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	05/22/2026

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 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 develop and implement a care plan (CP - summary of a person's health condition, care needs, treatments, goals of treatment, and specific interventions for each identified condition or care need) for one of four sampled residents (Resident 1) when: 1. Resident 1 did not have a care plan for Resident 1's diagnosis of multiple myeloma (a type of blood cancer). 2. Resident 1 did not have a care plan for Resident 1's diagnosis of osteopenia (bones are weaker than normal). These failures had the potential for Resident 1 to receive inappropriate care and services. During a review of Resident 1's Face Sheet (FS, document that contains a patient's personal and contact information, diagnoses, and medical history), the FS indicated Resident 1 was readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's History and Physical Examination (H&P, physician's clinical evaluation and examination of the resident), dated 10/1/2025, the H&P indicated Resident 1 was able to make decisions for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 4/21/2026, the MDS indicated Resident 1's cognitive skills (reasoning, learning, and problem-solving) for daily decision making was severely impaired. The MDS indicated Resident 1 was dependent on staff for most ADLs. During a review of Resident 1's physician's assessment (PA) from General Acute Care Hospital (GACH) 1, dated 9/29/2025, the PA indicated Resident 1 was diagnosed with multiple myeloma and osteopenia. During a review of Resident 1's left shoulder X-ray (picture or digital image of the inside of the body), dated 5/17/2026, the X-ray indicated Resident 1 had osteopenia and lytic lesions (areas of bone destruction that occurs due to diseases such as cancer) from metastasis (spread of cancer cells to other parts of the body) or myeloma. During a review of Resident 1's electronic medical record, there was no care plan for Resident 1's diagnosis of myeloma and osteopenia found in the medical record. During an interview on 5/22/2026 at 1:26 p.m. with the Director of Nursing (DON), the DON stated a care plan was an individualized plan of care for a resident that included interventions to help the resident achieve highest care. The DON stated it was important to develop and implement care plans to set a plan of care for residents' health issues. The DON stated if a resident did not have a care plan for all their health issues there was a risk that the resident might not receive the appropriate care and there was no way to follow up on resident's care. The DON stated care plans are developed on admission, quarterly, with any change of condition, and for new orders or a new diagnosis. The DON stated the DON was not aware that Resident 1 had a diagnosis of myeloma and osteopenia and that was the reason why Resident 1 did not have a care plan. The DON stated during readmission to the facility from the GACH, nursing staff (in general) should have noticed the diagnosis of myeloma and osteopenia and created a care plan for Resident 1. The DON stated with a care plan Resident 1 would have a plan of care for Resident 1's symptoms, pain management and fall precautions. The DON stated the facility did not provide the care Resident 1 required for the (continued on next page)

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

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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	diagnosis of myeloma and osteopenia because no one knew Resident 1 had cancer. The DON stated Resident 1 should have been referred to see an oncologist and Resident 1 should have received proper medication for pain management. During a review of facility's Policy and Procedure (P&P) titled The Resident Care Plan, undated, the P&P indicated the objective was to provide an individualized nursing care plan and to promote continuity of resident care. The P&P indicated a care plan included identification of medical, nursing, and psychosocial needs. The P&P indicated it was the responsibility of the licensed vocational nurse to ensure the plan of care was initiated and evaluated.