:29 am with Restorative Nurse Assistant 1 (RNA 1), RNA 1 stated Resident 8 had contracted hands, and the left lower extremity was also contracted. RNA 1 stated Resident 8 received range of motion exercises (ROM) and had splints and heel protectors applied every day. RNA 1 stated the documentation was in the electronic medical record. During a concurrent interview and record review on 1/2/2026 at 10:04 am with Registered Nurse 1 (RN 1), Resident 8's Restorative Administration Record (RAR -a daily documentation record used to document restorative treatments given to a resident) from 12/29/2025 to 1/1/2026 was reviewed. The RAR did not indicate any documentation from 12/29/2025 to 1/1/2026. RN 1 verified documentation was missing and stated RNA 1 may not have been able to document electronically for RNA services given to Resident 8. During an interview on 1/2/2026 at 10:17 am with Infection Preventionist Nurse 1 (IPN 1), IPN 1 stated Resident 8 needed restorative nursing care to help improve mobility, prevent contractures from worsening, and prevent further complications. IPN 1 stated, without documentation, the task was not completed and if staff experienced computer issues a hard copy could have been provided for their documentation. During an interview on 1/2/2026 at 12:54 pm with the Director of Nursing (DON), the DON stated Resident 8 was in the RNA program and needed restorative nursing care because Resident 8 was bedbound, had contractures, and needed exercises to stretch and move (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident. The DON stated it was important to document restoring nursing care as proof that it was completed for the resident. The DON stated, if it was not charted, it was not done. During a review of the facility's undated policy and procedure (P&P) titled, Documentation Principles, the P&P indicated, it was the policy of the facility to adhere to standardized documentation principles and maintain clinical records in a manner that would comply with licensing and certification governmental agency requirements and professional standards. The P&P indicated, entries in the clinical record must be accurate, legible, clear, and timely. During a review of the facility's undated P&P titled, Restorative Nursing Care, the P&P indicated, it was the policy of the facility to provide restorative nursing care to residents to promote the resident's ability to attain his or her maximum functional potential. The P&P indicated, for passive ROM, these exercises must be planned, scheduled, and documented in the clinical record.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review (RR), the facility failed to ensure 19 of 21 resident rooms (Rooms 1, 2, 3, 4, 5, 6, 7, 8, 9, 10,11, 12, 14, 15, 17, 18, 19, 20 and 22) met the square footage requirement of 80 square feet (sq. ft., unit of measurement) per resident in multiple resident rooms. This deficient practice had the potential for the residents not to have enough space for activities of daily living and hinder staff from providing nursing care to the residents, affecting the overall quality of life of the residents. Findings: During a review of the facility's request for room waiver letter dated 1/2/2026, the request for room waiver letter indicated there was ample room to accommodate wheelchairs and other medical equipment as well as space for mobility and movement of ambulatory residents for Rooms 1, 2, 3, 4, 5, 6, 7, 8, 9, 10,11, 12, 14, 15, 17, 18, 19, 20 and 22. The request for room waiver indicated there was adequate space for nursing care and that the health and safety of the residents occupying these rooms were not in jeopardy. The request for room waiver indicated the rooms were in accordance with special needs of the resident's health and safety and did not impede the ability of resident in the rooms to attain his or her highest practicable well-being. During a review of the facility's Client Accommodations Analysis (CAA) dated 1/2/2026, the CAA Indicated the following: Room No. # Of Beds Dimensions#1 4 298.38 sq. ft.#2 2 154.91 sq. ft.#3, 4 2 152.83 sq. ft.#5 2 158.08 sq. ft.#6 4 298.68 sq. ft.#7 2 152.25 sq. ft.#8 2 154.19 sq. ft.#9 ,11 2 153.41 sq. ft.# 10 2 153.74 sq. ft.# 12,14 2 153.28 sq. ft.# 15 4 267.00 sq. ft.# 17 2 154.96 sq. ft.# 18, 20 2 152.56 sq. ft.# 19 2 156.75 sq. ft.# 22 2 151.66 sq. ft. During an interview with the facility's Assistant Administrator (AA) on 12/30/2025 at 9:25 AM, the AA stated the facility was requesting room waiver for Rooms 1, 2, 3, 4, 5, 6, 7, 8, 9, 10,11, 12, 14, 15, 17, 18, 19, 20 and 22. The AA stated nothing was changed from the last recertification survey and the number of bed occupancy remained the same in Rooms 1, 2, 3, 4, 5, 6, 7, 8, 9, 10,11, 12, 14, 15, 17, 18, 19, 20 and 22. During an observation from 12/30/2025 to 1/2/2026 during the Health Recertification Survey, Rooms 1, 2, 3, 4, 5, 6, 7, 8, 9, 10,11, 12, 14, 15, 17, 18, 19, 20 and 22 had adequate space, nursing care, comfort, and privacy to the residents. The residents had enough space to move freely inside the rooms. Each resident inside the affected rooms had beds and bedside tables with drawers. There was an adequate room for the operation and use of wheelchairs (a chair fitted with wheels for use as a means of transport) and walkers (a device that gives additional support to maintain balance or stability while walking). The room size did not affect the care and services provided to the residents when nursing staff were observed providing care to the residents. During an interview with the facility's Director of Nursing (DON) on 12/30/2025 at 2:01 PM, the DON stated there was enough space inside the rooms and staff were able to provide care for the residents. The DON stated the nurses and Certified Nursing Assistant (CNAs) were able to move wheelchairs and walkers inside the rooms with no issues. According to the DON, the residents did not complain about not having enough room inside their rooms for personal belongings or medical equipment. During an interview with Resident 34 on 12/30/2025 at 2:53 PM, Resident 34 was awake and lying in bed inside room [ROOM NUMBER]. Resident 34 stated Resident 34 was able to walk in and out of the room with no concerns or issues. Resident 34 stated there was enough space for all of Resident 34's personal belongings. Resident 34 stated the room space was enough for Resident 34.		