

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  06/27/2025
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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure call lights were within reach for two of two sampled residents (Residents 24 and 1).</p> <p>These failures had the potential to result in Residents 24 and 1 to not receive necessary care or receive delayed services.</p> <p>Findings:</p> <p>a. During a review of Resident 24's admission Record (AR), the AR indicated Resident 24 was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing) and osteoarthritis (OA, a progressive disorder of the joints, caused by gradual loss of cartilage).</p> <p>During a review of Resident 24's Minimum Data Set (MDS, a resident assessment tool), dated 5/4/2025, the MDS indicated, Resident 24 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 24 was dependent (helper did all the effort, resident did none of the effort to complete the activity) with eating, oral hygiene, toileting, shower, upper and lower body dressing and personal hygiene.</p> <p>During a review of Resident 24's Care Plan (CP), dated 6/26/2025, the CP indicated Resident 24 was at risk for falls and injury related to generalized weakness, impaired cognition and poor safety awareness and judgement. The CP interventions included keeping the call light within easy reach and encouraging the resident to use the call light to receive assistance.</p> <p>During a concurrent observation while inside Resident 24's room and during an interview on 6/24/2025 at 9:05 a.m. with Certified Nurse Assistant 3 (CNA 3), Resident 24 was lying in bed, on Resident 24's back and the call light was tucked under the pillow. CNA 3 stated Resident 24 was confused and disoriented. CNA 3 stated Resident 24 did not know where Resident 24's call light was. CNA 3 stated the call light should be placed next to Resident 24 and Resident 24 should be aware of the call light's location to use and be able to call for help when needed.</p> <p>During an interview on 6/27/2025 at 10:30 a.m. with the Director of Nursing (DON), the DON stated the call light should be placed where the resident could see it, access it and reach it. The DON further stated the call light should be placed on the strong arm and hand of the resident to use and call for help every time assistance was needed.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included muscle weakness, lack of coordination and parkinsonism (a progressive disease marked by tremor, muscular rigidity, and slow, imprecise movements).</p> <p>During a review of Resident 1's untitled Care Plan (CP) dated 12/7/2023, the CP indicated Resident 1 had scheduled toileting plan to prevent falls related to attempts to go to bathroom secondary to incontinence (involuntary loss of bladder or bowel control) related to dementia ( long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning). The CP intervention indicated for the nursing staff have Resident 1's call light within reach.</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 6/5/2025, the MDS indicated Resident 1 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 1 needed set up pr clean-up assistance (helper sets up or cleans up) on staff for shower, upper/lower body dressing and putting on/off footwear.</p> <p>During a review of Resident 1's Fall Risk Assessment (FRA- method of assessing a patient's likelihood of falling) dated 6/13/2025, the FRA indicated Resident 1 was assessed as high risk for falls due to intermittent confusion, history of falls in the last 12 months, unable to stand without assistance and presence of predisposing disease condition.</p> <p>During an observation on 6/24/2025 at 8:58 am, Resident 1 was awake, sitting in bed with the call light hanging on the wall. Resident 1 stated Resident 1 cannot find Resident 1's call light.</p> <p>During an interview on 6/25/2025 at 12:45 pm with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated resident's call light needed to be within reach at all times to call staff for help or assistance. LVN 1 stated Resident 1 was high risk for fall.</p> <p>During an interview on 6/27/2025 at 10:31 am with the facility's Director of Nursing (DON), the DON stated, a residents' call light needed to be within reach at all times and easily accessible for residents to use to call for assistance from staff and to keep residents safe.</p> <p>During a review of the facility's undated Policy and Procedure (P&amp;P) titled, Call Light, the P&amp;P indicated to ensure that the call light was within the resident's reach when in his/her room or when on the toilet.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> c. During a review of Resident 24's admission Record (AR), the AR indicated Resident 24 was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing) and osteoarthritis (OA, a progressive disorder of the joints, caused by gradual loss of cartilage).</p> <p>During a review of Resident 24's Minimum Data Set (MDS, a resident assessment tool), dated 5/4/2025, the MDS indicated, Resident 24 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 24 was dependent (helper did all the effort, resident did none of the effort to complete the activity) with eating, oral hygiene, toileting, shower, upper and lower body dressing and personal hygiene.</p> <p>During a concurrent interview and record review on 6/24/2025 at 1:08 p.m. with Medical Records (MR), Resident 24's chart, EMR and AD Acknowledgement form, dated 8/16/2024, were reviewed. MR stated Resident 24's AD Acknowledgement form indicated Resident 24 had executed an AD. MR stated there was no copy of the AD found in Resident 24's chart and/or uploaded in Resident 24's EMR.</p> <p>During an interview on 6/27/2025 at 10:03 p.m. with the Director of Nursing (DON), the DON stated a copy of the AD should be in the chart and/or EMR and accessible to the staff to address and identify the resident's end-of-life wishes and preferences.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Advance Directives, last revised September 2022, the policy and procedure indicated prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. The P&amp;P indicated information about whether or not the resident has executed an advance directive is displayed prominently in the medical record in a section of the record that is retrievable by any staff.</p> <p>b. During a review of Resident 57's admission Record (AR), the AR indicated Resident 57 was admitted to the facility on [DATE] with diagnoses that included muscle weakness and abnormalities of (a person's manner of walking) and mobility (the ability to move.)</p> <p>During a review of Resident 57's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 3/29/2025, the MDS indicated Resident 57 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 57 needed set up or clean-up assistance (helper sets up or cleans up) on staff for shower, upper/lower body dressing and putting on/off footwear.</p> <p>During an interview and concurrent record review on 6/24/2025 at 11:07 p.m., with the Licensed Vocational Nurse 1 (LVN 1) of Resident 57's medical records (PointClickCare - PCC, a cloud-based software used in long-term and post-acute care facilities and chart), LVN 1 stated the AD Acknowledgement Form needed to be signed and initialed completely to follow the residents wishes and wants and needed to be discussed with the resident or responsible party upon admission.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/27/2025 at 11:29 a.m., with the facility's Director of Nursing (DON), the DON stated the AD Acknowledgement Form needed to be filled out completely upon admission by Social Services to assess if the resident executed an AD or wanted to execute. The facility's DON stated there was no clinical documentation that Social Services attempted to reach out to the responsible party or Resident 57 to offer information regarding an AD.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Advance Directives, dated 9/2022, the P&amp;P indicated the resident has the right to formulate an advance directive including the right to accept or refuse medical or surgical treatment. The P&amp;P indicated advance directives are honored in accordance with state law and facility policy. The P&amp;P indicated prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. The P&amp;P indicated the resident, or representative is provided with written information . to formulate an advance directive if he or she chooses to do so. The P&amp;P indicated information about whether or not the resident has executed an advance directive is displayed prominently in the medical record that is retrievable by any staff. Based on interview and record review, the facility failed to ensure policies and procedures (P&amp;P) regarding Advance Directive (AD, a legal document indicating resident preference on end-of-life treatment decisions) were implemented for three of three sampled residents (Residents 24, 46 and 57) by failing to:</p> <ol style="list-style-type: none"> <li>Ensure Resident 46's medical record had information about whether or not the resident executed an AD displayed prominently in the medical record.</li> <li>Ensure Resident 57 was provided with information regarding an AD and a copy was in the resident's medical record (chart) and/or uploaded to the resident's electronic medical record (EMR).</li> <li>Ensure Resident 24's copy of AD was in the resident's chart and/or uploaded in the resident's EMR.</li> </ol> <p>These failures had the potential to result in the facility staff to provide medical treatment and services against the will of the residents.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>During a review of Resident 46's admission Record (AR), the admission Record indicated Resident 46 was admitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities) and anemia (a condition where the body does not have enough healthy red blood cells).</li> </ol> <p>During a review of Resident 46's History &amp; Physical (H&amp;P), dated 2/25/2024, the H&amp;P indicated the resident did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 46's Minimum Data Set assessment, dated 5/16/2025, the MDS indicated Resident 46 was rarely or never understood.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 46's Medical Record, there was no record of a 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) or Advance Directive Acknowledgement Form within the chart to indicate if Resident 46 had an Advance Directive.</p> <p>During a review of Resident 46's Progress Notes, dated 6/24/2025 to 6/25/2025, the progress notes indicated nursing staff attempted to call family regarding Resident 46's AD and POLST.</p> <p>During a concurrent interview and record review on 6/26/2025 at 2:56 p.m. with Licensed Vocational Nurse 2 (LVN 2), Resident 46's Advance Healthcare Directive Acknowledgment (ADA) form was reviewed. The ADA Form was not completed and indicated that Resident 46's doctor and family member were contacted on 6/24/2025. LVN 2 stated that the Resident was admitted to the facility on [DATE] and the ADA form should have been completed already. LVN 2 stated, this information was important for nursing to have during an emergency to allow them to know what treatment the resident should have, whether a full code or if they should not attempt to resuscitate.</p> <p>During an interview on 6/27/2025 at 11:21 a.m. with the Director of Nursing (DON), the DON stated the ADA form allowed them to know the resident's wishes and provide the resident with the desired care. The DON stated that the ADA form was completed by Social Services and should have been followed up on, but did not find any documentation of previous follow-up attempts prior to this week. The DON stated Resident 46 was not clinically stable and it was very important to have the ADA and POLST forms completed to allow nursing staff to provide the proper emergency care for her.</p>

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide privacy for one of one sampled resident (Resident 10) when staff did not close the privacy curtain while changing Resident 10's clothes.</p> <p>This deficient practice violated Resident 10's right to bodily privacy and resulted in unnecessary exposure of Resident 10's upper chest area. This deficient practice had the potential to affect Resident 10's psychosocial (mental and emotional) well-being, self-esteem, and self-worth.</p> <p>Findings:</p> <p>During a review of Resident 10's admission Record (AR), the AR indicated Resident 10 was admitted to the facility on [DATE], with diagnoses that included encounter for attention to gastrostomy (creation of an artificial external opening into the stomach for nutritional support) and dysphagia (difficulty swallowing).</p> <p>During a review of Resident 10's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 4/4/2025, the MDS indicated Resident 10 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 10 was dependent (helper does all of the effort) on staff for oral hygiene, toileting, showering/bathing self, upper and lower body dressing, putting on/taking off footwear, and personal hygiene.</p> <p>During a review of Resident 10's Order Summary Report (O) dated 5/8/2025, the OSR indicated for staff to administer Glucerna 1.2 (liquid formula used for G-tube feeding) at 50 cubic centimeters per hour (cc/hr.- unit of measurement) for 20 hours via pump (medical device used to deliver tube feeding) to provide 1,100 cc per 1,320 kilo calories (kcal, unit of energy) per day.</p> <p>During a review of Resident 10's Care Plan (CP) initiated on 4/22/2022, the CP indicated Resident 10 required assistance with activities of daily living (ADL) as needed. The CP interventions indicated for staff to maintain Resident 10's privacy and respect Resident 10's rights.</p> <p>During a concurrent observation and interview on 6/24/2025 at 8:45 a.m. with the Certified Nurse Assistant 4 (CNA 4, while in Resident 10's room, Resident 10 was awake, sitting in shower chair with upper chest exposing to roommate and possible the hallway. The CNA 3 stated, privacy curtain needed to be closed while doing ADLs to provide resident privacy.</p> <p>During an interview on 6/24/2025 at 8:47 a.m. with the Director of Staff and Development (DSD), the DSD stated the privacy curtain was not closed while the CNA was providing care to Resident 10 and exposing Resident 10's upper chest area. The DS stated staff needed to pull the curtain close to provide privacy while giving care and treatment to residents.</p> <p>During an interview on 6/27/2025 at 10:27 a.m. with the Director of Nursing (DON), the DON stated Resident 10's privacy curtain needed to be closed during care and ADL's to maintain Resident 10's dignity and privacy and not exposing residents body parts.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&amp;P) titled, Dignity, revised 2/2021, the P&amp;P indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The P&amp;P indicated staff would promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 46), Minimum Data Set (MDS - a federally mandated resident assessment tool) assessment related to respiratory treatments - oxygen therapy was accurately documented to reflect the resident's use of oxygen.</p> <p>This failure had the potential to negatively affect Resident 46's plan of care and delivery of necessary care and services.</p> <p>Findings:</p> <p>During a review of Resident 46's admission Record (AR), the admission Record indicated Resident 46 was admitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities) and anemia (a condition where the body does not have enough healthy red blood cells).</p> <p>During a review of Resident 46's History &amp; Physical (H&amp;P), dated 2/25/2024, the H&amp;P indicated the resident did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 46's Minimum Data Set assessment, dated 5/16/2025, the MDS indicated Resident 46 was rarely or never understood and no oxygen therapy was indicated for continuous or intermittent.</p> <p>During a review of Resident 46's Order Summary Report, dated 6/27/2025, the Order Summary indicated Resident 46 had active orders to administer oxygen at two liters per minute via nasal cannula for shortness of breath -with titration up to five liters per minute for oxygen saturation less than 91% as needed for shortness of breath, ordered 3/12/2025 and to monitor oxygen saturation every shift, ordered on 11/13/2024.</p> <p>During an observation on 6/24/2025 at 9:55 a.m. in Resident 46's room, Resident 46 was observed awake in bed receiving oxygen via nasal cannula.</p> <p>During an interview on 6/26/2025 at 10:56 a.m. with Minimum Data Set Coordinator (MDSC), MDSC stated Resident 46 was not on oxygen at the time of assessment and did not see any documentation showing Resident 46 used oxygen during that time and within the seven-day look back period.</p> <p>During an interview on 6/26/2025 at 11:16 a.m. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 46 used oxygen as needed for shortness of breath, and it was only removed for showers. LVN 2 stated Resident 46 used oxygen every day, consistently ever since a desaturation (a decrease in oxygen) episode that occurred in March 2025.</p> <p>During a review of Resident 46's Weights and Vitals Summary (summary of resident weights and vital signs) for May 2025, the summary indicated oxygen use for Resident 46 every day from 5/2/2025 to 5/31/2025.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 6/26/2025 at 3:04 p.m. with MDSC, Resident 46's Weights and Vitals Summary showed Resident 46 utilized oxygen via nasal cannula every day during the assessment period. MDSC stated that the oxygen saturations showed she used oxygen via nasal cannula, and he failed to review the oxygen saturation summary data. The MDSC stated, the MDS was used to provide better care for the residents and when submitted to The Centers for Medicare and Medicaid Services (CMS) should be coded as accurately as possible.</p> <p>During an interview on 6/27/2025 at 10:10 a.m. with Certified Nurse Assistant 5 (CNA 5), CNA 5 stated Resident 46 was always on oxygen when seen by her and did not utilize it during shower time.</p> <p>During an interview on 6/27/2025 at 11:26 a.m. with the Director of Nursing (DON), the DON stated, Resident 46 received oxygen as needed. The DON stated residents need to be assessed properly and when data is submitted to CMS it should be coded accurately and properly.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Resident Assessments, last revised March 2022, the P&amp;P indicated anyone who completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information.</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure residents were provided with a communication device in a language that the resident understood for one of one sampled resident (Resident 30).</p> <p>This failure had the potential to affect Resident 30's communication with the staff and had the potential to result in a delay in the provision of care, treatment, and services to the residents.</p> <p>Findings:</p> <p>During a review of Resident 30's admission Record (AR), the AR indicated Resident 30 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and anxiety (characterized by excessive, persistent worry and fear that can interfere with daily life).</p> <p>During a review of Resident 30's Care Plan (CP), dated 3/22/2023, the CP indicated Resident 30 had a cognitive and communication deficit related to Resident 30 speaks Cantonese. The CP indicated Resident 30 needed translator/communication devices.</p> <p>During a review of Resident 30's Minimum Data Set (MDS, a resident assessment tool), dated 3/24/2025, the MDS indicated Resident 30's preferred language was Cantonese (a form of Chinese spoken mainly in southeastern China) and needed or wanted an interpreter to communicate with a doctor or healthcare staff. The MDS indicated Resident 30 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 30 needed setup or clean-up assistance (helper sets up or cleans up, resident completes the activity) with eating, oral hygiene, upper and lower body dressing and personal hygiene.</p> <p>During a concurrent observation and interview while inside Resident 30's room on 6/24/2025 at 9:16 a.m. with Licensed Vocational Nurse 2 (LVN 2), Resident 30 was lying in bed and on her back. Resident 30 was responding in Chinese language when asked. LVN 2 stated Resident 30 did not have a communication board inside the room. LVN 2 stated Cantonese speaking staff were not always available in the facility. LVN 2 stated all non-English speaking residents should have a communication board to be able to communicate their needs better to the staff.</p> <p>During an interview on 6/27/2025 at 10:01 a.m. with the Director of Nursing (DON), the DON stated staff identified the language spoken by the residents and provide a communication board to be able to communicate and express their needs and staff address the residents' needs appropriately.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Accommodation of Needs Related to Communication, revised May 2023, the P&amp;P indicated, The facility will take reasonable steps to ensure that the staff will communicate with residents to accommodate residents with limited English proficiency and disabilities. Provide communication board with written translation as indicated.</p>		

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NAME OF PROVIDER OR SUPPLIER  Mayflower Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  5043 Peck Rd El Monte, CA 91732	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure policies and procedures for oxygen administration were implemented for two of two sampled residents (Resident 49 and Resident 46) by failing to:</p> <p>a. Ensure Resident 49's nasal cannula tubing was not touching the floor when in use.</p> <p>b. Ensure Resident 46's nasal cannula tubing was labeled and was receiving oxygen according to physician's order.</p> <p>These failures had the potential to result in contamination of Resident 49's and Resident 46's care equipment, placing the residents at risk for infection and could have caused complications associated with oxygen therapy for Resident 46.</p> <p>Findings:</p> <p>a. During a review of Resident 49's admission Record (AR), the admission Record indicated Resident 49 was admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and heart failure.</p> <p>During a review of Resident 49's History &amp; Physical (H&amp;P), dated 10/2/2024, the H&amp;P indicated the resident did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 49's Minimum Data Set (MDS - a federally mandated resident assessment tool) assessment, dated 4/10/2025, the MDS indicated Resident 49 was cognitively intact.</p> <p>During a review of Resident 49's Order Summary Report, dated 6/26/2025, the Order Summary indicated Resident 49 had an active order for oxygen to be administered at two liters per minute (L/min) via nasal cannula (may titrate to five L) as needed for shortness of breath or wheezing, ordered on 10/1/2024.</p> <p>During a concurrent observation and interview on 06/24/2025 at 11:14 a.m. with Licensed Vocational Nurse 2 (LVN 2) while in Resident 49's room, Resident 49 was receiving oxygen through a nasal cannula and the oxygen tubing was touching the floor. LVN 2 stated Resident 49 was on continuous oxygen and the oxygen tubing should not be touching the floor because the resident could acquire an infection.</p> <p>During an interview on 6/27/2025 at 11:13 am with the Director of Nursing (DON), the DON stated, Resident 49 received oxygen continuously for COPD and his heart failure. The DON stated oxygen tubing touching the floor while in use was an infection control risk for the residents.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Oxygen Administration, last revised March 2022, the P&amp;P indicated oxygen tubing should be used in a manner that prevents it from touching the floor.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. During a review of Resident 46's admission Record (AR), the admission Record indicated Resident 46 was admitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities) and anemia (a condition where the body does not have enough healthy red blood cells).</p> <p>During a review of Resident 46's History &amp; Physical (H&amp;P), dated 2/25/2024, the H&amp;P indicated the resident did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 46's Minimum Data Set (MDS - a federally mandated resident assessment tool) assessment, dated 5/16/2025, the MDS indicated Resident 46 was rarely or never understood.</p> <p>During a review of Resident 46's Order Summary Report, dated 6/27/2025, the Order Summary indicated Resident 46 had an active order to administer oxygen at two L/min via nasal cannula for shortness of breath -with titration up to five L/min for oxygen saturation less than 91% as needed for shortness of breath, ordered on 3/12/2025. The Order Summary also indicated an active order to monitor Resident 46's oxygen saturation every shift, ordered on 11/13/2024.</p> <p>During a concurrent observation and interview on 6/24/2025 at 10:14 a.m. with Licensed Vocational Nurse 2 (LVN 2) while in Resident 46's room, Resident 46 was receiving oxygen through a nasal cannula that was unlabeled and set at 1.5 L of oxygen. LVN 2 stated, Resident 46's tubing should have been labeled for infection control, stating if it was old, it could accumulate moisture and build bacteria. LVN 2 further stated, the physician's order was for 2 L of oxygen and changed the oxygen concentration.</p> <p>During an interview on 6/27/2025 at 11:14 a.m. with the Director of Nursing (DON), the DON stated, Resident 46 received oxygen as needed. The DON stated that oxygen tubing should be labeled to prevent the risk of infection. The DON stated, oxygen requires a physician's order and if the oxygen is not at the correct setting the nurses are not following the physician's order.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Oxygen Administration, last revised March 2022, the P&amp;P indicated oxygen tubing should be changed weekly and as needed with a date, time and initials noted on the oxygen equipment when initially used and when changed. The P&amp;P indicated, oxygen should be administered as ordered by the physician.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to implement its policy and procedures (P&amp;P) titled, Physical Restraint, for four of four sampled residents (Residents 29, 57, 7 and 49) by failing to:</p> <p>a. Ensure to obtain an informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) before the installation of side rails.</p> <p>b. Ensure appropriate alternative interventions to side rails/bed rails (adjustable metal or rigid plastic bars attached to the bed) were attempted and did not meet the needs of Resident 57 and ensure the side rails/bed rails pads for Resident 57 were free from damage and wear and tear.</p> <p>c. Ensure Resident 7 had padded bedside rails for seizures as ordered by the physician.</p> <p>d. Ensure Resident 49 had padded bedside rails for seizures as ordered by the physician</p> <p>These failures placed Residents 29, 57, 7, and 49 at risk for entrapment (an event in which residents were caught, trapped, or entangled in a tight space around the bed) and injury from the use of side rails.</p> <p>Findings:</p> <p>a. During a review of Resident 29's admission Record (AR), the AR indicated Resident 29 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (weakness on one side of the body) and muscle weakness (lack of muscle strength).</p> <p>During a review of Resident 29's Minimum Data Set (MDS, a resident assessment tool), dated 5/14/2025, the MDS indicated Resident 29 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 29 was dependent (helper did all the effort, resident did none of the effort to complete the activity) with eating, oral hygiene, toileting, shower, upper and lower body dressing and personal hygiene.</p> <p>During a review of Resident 29's Order Summary Report (OSR), dated 6/9/2025, the OSR indicated Resident 29 had an order for bilateral upper half side rails up and locked up when in bed for activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily) changes, mobility, positioning, and as enabler.</p> <p>During a concurrent observation while inside Resident 29's room and interview on 6/24/2025 at 9:14 a.m. with Certified Nurse Assistant 3 (CNA 3), Resident 29 was lying in bed and on her back with side rails up on both sides of the bed. CNA 3 stated Resident 29 was confused.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 6/25/2025 at 1:59 p.m. with Licensed Vocational Nurse 2 (LVN 2), Resident 29's medical record (chart) and electronic medical record (EMR) were reviewed. LVN 2 stated there was no informed consent obtained and signed for the use of bilateral upper half side rails in Resident 29's chart and EMR. LVN 2 stated staff need to obtain an informed consent from Resident 29 or Resident 29's responsible party (RP) to make sure Resident 29 and/or RP understood and educated on the risks and benefits of using side rails/bed rails.</p> <p>During an interview on 6/27/2025 at 10:05 a.m. with the Director of Nursing (DON), the DON stated signed informed consent should be obtained and a copy retained in the chart before the use and installation of side rails/bed rails indicating the risks and benefits were explained and understood.</p> <p>b. During a review of Resident 57's admission Record (AR), the AR indicated Resident 57 was admitted to the facility on [DATE] with diagnoses that included muscle weakness and abnormalities of (a person's manner of walking) and mobility (the ability to move).</p> <p>During a review of Resident 57's Order Summary Report (OSR) dated 12/20/2024, the OSR indicated an order for staff to apply bilateral upper side rails up and lock when in bed for ADL changes, mobility, positioning and as enabler.</p> <p>During a review of Resident 57's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 3/29/2025, the MDS indicated Resident 57 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 57 needed set up or clean-up assistance (helper sets up or cleans up) by staff for showers, upper/lower body dressing and putting on/off footwear. The MDS indicated Resident 57 was independent (resident completes the activity by himself with no assistance from a helper) to roll left and right (ability to roll from lying on back to left and right side and return to lying on back on the bed), sitting to lying, and lying on side of bed.</p> <p>During a concurrent observation and interview on 6/24/2025 at 10:57 a.m., while in Resident 57's room, Resident 57 was sitting up on the side of the bed and the bilateral side rails were observed to be ripped and damaged. The damaged padded bilateral side rails on the bed were up. Resident 57 stated I do not use the rails (referring to side rails). I do not need it.</p> <p>During a concurrent observation and interview on 6/24/2025 at 9:04 a.m. with the Director of Staff and Development (DSD), the DSD stated the padded side rails were ripped and damaged. The DSD stated the pads needed to be replaced to prevent Resident 57 from injury.</p> <p>During a concurrent interview and observation on 6/25/2025 at 11:04 a.m. while inside Resident 57's room, together with the Director of Nursing (DON), Resident 57 stated I want the side rails out.</p> <p>During a concurrent interview and record review on 6/27/2025 at 10:06 a.m.) with the DON, Resident 57's medical records (PointClickCare - PCC, a cloud-based software used in long-term and post-acute care facilities and chart) was reviewed. The DON stated there was no clinical documentation that appropriate alternatives were attempted before bedrail/siderails were used on Resident 57. The DON stated appropriate alternatives needed to be attempted before installation of side rails. The DON stated, padded side rails needed not to be ripped or damaged for the Residents safety and dignity. The DON stated padded side rails needed to be presentable.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Homelike Environment, dated 2/2021, the P&amp;P indicated residents are provided with a safe, clean, comfortable and homelike environment.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Physical Restraint, revised 3/2022, the P&amp;P indicated siderails are an enabler to assist with repositioning, transfers or safety. The P&amp;P indicated side rail padding is used to protect the resident from potential injuries due to involuntary movements, fragile skins, osteoporosis (a condition that causes bones to become less solid and less dense which gradually makes them weaker and more brittle) /degenerative joint disease (also known as osteoarthritis, type of joint disease that results from breakdown of joint cartilage [connective tissue] and underlying bone), striking out behavior, etc. The P&amp;P indicated if other interventions such as lowering bed using pillows, alarms, wedge cushions, etc. did not work, a physical restraint assessment shall be completed by the licensed nurse with input from the interdisciplinary team (IDT). The P&amp;P indicated, during an observation period, one or many less restrictive measures shall be attempted such as lowering the bed, using pillows alarms, trapeze, verbal cueing, non-skid mat, wedge cushion, etc. the duration of application, residents' response and effectiveness of less these restrictive measures is to be documented. The P&amp;P indicated informed consent is to be obtained from resident or from surrogate decision maker.</p> <p>c. During a review of Resident 7's admission Record (AR), the admission Record indicated Resident 7 was admitted on [DATE] with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and convulsions (involuntary, rapid muscle spasms that cause uncontrollable shaking and limb movements).</p> <p>During a review of Resident 7's History &amp; Physical (H&amp;P), dated 2/25/2024, the H&amp;P indicated the resident did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 7's Minimum Data Set (MDS - a federally mandated resident assessment tool) assessment, dated 4/7/2025, the MDS indicated Resident 7 was severely cognitively impaired (ability to think).</p> <p>During a review of Resident 7's Order Summary Report, dated 6/27/2025, the Order Summary indicated Resident 7 had an active order for foam circle padded side rails for safety precautions due to diagnosis of a seizure disorder, ordered on 11/7/2021. The Order Summary also indicated an active order to monitor for seizure activity, ordered on 11/18/2021.</p> <p>During a concurrent observation and interview on 06/24/2025 at 10:56 a.m. with Licensed Vocational Nurse 2 (LVN 2) in Resident 7's room, both of Resident 7's bedside rails lacked any foam padding. LVN 2 stated, he had an order for the foam circle padded rails which were not present on both rails. LVN 2 stated, Resident 7 had a history of seizures and needed the padding for safety to protect his head and prevent any injuries if a seizure occurred.</p> <p>During an interview on 6/27/2025 at 11:10 a.m. with the Director of Nursing (DON), the DON stated, Resident 7 had a convulsion disorder, and it was important to pad the resident's bedside rails to prevent further injury during seizures.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedure (P&amp;P) titled, Seizure Management and Prevention, last revised March 2023, indicated, its purpose is to ensure residents with seizure diagnosis will receive proper care. The P&amp;P indicated, to follow physician orders and pad the side rails if the physician orders.</p> <p>d. During a review of Resident 49's admission Record (AR), the admission Record indicated Resident 49 was admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and seizures.</p> <p>During a review of Resident 49's History &amp; Physical (H&amp;P), dated 10/2/2024, the H&amp;P indicated the resident did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 49's Minimum Data Set (MDS - a federally mandated resident assessment tool) assessment, dated 4/10/2025, the MDS indicated Resident 49 was cognitively intact and had an active diagnosis (in the last seven days) of a seizure disorder or epilepsy.</p> <p>During a review of Resident 49's Care Plan (CP), last revised on 6/23/2025, the CP indicated Resident 49 had a seizure disorder with an intervention for padded side rails if indicated.</p> <p>During a review of Resident 49's Order Summary Report, dated 6/26/2025, the Order Summary indicated Resident 49 had an active order for levetiracetam (a medication used to treat certain types of seizures) oral tablet 1000 milligrams (mg) and was to receive 1.5 tablets by mouth every 12 hours for seizures, ordered on 10/1/2024. The order summary indicated Resident 49 also had an active order for foam circle padded side rails for safety precautions due to a seizure diagnosis, ordered on 10/8/2024.</p> <p>During a concurrent observation and interview on 06/24/2025 at 11:10 am with Licensed Vocational Nurse 2 (LVN 2) while in Resident 49's room, both of Resident 49's bedside rails lacked any foam padding. LVN 2 stated that the bedside rails would be padded by maintenance for the resident's seizures and were needed as a preventative measure for his safety during a seizure.</p> <p>During an interview on 6/27/2025 at 11:07 a.m. with the Director of Nursing (DON), the DON stated, Resident 49 had a history of seizures and one of the interventions used was padded side rails. The DON stated that the bedside rails should have been padded to prevent any injury to the resident from seizures.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Seizure Management and Prevention, last revised March 2023, indicated, its purpose is to ensure residents with seizure diagnosis will receive proper care. The P&amp;P indicated, to follow physician orders and pad the side rails if the physician orders.</p>

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide supervision to a resident who used a plate guard (a dining aid that can help people with limited control, grip, or dexterity eat with one hand and reduce the risk of spills) during meals for one of one sampled resident (Resident 39).</p> <p>This failure had the potential to result in Resident 39's decline in nutritional status and inability to maintain independence during mealtimes.</p> <p>Findings:</p> <p>During a review of Resident 39's admission Record (AR), the AR indicated Resident 39 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included muscle weakness (lack of muscle strength), osteoarthritis (OA, a progressive disorder of the joints, caused by a gradual loss of cartilage) and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities).</p> <p>During a review of Resident 39's Care Plan (CP), dated 8/19/2022, the CP indicated Resident 39 had an alteration in nutritional status. The CP interventions indicated for Resident 39 to have a plate guard and two (2) handled cup to prevent spillage while eating.</p> <p>During a review of Resident 39's Minimum Data Set (MDS, a resident assessment tool), dated 4/30/2025, the MDS indicated Resident 39 had impaired cognition (ability to understand and process information). The MDS indicated Resident 39 required setup or clean-up assistance (helper sets up or cleans up, resident completes the activity) with eating and substantial/maximal assistance (helper did more than half the effort) with oral hygiene, toileting, shower, upper and lower body dressing and personal hygiene.</p> <p>During a concurrent observation while inside the dining room and interview on 6/24/2025 at 12:51 p.m. with Assistant Director of Staff Development (ADSD), Resident 39 was eating lunch by himself using a plate guard. The plate guard opening was in the front and facing Resident 39. There was a moderate amount of food spilled in front of Resident 39's tray and clothes. ADSD stated Resident 39 was right-handed. The ADSD stated the opening of the plate guard should be positioned on Resident 39's dominant hand and arm for the hand to have access on the plate guard, push food on the wall of the plate guard which served as guard when scooping food and keep the food on the plate and off the table and Resident 39's clothes.</p> <p>During an interview on 6/27/2025 at 10:33 a.m. with the Director of Nursing (DON), the DON stated the opening of the plate guard should be positioned on the strong arm/hand of the resident to have access on the plate guard, scoop food better and minimize spilling of food on the tray and clothes to maintain the resident's independence during mealtime.</p> <p>(continued on next page)</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's undated policy and procedure (P&amp;P) titled, Adaptive Equipment, the P&amp;P indicated, Resident will have the adaptive equipment as indicated to maintain/improve their functional level. A specific Medical/Adaptive Device shall be obtained such as splint, brace, plate guard, sippy cup, Rocker knife, sling, etc. The staff will observe resident tolerance /effectiveness and notify the physician if there are any signs/symptoms of complications. Provide training on the proper use of equipment as needed.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to follow proper food storage and sanitation standards by failing to:</p> <ol style="list-style-type: none"> <li>Ensure there were no expired items stored in the refrigerator: one bag of tortillas, four cheese sandwiches, and seven peanut butter and jelly sandwiches.</li> <li>Ensure one tray of apple sauce (20 individual serving containers), and one tray of fruit cocktail (26 individual serving containers) were stored with a preparation date label.</li> <li>Ensure monitoring and documenting logs for the Dish machine temperature log, Quat Sanitizer log, and the Refrigerator &amp; Freezer temperature logs for June 2025 were completed.</li> </ol> <p>These failures had the potential to result in foodborne illness (illness caused by consuming contaminated food or beverages).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>During a concurrent observation and interview of the initial kitchen tour on 6/24/2025 at 8:47 a.m. with the Dietary Supervisor (DS) while in the walk-in refrigerator, one bag of tortillas in a clear storage bag had a past best buy date of 6/18/2025, four cheese sandwiches had a past best buy date of 6/18/2025, and seven peanut butter and jelly sandwiches had a best buy date of 6/21/2025. DS stated that the refrigerator was checked by the cooks for expired food items and if a resident received expired food, it could make them ill.</li> <li>During a concurrent observation and interview of the initial kitchen tour on 6/24/2025 at 8:47 am with the Dietary Supervisor (DS) while in the walk-in refrigerator, one tray of apple sauce (20 individual serving containers) and one tray of fruit cocktail (26 individual serving containers) were stored without a preparation date label. The DS stated the trays should have been labeled when made, otherwise kitchen staff wouldn't know when they were produced for the residents.</li> <li>During a concurrent interview and record review 6/24/2025 at 9:09 a.m. with the Dietary Supervisor (DS) the Dish Machine Temperature Log dated June 2025 was reviewed. The Dish Machine Temperature Log indicated there was missing data on 6/20/2025, 6/21/2025 and 6/22/2025. The DS stated the log was completed by the dishwasher and should have been done to ensure the dishes were coming out sanitized for the residents.</li> </ol> <p>During a concurrent interview and record review 6/24/2025 at 9:13 a.m. with the Dietary Supervisor (DS) the Quat Sanitizer (quaternary sanitizer-disinfectant used to sanitize surfaces) Log dated June 2025 was reviewed. The Quat Sanitizer Log indicated, missing data on 6/19/2025, 6/21/2025, 6/22/2025, and 6/23/2025. The DS stated the log was his responsibility and should have been completed to ensure the sanitizer was disinfecting the kitchen appropriately.</p> <p>(continued on next page)</p>

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

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review 6/24/2025 at 9:13 a.m. with the Dietary Supervisor (DS) the Refrigerator &amp; Freezer Temperature Log dated June 2025 was reviewed. The Refrigerator &amp; Freezer Temperature Log indicated, missing data on 6/21/2025 and 6/22/2025. The DS stated that the cook should have checked the temperatures. The DS stated, the temperature checks needed to be done to confirm food stayed at the proper temperatures to prevent bacteria growth.</p> <p>During a review of the facility's undated policy and procedure (P&amp;P) titled, Refrigerator/Freezer Storage, indicated no food item that is expired or beyond the best buy date are in stock. The P&amp;P indicated, leftover food or unused portions of packaged foods should be covered, dated, and labeled to ensure they will be used first. The P&amp;P indicated, dietary staff will check and record temperatures of all refrigerators and freezers to ensure the equipment is within appropriate temperatures for food storage and handling and record and initial the temperature log at the beginning of the shift.</p> <p>During a review of the facility's undated policy and procedure (P&amp;P) titled, Dish Washing Procedures-Dish Machine, indicated, a temperature and chlorine log will be kept and maintained by the dish washer to ensure that the dish machine is working properly.</p> <p>During a review of the facility's undated policy and procedure (P&amp;P) titled, Sanitizing Equipment and Surfaces, indicated sanitizing solution will be used to sanitize equipment and surfaces after each use or as often as needed. The P&amp;P indicated, sanitizer levels will be checked and recorded at least once per shift to ensure equipment and surfaces are sanitized appropriately and dietary staff are to record PPM (parts per million) at least once per shift.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure Certified Nurse Assistants 1 and 2 (CNA 1 and CNA 2) donned (put on) the required personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) while providing care to one of one sampled resident (Resident 10) who was on Enhanced Barrier Precaution (EBP, an approach for the use of PPE to reduce transmission of multidrug-resistant organisms [MDRO] between residents in skilled nursing facilities).</p> <p>This deficient practice had the potential to transmit infectious microorganisms and increase the risk of infection for the residents and the staff that could result in a widespread infection in the facility.</p> <p>Findings:</p> <p>During a review of Resident 10's admission Record (AR), the AR indicated Resident 10 was admitted to the facility on [DATE], with diagnoses that included encounter for attention to gastrostomy (creation of an artificial external opening into the stomach for nutritional support) and dysphagia (difficulty swallowing).</p> <p>During a review of Resident 10's Care Plan (CP) titled Enhanced Standard Precaution, initiated on 12/4/2024, the CP indicated Resident 10 was at high risk for infection due to feeding tubes. The CP interventions indicated for staff to provide enhance standard precaution such as gloves, gown and masks.</p> <p>During a review of Resident 10's Order Summary Report (OSR) dated 12/16/2024, the OSR indicated for staff to place Resident 10 on EBP every shift.</p> <p>During a review of Resident 10's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 4/4/2025, the MDS indicated Resident 10 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 10 was dependent (helper does all of the effort) on staff for oral hygiene, toileting, showering/bathing self, upper and lower body dressing, putting on/taking off footwear, and personal hygiene.</p> <p>During a review of Resident 10's OSR dated 5/8/2025, the OSR indicated for staff to administer Glucerna 1.2 (liquid formula used for G-tube feeding) at 50 cubic centimeters per hour (cc/hr.- unit of measurement) for 20 hours via pump (medical device used to deliver tube feeding) to provide 1,100 cc per 1,320 kilo calories (kcal, unit of energy) per day.</p> <p>During an observation on 6/25/2025 at 8:32 a.m. while inside Resident 10's room, CNA 1 and CNA 2 were cleaning and changing Resident 10. CNA 1 and CNA 2 were only wearing gloves and did not wear a gown while handling Resident 10.</p> <p>During an interview on 6/25/2025 at 8:36 a.m. with CNA 1, CNA 1 stated, I did not wear a gown while doing resident care for Resident 10, it completely slipped my mind. CNA 1 stated, she needed to wear a gown to protect the residents and staff from spreading infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/27/2025 at 9:45 a.m. with the Infection Prevention Nurse (IPN, a healthcare professional who specializes in preventing the spread of infections in healthcare settings), the IP stated Resident 10 was placed on EBP and staff needed to wear gloves and gowns while providing care especially for resident's who had a gastrostomy tube (a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications).</p> <p>During an interview on 6/27/2025 at 11:04 a.m. the facility Director of Nursing (DON), the facility DON stated staff needed to wear gowns and gloves when providing care to residents who are on EBP to prevent the spread of infection and to avoid cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect.)</p> <p>During a review of the facility's undated policy and procedure (P&amp;P) titled, Enhanced Barrier Precautions, the P&amp;P indicated, Enhanced Barrier Precautions involve gown and glove use during high contact resident care activities for residents known to be infected or colonized with a MDRO as well as those at increased risk of MDRO acquisition. The P&amp;P indicated to perform hand hygiene, wear gowns and gloves while performing the following tasks associated with residents who require EBP: device care for example . feeding tube and any care activity where close contact with the resident is expected to occur such as bathing, peri-care, assisting with toileting, changing incontinence briefs, transferring, respiratory care.</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure the wheelchair pad alarm was functional to alert the staff for one of one sampled resident (Resident 51) as indicated in the facility's policy titled Alarm Monitor and plan of care.</p> <p>This failure had the potential to result in Resident 51 not receiving care or receiving delayed services to meet the residents' needs and had the potential to result in a fall or injury.</p> <p>Findings:</p> <p>During a review of Resident 51's admission Record (AR), the AR indicated Resident 51 was originally admitted to the facility on [DATE], and readmitted to the facility on [DATE] with diagnoses that included unspecified dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning) and Alzheimer's disease (irreversible, progressive brain disorder that slowly destroys memory and thinking skills, and eventually the ability to carry out the simplest tasks).</p> <p>During a review of Resident 51's Care Plan (CP) revised 3/21/2024, the Care Plan indicated Resident 51 was at risk for falls/injury related to dementia, unstable balance, and unsteady gait. The CP intervention indicated for the nursing staff to provide Resident 51's safety instruction regarding ambulation, transfers and activities of daily living's when appropriate. The CP interventions indicated to provide Resident 51 a safety device pad alarm when up in wheelchair or bed.</p> <p>During a review of Resident 51's Fall Risk Assessment (FRA- method of assessing a patient's likelihood of falling) dated 5/30/2025, the FRA indicated Resident 51 was assessed as a high risk for falls due to intermittent confusion, incontinent (involuntary loss of bladder or bowel control), unable to stand without assistance, took three or more medications and the presence of predisposing disease condition.</p> <p>During a review of Resident 51's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 6/5/2025, the MDS indicated Resident 1 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 1 needed set up pr clean-up assistance (helper sets up or cleans up) from staff for shower, upper/lower body dressing and putting on/off footwear.</p> <p>During a review of Resident 51's Restraint - Physical Assessment (RPA) dated 6/18/2025, the RPA indicated Resident 51 had unsteady gait, attempted to transfer and had poor safety awareness. The RPA indicated Resident 51 had episodes of attempts to self-transfer from the bed and wheelchair.</p> <p>During a concurrent observation and interview on 6/24/2025 at 9:11 a.m. with the Director of Staff and Development (DSD), Resident 51 was in the activity room, sitting in his wheelchair. Resident 51's wheelchair pad alarm was disconnected. The facility DSD stated the cable was not connected because it was broken. The DSD stated Resident 51 had a high risk for falls, and the purpose of the wheelchair pad alarm was to alert staff if Resident 51 tried to get up from wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/27/2025 at 11:04 a.m. with the facility's Director of Nursing (DON), the facility's DON stated Resident 51's wheelchair pad alarm needed to be working and functioning properly. The DON stated the wheelchair pad alarm needed to be working properly to alert staff if Resident 51 tried to get up from the wheelchair. The facility DON stated Resident 51 was at a high risk of falls.</p> <p>During a review of the undated facility's Policy and Procedure (P&amp;P) titled, Alarm Monitor, the P&amp;P indicated the facility may use an alarm monitor as one of the less restrictive measures to alert staff members and provide immediate assist as needed. The P&amp;P indicated the staff will apply the alarm to the resident, following the manufacturers instruction, to ensure its functionality.</p>