

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/17/2026
NAME OF PROVIDER OR SUPPLIER Mayflower Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5043 Peck Rd El Monte, CA 91732	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light was within reach and appropriate to the resident's physical ability for three of three sampled residents (Residents 25 49 and 54). These failures had the potential for Residents 25, 49 and 54 not to receive necessary care or receive delayed services to meet Residents 25, 49 and 54's needs. Findings: a. During a review of Resident 25's Face Sheet (FS), the FS indicated the facility initially admitted Resident 25 on 12/24/2015 and readmitted on [DATE] with diagnoses including Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) and dementia (a progressive state of decline in mental abilities). During a review of Resident 25's untitled Care Plan (CP) dated 4/8/2016, the CP indicated Resident 25 was at risk for falls/injury related to impaired vision, poor body balance/control, history of falls, and Alzheimer's disease. The CP interventions included for nursing staff to keep the resident's call light within easy reach to get assistance. During a review of Resident 25's Minimum Data Set (MDS, a resident assessment tool) dated 6/14/2026, the MDS indicated Resident 25 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 25 was dependent (helper did all the effort) with eating, oral hygiene, toileting, shower, upper/lower body dressing and personal hygiene. During a concurrent observation inside Resident 25's room and interview on 7/14/2026 at 9:54 am with Certified Nurse Assistant 4 (CNA 4), Resident 25 was in bed with a pad sensor (flat call light activated by gross movement) call light hanging on the right side of the bed. CNA 4 stated the pad sensor was not accessible to Resident 25. CNA 25 stated call lights should be accessible and reachable all the time to the residents to use to call staff for assistance whenever help was needed. During an interview on 7/14/2026 at 9:57 am with Registered Nurse Supervisor 1 (RN 1), RN 1 stated call lights should always be accessible to the residents to call staff for help and assistance. During a review of the facility's Policy and Procedure (P&P) titled, Call System, Residents, revised September 2022, the P&P indicated, Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 a specific and individualized care plan to meet the residents' needs for two of two sampled residents (Residents 4 and 5) by failing to: a. Ensure a care plan (CP) was developed for Resident 4 on the use of Buspirone (a medication used to treat anxiety). b. Ensure a CP was developed for Resident 5 on the use of Seroquel (an antipsychotic medication helps to stabilize moods and reduce psychotic symptoms) and Lexapro (a medication used to treat depression and anxiety). These failures had the potential for Residents 4 and 5 not to receive necessary care, treatment, and services. Findings: a. During a review of Resident 4's Face Sheet (FS), the FS indicated the facility initially admitted Resident 4 on 5/21/2025 and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), schizophrenia (a mental illness that is characterized by disturbances in thought), and anxiety disorder (a mental illness characterized by excessive, persistent, and uncontrollable fear or worry). During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool) dated 5/25/2026, the MDS indicated Resident 4 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 4 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 shower and upper/lower body dressing. The MDS indicated Resident 4 was dependent (helper did all the effort, resident did none) with oral hygiene, toileting and personal hygiene. During a review of Resident 4's Order Summary Report (OSR) dated 7/9/2026, the OSR indicated Resident 4 had an order for Buspirone 5 milligrams (mg- unit of measurement) by mouth three times a day for anxiety. During a concurrent interview and record review on 7/16/2026 at 11:25 am with Registered Nurse Supervisor 1 (RN 1), Resident 4's medical record (chart) and electronic medical record (EMR) were reviewed. RN 1 stated there was no CP developed to address Resident 4's use of Buspirone. RN 1 stated a CP should be developed based on the residents' diagnoses, assessment, and medication to be able to plan individualized care, treatment, and services for each resident and monitor its effectiveness. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised March 2022, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. b. During a review of Resident 5's FS, the FS indicated the facility initially admitted Resident 5 on (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/29/2021 and readmitted on [DATE] with diagnoses including psychosis (severe mental disorder in which contact with external reality is lost), major depressive disorder (persistent feeling of sadness and loss of interest) and bipolar disorder (mental disorder with periods of depression and elevated mood). During a review of Resident 5's OSR dated 6/23/2026, the OSR indicated Resident 5 had an order for Lexapro 5 mg by mouth one time a day for depression manifested by verbalization of sadness. During a review of Resident 5's OSR dated 6/23/2026, the OSR indicated Resident 5 had an order for Seroquel 25 mg by mouth at bedtime for mood disorder manifested by agitation as evidence by restlessness affecting sleep. During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5 had severely impaired cognition. The MDS indicated Resident 5 was dependent on staff for shower and upper/lower body dressing. The MDS indicated Resident 5 required maximum assistance from staff for oral hygiene, toileting hygiene and putting on/taking off footwear. During a concurrent interview and record review on 7/15/2026 at 10:46 am with the facility's Director of Nursing (DON), Resident 5's medical record (PointClickCare - PCC, a cloud-based software) was reviewed. The DON stated there was no CP developed to address Resident 5's use of Lexapro and Seroquel. The DON stated a CP for Lexapro and Seroquel should have been initiated within 24 hours when the medication was ordered for staff to determine interventions on how to provide care and treatment to Resident 5. During a review of the facility's P&P titled, Care Plan, Comprehensive Person-Centered revised March 2022, the P&P indicated the Care Plan will include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs. The P&P indicated the comprehensive care plan is developed within 7 days of the completion of the required MDS assessment and no more than 21 days after admission.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to follow proper sanitation and food handling practices by failing to ensure food items were dated when they were first opened and prepared in one of one facility freezer. These deficient practices placed the residents at risk for food borne illnesses (infections caused by ingesting contaminated food or beverages). Findings: During initial tour and observation of the facility's kitchen on 7/14/2026 at 9:04 am, together with the Dietary Supervisor (DS), 48 cups of ice cream did not have a label or date when it was first prepared. One bag of waffles was not dated when it was first opened. The DS stated 48 cups of ice cream were not dated to determine when they were prepared by Kitchen Aid 1 (KA 1). The DS stated the bag of waffles should have been dated with used by date and expiration date to determine when it was opened. The DS stated food items should be dated and labeled when they were prepared. During an interview with KA 1 on 7/14/2026 at 9:13 am, KA 1 stated KA 1 prepared 48 cups of ice cream around 8 am and did not indicate the date when they were prepared. During a review of the facility's undated Policy and Procedure (P&P) titled, Dating and Labeling, the P&P indicated, To ensure food safety and prevent contamination within the facility, all food items should be properly covered, dated and labeled in dry storage and refrigerator/freezer areas. All food will be dated according to - month, day and year. Staff should be trained in the importance of food labeling and proper storage procedures to maintain food safety.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent unnecessary use of psychotropic medication (any medication capable of affecting the mind, emotions, and behavior) in accordance with the facility's policies and procedures (P&P) titled Antipsychotic Medication Use and Psychotherapeutic Medications for one of five sampled residents (Resident 5). This deficient practice had the potential to result in significant adverse (harmful) consequences to Resident 5 for the use of Seroquel (medication used to treat mental health condition). Findings: During a review of Resident 5's Face Sheet (FS), the FS indicated the facility initially admitted Resident 5 on 10/29/2021 and readmitted on [DATE] with diagnoses including psychosis (severe mental disorder in which contact with external reality is lost), major depressive disorder (persistent feeling of sadness and loss of interest) and bipolar disorder (mental disorder with periods of depression and elevated mood). During a record review of Resident 5's Order Summary Report (OSR) dated 6/23/2026, the OSR indicated for licensed staff to administer Resident 5 Seroquel 25 milligrams (mg-unit of measurement) by mouth at bedtime for mood disorder manifested by agitation as evidenced by restlessness affecting sleep. The OSR did not indicate an order for staff to monitor Resident 5's hours of sleep to evaluate the effectiveness of Seroquel use. During a review of Resident 5's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 6/27/2026, the MDS indicated Resident 5 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 5 was dependent (helper does all of the effort) from staff for shower and upper/lower body dressing. The MDS indicated Resident 5 required maximum assistance (helper does more than half of the effort) from staff for oral hygiene, toileting hygiene and putting on/taking off footwear. During a concurrent interview on 7/15/2026 at 10:37 am with the facility's Director of Nursing (DON) and record review of Resident 5's medical records (PointClickCare - PCC, a cloud-based software), the DON stated Resident 5 was ordered Seroquel for mood disorder manifested by agitation as evidenced by restlessness affecting sleep. The DON stated agitation and restlessness were not specific indications or target behaviors for the use of Seroquel. The DON stated Seroquel needed to be administered for specific symptoms to avoid unnecessary psychotropic medication. The DON stated Resident 5's hours of sleep was not monitored on the use of Seroquel since 6/23/2026. The DON stated it was important to monitor Resident 5's hours of sleep to determine if Seroquel was effective or not. During a review of the facility's P&P titled, Antipsychotic Medication Use, revised 7/2022, the P&P indicated, Antipsychotic medications will not be used if the only symptoms are one or more of the following: a. Wandering; b. Poor self-care; c. Restlessness; d. Impaired memory; e. Mild anxiety; f. Insomnia; g. Inattention or indifference to surroundings; h. Sadness or crying alone that is not related to depression or other psychiatric disorders; i. Fidgeting; j. Nervousness; or k. Uncooperativeness. During a review of the facility's P&P titled, Psychotherapeutic Medications, revised 3/2025, the P&P indicated, Evaluate the resident's response to psychotropic medication therapy (Antianxiety, Antidepressant, hypnotic and antipsychotic) to determine that the medications are appropriate and resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. The licensed nurse will assess the resident to ensure specific behavior is monitored every shift.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to provide required assistance during activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) for one of one sampled resident (Resident 51). This failure placed Resident 51 at risk for accidents/injury during bed mobility. Findings: During a review of Resident 51's Face Sheet (FS), the FS indicated the facility admitted Resident 51 on 8/29/2025 with diagnoses including dementia (a progressive state of decline in mental abilities), Parkinson's disease (a progressive disease marked by tremors, muscular rigidity, and slow, imprecise movements), and Alzheimer's disease (progressive decline in mental abilities). During a review of Resident 51's Minimum Data Set (MDS, a resident assessment tool) dated 5/20/2026, the MDS indicated Resident 51 had severely impaired cognition (ability to understand and process information) for daily decision making. The MDS indicated Resident 51 was dependent (helper did all the effort, resident did none) with eating, oral hygiene, toileting, shower, upper/lower body dressing and personal hygiene. During a concurrent observation inside Resident 51's room and interview on 7/14/2026 at 9:23 am with Certified Nurse Assistant 3 (CNA 3), CNA 3 was alone cleaning and turning Resident 51 on Resident 51's right side while in bed. CNA 3 stated Resident 51 was totally dependent on staff for all ADLs. CNA 3 stated Resident 51 could not move from side to side and unable to hold position. During an interview on 7/14/2026 at 9:38 am with the facility's Director of Nursing (DON), the DON stated Resident 51 required 2-person assistance with ADLs, bed mobility and transfers. The DON stated dependent residents should be provided with appropriate assistance during ADLs to ensure safety and for residents to receive adequate care. During a review of the facility's Policy and Procedure (P&P) titled, Activities of Daily Living (ADL), Supporting, revised in 2022, the P&P indicated, Residents who were unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were kept secure by failing to lock one of two medication carts (Med Cart) that contained residents' medications, when not attended to and outside the view of the licensed staff. This deficient practice had the potential for residents' medications to be accessible to others not authorized to have access to the medications and increased the risk for loss of safety and security of all medications necessary to meet the health needs of residents. Findings: During a review of Resident 53's Face Sheet (FS), the FS indicated Resident 53 was admitted to the facility on [DATE] with diagnoses including encephalopathy (a condition that affects the structure or function of the brain), urinary tract infection (UTI- infection that affects any part of the urinary tract) and muscle weakness. During a review of Resident 53's History and Physical (H&P) dated 5/13/2026, the H&P indicated Resident 53 had the capacity to make decisions for activities of daily living. During a review of Resident 53's Minimum Data Set (MDS- a resident assessment tool) dated 6/16/2026, the MDS indicated Resident 53 was dependent (helper does all the effort) on staff for oral, toileting and personal hygiene, showers, upper and lower body dressing and putting on/taking off footwear. During a medication pass observation for Resident 53 on 7/16/2026 at 8:37 AM, with Licensed Vocational Nurse 2 (LVN 2), LVN 2 left the Med Cart outside Resident 53's room in the hallway, unlocked and out of view. During an observation and interview outside Resident 53's room in the hallway with the Treatment Nurse (TN) on 7/15/2026 at 8:53 AM, the TN stated the Med Cart should be locked if left unattended in the hallway. The TN stated anyone who passed by could take medications if the Med Cart was left unlocked. During an observation and interview with LVN 2 in the hallway outside Resident 53's room on 7/15/2026 at 8:56 AM, LVN 2 stated LVN 2 did not lock the Med Cart. LVN 2 stated LVN 2 forgot to lock the Med Cart. LVN 2 stated if the Med Cart was unlocked, anyone could open the Med Cart and take medications and could result in harmful consequences. LVN 2 stated it was LVN 2's responsibility to lock the Med Cart for residents' safety. During an interview on 7/16/2025 at 3:28 PM, with the facility's Director of Nursing (DON), the DON stated, the Med Cart should be locked at all times if the Med Cart was outside the view of the licensed nurse. During a review of the facility's Policy and Procedures (P&P's) titled, Security of Medication Cart dated 3/2023, the P&P indicated, The medication cart shall be secured during medication passes. The cart must be locked before the nurse enters the resident's room. During a review of the facility's P&P titled, Administering Medications dated 3/23, the P&P indicated, During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to the residents or other passing by.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the privacy of one of one sampled resident (Resident 53) when Licensed Vocational Nurse 2 (LVN 2) left the computer screen unattended, exposing Resident 53's medication information. This deficient practice violated Resident 53's right to privacy and confidentiality. Findings: During a review of Resident 53's Face Sheet (FS), the FS indicated Resident 53 was admitted to the facility on [DATE] with diagnoses including encephalopathy (a condition that affects the structure or function of the brain), urinary tract infection (UTI- infection that affects any part of the urinary tract) and muscle weakness. During a review of Resident 53's History and Physical (H&P) dated 5/13/2026, the H&P indicated Resident 53 had the capacity to make decisions for activities of daily living. During a review of Resident 53's Minimum Data Set (MDS- a resident assessment tool) dated 6/16/2026, the MDS indicated Resident 53 was dependent (helper does all the effort) on staff for oral, toileting and personal hygiene, showers, upper and lower body dressing and putting on/taking off footwear. During a medication pass observation for Resident 53 on 7/15/2026 at 8:37 AM, with LVN 2, LVN 2 left the computer screen on and unattended with Resident 53's medication information exposed to other residents and staff who passed by. During a concurrent observation of LVN 2 on 7/15/2026 at 8:48 AM, LVN 2 walked away from the medication cart and left the computer screen on while walking in the hallway to ask Certified Nurse Assistant 1 (CNA1) to get Resident 53 from the Activities Room so that LVN 2 could administer Resident 53's medications. During an interview with CNA1 in the hallway outside of Resident 53's room on 7/15/2026 at 8:50 AM, CNA1 stated LVN 2 left the computer on while walking away to the nursing station to wash LVN 2's hands. CNA1 stated the computer should be turned off/locked due to HIPAA (Health Insurance Portability and Accountability Act - a federal law passed in 1996 that sets national standards to protect sensitive patient medical information from being disclosed without consent) laws and to maintain the resident's privacy. During an observation in the hallway and interview outside Resident 53's room with the Treatment Nurse (TN) on 7/15/2026 at 8:53 AM, the TN stated the computer screen should not be left on if it was displaying Resident 53's medication information. The TN stated the computer screen should be minimized or closed if LVN2 was inside Resident 53's room. The TN stated LVN 2 should not walk away from the computer leaving Resident 53's information on the screen for privacy reasons. During an observation and interview with LVN 2 in the hallway outside Resident 53's room on 7/15/2026 at 8:56 AM, LVN 2 stated, LVN 2 forgot to turn off the computer screen. LVN 2 stated it was LVN 2's responsibility to lock or minimize the computer screen when not in use. During an interview on 7/16/2025 at 3:28 PM, with the facility's Director of Nursing (DON), the DON stated the computer screen should be locked or minimized when it was outside the view of the licensed nurses to protect the resident's confidentiality. During a review of the facility's undated Policy and Procedure (P&P) titled, Electronic Protected Health Information Security, the P&P indicated the facility should ensure the security and integrity of medical records of patients at the facility. During a review of the facility's P&P titled, Resident Rights, dated 2/2021, the P&P indicated the unauthorized release, access, or disclosure of resident information is prohibited. All release, access, or disclosure of resident information must be in accordance with current laws governing privacy of information issues.		