STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555374	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayflower Care Center	5043 Peck Rd El Monte, CA 91732

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 - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687 Based on observation, interview, and record review, the facility failed to accommodate the needs and preferences of one of 22 sampled residents (Resident 1) by failing to ensure Resident 1's bedside tray was within reach and not broken for Resident 1 to use. This deficient practice had the potential to result in a decline in Resident 1's psychosocial well-being due to possible loss of homelike environment and maintaining independence to the extent possible. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated the facility initially admitted Resident 1 to the facility on [DATE], and readmitted Resident 1 on 1/2/2024, with diagnoses that included generalized muscle weakness (weakness of muscles caused by lack of exercise, ageing, injury, or disease), glaucoma (group of eye diseases that could affect vision and cause blindness by damaging the optic nerve), and unqualified visual loss, both eyes (decrease in vision and/or visual field that spanned from mild blurriness to complete blindness). During a review of Resident 1's Minimum Data Set (MDS- a standardized resident assessment and care screening tool), dated 4/19/2024, the MDS indicated Resident 1 had severely impaired cognition (ability to think, remember, and reason). The MDS indicated Resident 1 required supervision (oversight, encouragement, or cueing) with eating. The MDS indicated Resident 1 required partial/moderate assistance (helper did less than half the effort and lifted or held trunk or limbs, but provided less than half the effort) from staff for oral hygiene, toileting hygiene, showering/bathing self, personal hygiene, rolling left to right, sitting to lying, lying to sitting on side of bed, sitting to standing, chair/bed to chair transfer, tub transfers, and walking 10, 50, and 150 feet . The MDS indicated Resident 1 was dependent (helper did ALL the effort or the assistance of 2 or more helpers was required for the resident to complete the activity) with upper and lower body dressing and putting on and taking off footwear. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2024
NAME OF PROVIDER OR SUPPLIER Mayflower Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5043 Peck Rd El Monte, CA 91732	

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 - Few	During a concurrent observation and interview on 5/14/2024 at 10:30 am with Resident 1, in Resident 1's room, Resident 1's bedside tray was observed across from Resident 1's foot of the bed, against the parallel wall. Resident 1 had to get out of the bed to walk to the tray to reach it. Resident 1 stated Resident 1 did not have water and could not reach Resident 1's tray. Resident 1 stated staff (unidentified) always kept Resident 1's tray away from Resident 1's reach. Resident 1 stated Resident 1 could not keep personal items on the tray because the tray was slanted down at an angle, and no one would fix it. Resident 1 stated it was really hard to eat off the tray and keep things on the tray. During a concurrent observation and interview on 5/14/2024 at 10:34 am with Certified Nurse Assistant (CNA) 1, in Resident 1's room, Resident 1's bedside was observed. CNA 1 stated Resident 1 ate breakfast on Resident 1's bedside tray the morning of the interview. CNA 1 stated Resident 1's bedside tray was slanted down, and CNA 1 would not want to eat off the tray if that was CNA 1's bedside tray. CNA 1 stated Resident 1's bedside tray was not within reach, and Resident 1 could not reach for things like water or Resident 1's personal items. During an interview on 5/14/2024 at 10:39 am with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 was blind and therefore everything, including the bedside tray needed to be within reach of Resident 1 for Resident 1's safety. LVN 1 stated if Resident 1's bedside tray was not within reach, Resident 1 could fall and get hurt trying to reach for things. During a concurrent observation and interview on 5/14/2024 at 11:10 am with the Maintenance Director (MD), inside of Resident 1's room, Resident 1's bedside tray was observed. The MD stated the arm of Resident 1's bedside tray was bent and that the tray was not in functional condition. The MD stated residents' furniture needed to be functional, so residents could use the furniture and would not get hurt trying to use a broken furniture The MD stated if furniture was missing or not functional it did not promote a homelike environment for residents. During a review of the facility's policy and procedure (PP) titled, Accommodation of Needs, revised in 3/2021, the PP indicated the resident's individual needs and preferences were accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. The PP indicated in order to accommodate individual needs and preferences, staff attitude and behaviors were directed towards assisting the residents in maintaining independence, dignity, and well-being to the extent possible and in accordance with the residents' wishes. For example: arranging toiletries and personal items so that they were in easy reach of the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2024
NAME OF PROVIDER OR SUPPLIER Mayflower Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5043 Peck Rd El Monte, CA 91732	

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 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure each resident has 1) at least one window to the outside in a room; 2) a room at or above ground level; 3) adequate bedding; 4) furniture that meets the resident's needs; or 5) adequate closet space. 46687 Based on observation, interview, and record review, the facility failed to follow its policy and procedure (PP) titled, Homelike Environment, for 19 of 22 sampled residents (Residents 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, and 22) by failing to: Ensure Residents 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, and 22 were provided bedside tables (adjustable table on wheel that can fit over a resident's bed used for eating, personal items and a table for treatment by nursing staff) to use according to each resident's needs. This deficient practice could result in a decline in Residents 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21 and 22's well-being due to failure to promote a homelike environment. Findings: During a review of Resident 2's Admission Record (AR), the AR indicated the facility admitted Resident 2 to the facility initially on 1/20/2021, and readmitted Resident 2 on 12/28/2023, with diagnoses that included dementia (impaired ability to think, remember or make decisions that interfered with doing everyday activities) and anxiety disorder (persistent feeling of dread or panic that could interfere with daily life). During a review of Resident 2's Minimum Data Set (MDS- a standardized assessment and care planning tool), dated 4/1/2024, the MDS indicated Resident 2 had severely impaired cognition. The MDS indicated Resident 2 required setup or clean-up assistance (helper set up or cleaned up while the resident completed the activity and helper assisted only prior to or following the activity) with eating, showering/bathing self, sitting to standing, chair/bed to chair transfers, toilet transfers, and tub/shower transfers. The MDS indicated Resident 2 required supervision or touching assistance with oral hygiene, toileting hygiene, upper and lower body dressing, putting on and taking off footwear, personal hygiene, rolling left and right, sitting to lying, and walking 10, 50, and 150 feet. During a concurrent observation and interview on 5/14/2024 at 10:12 am with Resident 2, inside of Resident 2's room, Resident 2's room furniture was observed. Resident 2 stated staff (unidentified) took Resident 2's bedside table away and Resident 2 did not know why. Resident 2 stated staff (unidentified) had not brought back the resident's bedside table. Resident 2 stated Resident 2 did not understand why Resident 2's roommate had a bedside table but Resident 2 did not. During a concurrent observation and interview on 5/14/2024 at 10:59 am with Certified Nursing Assistant (CNA) 2, inside Resident 2's room, Resident 2's room furniture was observed. CNA 2 stated both Resident 2 and Resident 2's roommate shared a bedside table because Resident 2 ate in the dining room. CNA 2 stated CNA 2 did not think all residents needed to have a bedside table. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayflower Care Center	5043 Peck Rd El Monte, CA 91732

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 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/14/2024 at 11:02 am with Licensed Vocational Nurse (LVN) 2, inside Resident 2's room, Resident 2's room furniture was observed. LVN 2 stated every resident needed to have his or her own bedside table. LVN 2 stated all residents needed to have a bedside table regardless of dining status. During a concurrent observation and interview on 5/14/2024 at 11 am with the Maintenance Director (MD), the MD stated the MD was not aware that there were missing bedside table in resident rooms. The MD stated there were missing bedside table for Residents 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, and 22. During an interview on 5/14/2024 at 11:31 am with the Director of Staffing Development (DSD), the DSD stated furniture requirements for resident rooms were a bed, bedside table, and nightstand. The DSD stated those items were required so residents could store personal belongings and the bedside table for meals, drinks, and/or for nurses to do medication pass or treatment, and so residents could do activities on the bedside table. The DSD stated the DSD noticed the bedside table had been missing for approximately one month. The DSD stated missing furniture did not promote a homelike environment and could make the residents feel depressed. During an interview on 5/14/2024 at 11:43 am with the Director of Nursing (DON), the DON stated the DON did not check to see if any furniture such as a bedside table was missing from residents' rooms while doing daily rounds. The DON stated residents needed to have bedside table because it was a room requirement. The DON stated residents should be able to place items and do activities on their bedside table. The DON stated the DON noticed that bedside tables were missing from residents' rooms but did not ask to order more. During a concurrent interview and record review on 5/14/2024 at 1:04 pm with the Administrator (ADM), the facility's PP titled, Homelike Environment, undated, was reviewed. The PP indicated the facility provided a safe, clean, comfortable, and homelike environment, allowing residents to use their personal belongings to the extent possible. The ADM stated the bedside table was listed in the PP and was something all residents needed to have in their rooms.