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	08/01/2024

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 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** 45553 Based on observation, interview, and record review, the facility failed to ensure resident environment remained as free of accident hazards as is possible as indicated in the facility's policies and procedures (P&P) titled, Policy & Procedure: Accident/Incident Prevention, and Policy: Call Lights, by failing to: 1. Ensure call light was within reach for two of 11 sampled residents (Residents 1 and 2) in the resident's room. 2. Ensure call light pull cords were within reach for 10 of 11 sampled residents (Residents 1, 2, 4, 5, 6, 7, 8, 9, 10, and 11) when using the bathroom. 3. Ensure call lights were functioning for three of 11 sampled residents (Residents 2, 6, and 7) when using the bathroom. These deficient practices increased the potential for an accident and/or a delay in care due to the inability to call for help because the call lights did not flash above the room door and/or the pull cords were too short to reach from the toilet. Cross Reference F919 Findings: 1. 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 7/27/24, with diagnoses that included encephalopathy (a group of conditions that causes brain dysfunction which alters brain function or structure), dementia without behavioral, psychotic or mood disturbance and anxiety (a group of symptoms affecting memory, thinking and social abilities); schizoaffective disorder (a mental health problem where you experience psychosis as well as mood symptoms), history of falling, other abnormalities of gait (pattern of walking/running) and mobility (the ability to move joints and use muscles easily and comfortably), generalized muscle weakness (sudden difficulty moving your limbs, walking, standing, or sitting upright). (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Minimum Data Set (MDS, a standardized resident assessment and care screening tool), dated 5/11/24, the MDS indicated, Resident 1 had moderately impaired cognition (ability to think and process information). The MDS indicated, Resident 1 required partial/moderate assistance with bathing, oral/personal hygiene, and supervision or touching assistance with toilet use, and upper/lower body dressing. During a review of Resident 1's Licensed Nurses Note (LNN), dated 7/28/24, the LNN indicated Resident 1 was alert and oriented with periods of confusion and disorientation. The LNN indicated, Resident 1 has impaired decision making. During a review of Resident 1's care plan for at risk for falls/injury related to dementia, general weakness, history of falls, impaired cognition, and history of myocardial infarction, the care plan goal indicated, reduce risk of falls and injury daily until the next assessment. The care plan interventions indicated, provide resident with a safe and clutter-free environment; keep call light within easy reach and encourage resident to use it to get assistance. 2. During a review of Resident 2's AR, the AR indicated, the facility initially admitted Resident 2 to the facility on [DATE], and readmitted Resident 2 on 5/4/24, with diagnoses that included urinary tract infection (an infection in any part of your urinary system: kidneys, bladder, ureters, and urethra), encephalopathy, dementia without behavioral, psychotic or mood disturbance and anxiety, schizoaffective disorder, history of falling, other abnormalities of gait and mobility, and generalized muscle weakness. During a review of Resident 2's History and Physical (H&P), dated 3/9/24, the H&P indicated, Resident 1 was able to make decisions for activities of daily living. During a review of Resident 2's LNN, dated 4/21/24, the LNN indicated, Resident 2 was alert and oriented with periods of confusion and disorientation. The LNN indicated, Resident 2 had impaired decision making. During a review of Resident 2's MDS, dated [DATE], the MDS indicated, Resident 2 had severely impaired cognition. The MDS indicated, Resident 2 required partial/moderate assistance with bathing, personal hygiene, upper/lower body dressing, and toilet use. During a review of Resident 2's care plan for at risk for falls/injury related to dementia, general weakness, impaired cognition, use of medications such as antihypertensive, psychotropic, hypoglycemic agents, and analgesic; the care plan goal indicated, reduce risk of falls and injury daily until the next assessment. The care plan interventions indicated, provide resident with a safe and clutter-free environment; keep call light within easy reach and encourage resident to use it to get assistance. 3. During a review of Resident 4's AR, the AR indicated, the facility initially admitted Resident 4 to the facility on [DATE], and readmitted Resident 4 on 7/24/24, with diagnoses that included encephalopathy, schizophrenia (a mental health condition that affects how people think, feel and behave), history of falling; other abnormalities of gait and mobility, generalized muscle weakness, and other lack of coordination. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 4's H&P, dated 9/1/22, the H&P indicated, Resident 4 did not have capacity to understand and make decisions. During a review of Resident 4's MDS, dated [DATE], the MDS indicated, Resident 4 had severely impaired cognition. During a review of Resident 4's CP for at risk for falls/injury related to arthritis, general weakness, history of falls, impaired cognition, impaired vision, seizure, schizophrenia and taking antipsychotic medications, revised on 4/4/23, the care plan goal indicated, reduce risk of falls and injury daily. The care plan interventions indicated, provide resident with a safe and clutter-free environment; keep call light within easy reach and encourage resident to use it to get assistance. 4. During a review of Resident 5's AR, the AR indicated, the facility initially admitted Resident 5 to the facility on [DATE], and readmitted Resident 5 on 4/12/22, with diagnoses that included dementia without behavioral, psychotic or mood disturbance and anxiety, benign prostatic hyperplasia without lower urinary tract symptoms (a condition that occurs when the prostate gland enlarges, potentially slowing or blocking the urine stream), transient ischemic attack (TIA- a temporary blockage of blood flow to the brain), anemia (a condition of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), and acute kidney failure (a condition that slows blood flow to your kidneys). During a review of Resident 5's H&P, dated 6/30/24, the H&P indicated, Resident 5 did not have capacity to understand and make decisions. During a review of Resident 5's MDS, dated [DATE], the MDS indicated, Resident 5 had severely impaired cognition. During a review of Resident 5's FRA, dated 3/4/24, the FRA indicated, Resident 5 was at high risk for fall. During a review of Resident 5's care plan for at risk for falls/injury related to CVA/TIA, dementia, difficulty walking, general weakness, history of falls, impaired cognition, initiated on 8/5/24, the care plan goal indicated, reduce risk of falls and injury daily until next assessment. The care plan interventions indicated, provide resident with a safe and clutter-free environment; keep call light within easy reach and encourage resident to use it to get assistance. 5. During a review of Resident 6's AR, the AR indicated, the facility initially admitted Resident 6 to the facility on [DATE], and readmitted Resident 6 on 3/13/24, with diagnoses that included anemia, other abnormalities of gait and mobility, generalized muscle weakness, other lack of coordination, and schizophrenia. During a review of Resident 6's H&P, dated 3/13/24, the H&P indicated, Resident 6 did not have capacity to understand and make decisions. During a review of Resident 6's MDS, dated [DATE], the MDS indicated, Resident 6 had severely impaired cognition. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. During a review of Resident 7's AR, the AR indicated, the facility initially admitted Resident 7 to the facility on [DATE], and readmitted Resident 7 on 6/19/20, with diagnoses that included generalized (osteo- relating to the bones) arthritis (a condition that affects your joints: spine, knees, hips, base of the thumb, tips of the fingers, and big toe), epilepsy (a brain disorder in which groups of nerve cells, or neurons, in the brain sometimes send the wrong signals and cause seizures), overactive bladder (a problem with bladder function that causes the sudden need to urinate), insomnia (a common sleep disorder where you may have trouble falling asleep, staying asleep, or getting good quality sleep), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and schizophrenia. During a review of Resident 7's H&P, dated 5/28/24, the H&P indicated, Resident 7 did not have capacity to understand and make decisions. During a review of Resident 7's MDS, dated [DATE], the MDS indicated, Resident 7 had moderately impaired cognition. During a review of Resident 7's care plan for at risk for falls/injury because of seizure disorder, osteoarthritis, use of medications such as antihypertensive, antipsychotic, antianxiety, and hypnotic, revised on 6/27/20, the care plan goal indicated, will reduce risk of falls and injury through appropriate interventions. The care plan interventions indicated, place call light within easy reach; staff will provide a safe and clutter-free environment. 7. During a review of Resident 8's AR, the AR indicated, the facility initially admitted Resident 8 to the facility on [DATE] with diagnoses that included senile degeneration of brain (a decrease in the ability to think, concentrate, or remember), other idiopathic peripheral autonomic neuropathy (damage of the peripheral nerves where cause could be determined), insomnia, unspecified psychosis not due to a substance or known physiological condition (a mental state characterized by a loss of touch with reality and may involve hallucinations, delusions, disordered thinking, and behavioral changes). During a review of Resident 8's H&P, dated 5/28/24, the H&P indicated, Resident 8 did not have capacity to make decisions due to current mental stage. During a review of Resident 8's MDS, dated [DATE], the MDS indicated, Resident 8 had severely impaired cognition. During a review of Resident 8's FRA, dated 6/7/24, the FRA indicated, Resident 8 was at high risk for falls. During a review of Resident 8's care plan for at risk for falls/injury related to general weakness, history of falls, impaired cognition, and impaired vision, revised on 8/5/24, the care plan goal indicated, reduce risk of falls and injury daily. The care plan interventions indicated, keep call light within easy reach and encourage resident to use it to get assistance; provide resident with a safe and clutter-free environment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 11's MDS, dated [DATE], the MDS indicated, Resident 11 had severely impaired cognition. During a review of Resident 11's FRA, dated 6/14/24, the FRA indicated, Resident 11 was at high risk for falls. During a review of Resident 11's care plan for at risk for unavoidable falls/injury related to general weakness, impaired cognition, taking hypertension, diabetes and anti-psychosis medications, history of fall, and other commodities, revised on 4/24/24, the care plan goal indicated, reduce risk of falls and injury daily. The care plan interventions indicated, keep call light within easy reach and encourage resident to use it to get assistance; provide resident with a safe and clutter-free environment. During an observation and concurrent interview with Resident 1 on 8/1/24 at 8:35 a.m., in Resident 1's room, Resident 1's call light cord was observed to be wrapped around the frame of the bed and dangling a few inches from the floor. Resident 1 stated she did not know where her call light was located. Resident 1 was informed her call light was wrapped around the bed frame. Resident 1 stated she could not reach the call light button in that position. Resident 1 stated she had a fall on her right side in the bathroom, and she thinks it happened a month ago, but she was not sure. The bathroom was observed to be a shared bathroom with a closed door from the adjacent resident's room. During an observation and concurrent interview with Resident 2 on 8/1/24 at 9:12 a.m., in Resident 2's room, Resident 2 was wearing a pink sweater top and pants with grey slippers. Resident 2 was sitting up on the side of the bed. Resident 2's call light cord was observed to be wrapped around the right siderail of the bed and dangling a few inches from the floor. The bed was in a low position. Resident 2 stated she did not know where her call light was located. Resident 2 was informed her call light was wrapped around the right siderail of the bed. Resident 2 stated she did not use the call light button. Resident 2 was asked if she use the call light for assistance in the bathroom and Resident 2 stated she did not because the cord was too short to reach when sitting on the toilet. Resident 2's bathroom was observed to be a shared bathroom with a closed door from the adjacent resident's room. The pull cord for the call light was observed to be less than 15 inches in length. During an observation and concurrent interview with Resident 1 on 8/1/24 at 2:43 p.m., in Resident 1's room, Resident 1's call light cord was observed to be in the same position as observed earlier in the morning, wrapped around the frame of the bed, and dangling a few inches from the floor. Resident 1 stated she did not have any way to call for help when she used the bathroom. Resident 1's bathroom was observed with no pull cord for the call light. When Resident 1 was asked about the pull cord to call for assistance, Resident 1 stated the cord was missing for quite some time (she could not remember how long), and she did inform the nurses about it, but nothing was done. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/1/24 at 2:47 p.m. with Certified Nursing Assistant (CNA) 1, in Resident 1's room, CNA 1 was informed that Resident 1's call light was wrapped around the bed rail on the lower part of the bed. CNA 1 stated, It should not be wrapped around the bed rail like that because Resident 1 will not be able to reach the call light. CNA 1 unwrapped the call light cord from the bed rail and pinned the call light to the bed blanket (at the head of bed) where it would be in Resident 1's reach to use to call for assistance. CNA 1 stated, It is important to have the call light be visible and within reach for Resident 1 to use to call for help if we are not around. CNA 1 was informed that Resident 1's bathroom was missing the red call light cord. CNA 1 checked the bathroom and when CNA 1 saw there was no red cord for the call light, CNA 1 stated, Should be there, don't know why it is not there. If an emergency occurred in the bathroom or if Resident 1 needed assistance, then Resident 1 would not be able to call for help. CNA 1 tried to flip the red button up on the silver plate call light switch, but it did not light up initially, then it flashed slightly. During a concurrent observation and interview with on 8/1/24 at 2:55 p.m. with CNA 2, in Resident 2's room, CNA 2 was informed that Resident 2's call light was wrapped around the right bed rail and dangling a few inches from the floor. CNA 2 removed the call light from the right side of the bedrail and clipped the call light to the bed sheet at the head of the bed near the pillow. CNA 2 stated, The call light should be in reach in case Resident 2 needs to call for help. CNA 2 was asked about Resident 2's shared bathroom with the adjacent resident's room (who is on enhanced precautions). CNA 2 stated, The resident is not mobile, so she does not use the bathroom. CNA 2 was informed Resident 2's bathroom cord is short. CNA 2 went to look in Resident 2's bathroom. CNA 2 stated the call light cord was too short for Resident 2 to reach. CNA 2 stated, Resident 2 would struggle to call for help if on the toilet and she wouldn't be able to reach a short cord. During an interview on 8/1/24 at 3:30 p.m. with Registered Nurse (RN) 2, at Nursing Station 2, RN 2 was informed about Resident 2's call light cord in the bathroom. RN 2 stated, The Maintenance Supervisor (MS 1) is on medical leave. RN 2 stated she would inform the administrator about the call light cord issue. During a random tour observation of Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, and Resident 11's bathrooms on 8/1/24 at 3:40 p.m., the pull cords for the bathroom call lights were observed to be 15 inches or less in length and not within reach from the bathroom toilet or the bathroom floor when help was needed. The light did not flash above Resident 6, Resident 7, Resident 10, and Resident 11's room door when the call light pull cord was tested for functionality. During an observation of Resident 1, Resident 2, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, and Resident 11's bathrooms on 8/1/24 at 4:20 p.m. with the Director of Nursing (DON), the following were observed: a. For Resident 1's bathroom, when the DON switched the red button in the upward position because there was no pull cord for the call light, the light flashed outside the adjacent room above the door but did not flash for Resident 1's room. b. For Resident 2's bathroom, the DON stated, Resident 2's cord was too short, and Resident 2 would not be able to call for help. The DON stated she would notify the administrator about the call light cord issue. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. For Resident 4 and Resident 5's bathroom, when the DON pulled the short white call light cord, the light did not flash outside above the room door. d. For Resident 6 and Resident 7's bathroom, when the DON pulled the short white call light cord, the light did not flash outside above the room door. During a review of the facility's P&P titled, Policy & Procedure: Accident/Incident Prevention, undated, the P&P indicated, This facility strives to prevent accidents by providing an environment that is free from accident hazards over which the facility has control, as well as identification of each resident at risk for accidents/incidents and the provision of adequate care plans with procedures to prevent accidents. The P&P indicated, Repair equipment to prevent defective equipment . The P&P indicated, monitor accidents or injuries that include falls, skin injuries, etc., and assessment/reassessment of residents who have had accidents/falls. During a review of the facility's P&P titled, Policy: Call Lights, revised 3/2023, the P&P indicated, Purpose: To assure residents receive prompt assistance. The P&P indicated, nursing care and duties included ensuring that the call light was within the resident's reach when in his/her room or when on the toilet.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45553 Based on observation, interview, and record review, the facility failed to provide a functioning and accessible call light system as indicated in the facility's policy and procedure titled, Policy: Call Lights, by failing to: 1. Ensure call light was within reach for two of 11 sampled residents (Residents 1 and 2) in the resident's room. 2. Ensure call light pull cords were within reach for ten of 11 sampled residents (Residents 1, 2, 4, 5, 6, 7, 8, 9, 10, and 11) when using the bathroom. 3. Ensure call lights were functioning for three of 11 sampled residents (Residents 2, 6, and 7) when using the bathroom. These deficient practices had the potential to delay the provision of care for Residents 1, 2, 4, 5, 6, 7, 8, 9, 10, and 11 and negatively affect the residents' well-being when the residents were unable to call staff for assistance. Cross Reference F689 Findings: 1. 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 7/27/24, with diagnoses that included encephalopathy (a group of conditions that causes brain dysfunction which alters brain function or structure), dementia without behavioral, psychotic or mood disturbance and anxiety (a group of symptoms affecting memory, thinking and social abilities); schizoaffective disorder (a mental health problem where you experience psychosis as well as mood symptoms), history of falling, other abnormalities of gait (pattern of walking/running) and mobility (the ability to move joints and use muscles easily and comfortably), generalized muscle weakness (sudden difficulty moving your limbs, walking, standing, or sitting upright). During a review of Resident 1's Minimum Data Set (MDS, a standardized resident assessment and care screening tool), dated 5/11/24, the MDS indicated, Resident 1 had moderately impaired cognition (ability to think and process information). The MDS indicated, Resident 1 required partial/moderate assistance with bathing, oral/personal hygiene, and supervision or touching assistance with toilet use, and upper/lower body dressing. 2. During a review of Resident 2's AR, the AR indicated, the facility initially admitted Resident 2 to the facility on [DATE], and readmitted Resident 2 on 5/4/24, with diagnoses that included urinary tract infection (an infection in any part of your urinary system: kidneys, bladder, ureters, and urethra), encephalopathy, dementia without behavioral, psychotic or mood disturbance and anxiety, schizoaffective disorder, history of falling, other abnormalities of gait and mobility, and generalized muscle weakness. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2's History and Physical (H&P), dated 3/9/24, the H&P indicated, Resident 1 was able to make decisions for activities of daily living. During a review of Resident 2's MDS, dated [DATE], the MDS indicated, Resident 2 had severely impaired cognition. The MDS indicated, Resident 2 required partial/moderate assistance with bathing, personal hygiene, upper/lower body dressing, and toilet use. 3. During a review of Resident 4's AR, the AR indicated, the facility initially admitted Resident 4 to the facility on [DATE], and readmitted Resident 4 on 7/24/24, with diagnoses that included encephalopathy, schizophrenia (a mental health condition that affects how people think, feel and behave), history of falling; other abnormalities of gait and mobility, generalized muscle weakness, and other lack of coordination. During a review of Resident 4's H&P, dated 9/1/22, the H&P indicated, Resident 4 did not have capacity to understand and make decisions. During a review of Resident 4's MDS, dated [DATE], the MDS indicated, Resident 4 had severely impaired cognition. 4. During a review of Resident 5's AR, the AR indicated, the facility initially admitted Resident 5 to the facility on [DATE], and readmitted Resident 5 on 4/12/22, with diagnoses that included dementia without behavioral, psychotic or mood disturbance and anxiety, benign prostatic hyperplasia without lower urinary tract symptoms (a condition that occurs when the prostate gland enlarges, potentially slowing or blocking the urine stream), transient ischemic attack (TIA- a temporary blockage of blood flow to the brain), anemia (a condition of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), and acute kidney failure (a condition that slows blood flow to your kidneys). During a review of Resident 5's H&P, dated 6/30/24, the H&P indicated, Resident 5 did not have capacity to understand and make decisions. During a review of Resident 5's MDS, dated [DATE], the MDS indicated, Resident 5 had severely impaired cognition. 5. During a review of Resident 6's AR, the AR indicated, the facility initially admitted Resident 6 to the facility on [DATE], and readmitted Resident 6 on 3/13/24, with diagnoses that included anemia, other abnormalities of gait and mobility, generalized muscle weakness, other lack of coordination, and schizophrenia. During a review of Resident 6's H&P, dated 3/13/24, the H&P indicated, Resident 6 did not have capacity to understand and make decisions. During a review of Resident 6's MDS, dated [DATE], the MDS indicated, Resident 6 had severely impaired cognition. (continued on next page)

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	555374	A. Building B. Wing	08/01/2024

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

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