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	01/14/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the nursing staff assisted with cleaning eye discharge around both eyes and underneath the eyes on the resident's face for one of three sampled residents (Resident 2). This deficient practice had the potential to negatively impact Resident 2's dignity and result in the resident not being treated with respect, kindness, and dignity.Findings: During a review of Resident 2's admission Record (AR), the AR indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis following cerebral infarction (the blood supply to the brain is blocked or reduced), heart failure (the heart muscle doesn't pump blood as well as it should), muscle weakness, and dry eye syndrome (eyes do not have enough tears or do not make the right type of tears or tears evaporate too fast). During a review of Resident 2's History and Physical (H&P), dated 5/12/2025, the H&P indicated Resident 2 does not have the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 10/20/2025, the MDS indicated Resident 2 was severely impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 2 was dependent (helper does all of the effort or the assistance of two or more helpers required for the resident to complete the activity) on eating, oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, and personal hygiene. During a review of Resident 2's Care Plan Report (CP), initiated 5/26/2019, the CP indicated Resident 2 had self-care deficit and needed extensive assistance with Activities of Daily Living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and physical function. The CP indicated goal that Resident 2 will be clean, dry, and well-groomed daily. During a concurrent observation and interview on 1/13/2026 at 9:42 AM with Resident 2, Resident 2 had discharge around both eyes and beneath the eyes on the face. Resident 2 stated that Resident 2 had discharge around both eyes and under the eyes and felt uncomfortable with eyes and needed help to clean the eyes. During a concurrent observation and interview on 1/13/2026 at 9:51 AM with the Activities Assistant (AA) in the activities room, Resident 2 had discharge around both eyes and underneath the eyes. The AA stated that the nurse should have cleaned Resident 2's eye discharge on face and ensured Resident 2 was well-groomed prior transferring Resident 2 to the activities room. The AA stated it is important to ensure residents are well-groomed to maintain residents' dignity. During an interview on 1/13/2026 at 12:20 PM with the Certified Nursing Assistant (CNA) 4, CNA 4 stated that it was nurses' responsibility, and that it was important to help residents with good personal hygiene to keep residents' dignity. During an interview on 1/14/2025 at 11:41 AM with the Director of Nursing (DON), the DON stated it is important for nurses to treat residents with respect, kindness, and dignity to keep residents clean and well-groomed, and to ensure residents' dignity. During a review of the facility's (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy and Procedure (P&P) titled, Activities of Daily Living (ADL), Supporting, revised in 2022, the P&P indicated that the facility should provide residents who are unable to carry out activities of daily living independently the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. During a review of the facility's Policy and Procedure (P&P) titled, Resident Rights, revised in 2/2021, the P&P indicated that the facility should guarantee the residents' rights to a dignified existence and to be treated with respect, kindness, and dignity.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 3 developed and implemented a person-centered care plan (a treatment plan that focused on the needs and preferences of a resident or individual) for one of three sampled residents (Resident 2) after Resident 2 was observed with skin discoloration on the left upper extremities, the left side of the body, and the right forearm on 12/1/2025. This deficient practice had the potential for Resident 2 to receive inadequate and inappropriate care.Findings: During a review of Resident 2's admission Record (AR), the AR indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness in the arm, leg, and face on one side of the body) following cerebral infarction (stroke, damage to brain tissue caused by loss of blood flow to a part of the brain), and current use of anticoagulants (medicines to help prevent blood clots). During a review of Resident 2's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 5/12/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 10/20/2025, the MDS indicated Resident 2 had severely impaired in cognitive skills (ability to make daily decisions) and was dependent on others (helper does all of the effort to complete the activity) for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). The MDS also indicated Resident 2 was dependent on others to move around in bed and for transfers. During a review of Resident 2's Change of Condition (COC) form, dated 12/1/2025, the COC indicated Resident 2 had skin discoloration on the left upper arm, the left side of the body, and the right forearm which a certified nursing assistant (unidentified) reported to LVN 3 on 12/1/2025 at 5 AM. During a concurrent interview and record review on 1/13/2026 at 2:08 PM with LVN 2, Resident 2's COC, dated 12/1/2025 and Resident 2's care plans were reviewed. LVN 2 stated there was no care plan regarding Resident 2's skin discoloration on the left upper arm, the left side of the body, and the right forearm which were identified on 12/1/2025. LVN 2 stated LVN 3 should have developed a care plan immediately after LVN 3 noticed Resident 2's skin discolorations and after LVN 3 created the COC. During a concurrent interview and record review on 1/14/2025 at 11:41 AM with the Director of Nursing (DON), Resident 2's COC, dated 12/1/2025 and Resident 2's care plans were reviewed. The DON stated there was no care plan regarding Resident 2's skin discoloration on the left upper arm, the left side of the body, and the right forearm which were identified on 12/1/2025. The DON stated the facility must develop and implement a care plan for Resident 2 to monitor Resident 2's physical and psychosocial condition right after Resident 2 was observed with skin discoloration on the left upper arm, the left side of the body, and the right forearm on 12/1/2025. The DON stated that it was important to develop a care plan to monitor the resident's healing process and to monitor any complications which could arise after noticing the skin discoloration on Resident 2. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 3/2022, the P&P indicated that the facility should develop and implement a comprehensive resident-centered care plan that includes measurable objectives and timetables to meet each resident's physical, psychosocial and functional needs. The P&P indicated, The comprehensive, person-centered care plan reflects currently recognized standards of practice for problem areas and conditions. The P&P indicated, Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.The interdisciplinary team (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviews and updates the care plan when there has been a significant change in the resident's condition.