

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555634	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Greater El Monte Community Hos		STREET ADDRESS, CITY, STATE, ZIP CODE 1701 Santa Anita Avenue El Monte, CA 91733	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure three of three sampled residents (Resident 9, Resident 11, and Resident 10) were provided with a safe and comfortable homelike environment by failing to ensure Resident 9, Resident 11, and Resident 10's rooms had comfortable and safe temperature levels. This deficient practice had the potential to result in Resident 9, Resident 11, and Resident 10 feeling uncomfortable and placed Residents 9, 11, and 10 at risk to develop hypothermia (a dangerous drop in body temperature) which could lead to health complications and physical declines to Residents 9, 11, and 10. Findings: a. During a review of Resident 9's admission Record (AR), the AR indicated, Resident 9 was admitted to the facility on [DATE] with multiple diagnoses including respiratory failure (a serious condition that makes it difficult to breathe on your own) and sepsis (a life-threatening blood infection). During a review of Resident 9's History and Physical (H&P), dated 7/3/2025, the H&P indicated, Resident 9 was vent (ventilator &ndash; a medical device used to help support or replace breathing) dependent and nonverbal. During a review of Resident 9's Minimum Data Set (MDS - an assessment and screening tool), dated 10/17/2025, the MDS indicated Resident 9's cognitive skills (ability to think and process information) for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated, Resident 9 was dependent (helper does all of the effort) on staff for ADLs (activities of daily living). b. During a review of Resident 11's AR, the AR indicated Resident 11 was admitted to the facility on [DATE] with chief complaints of sepsis and liver mass (a lump in the body) pos [possible] bowel obstruction (a partial or complete blockage of your small intestine or large intestine) and diagnosis of encounter for attention to tracheostomy (a surgically created hole, also called a stoma, in your windpipe). During a review of Resident 11's H&P, dated 7/3/2025, the H&P indicated Resident 11 had chronic (persistent or long-lasting) respiratory failure and was on vent support. During a review of Resident 11's MDS, dated [DATE], the MDS indicated Resident 11 was dependent for ADLs. During a concurrent observation and interview on 11/19/2025 at 10:14 AM with Certified Nursing Assistant (CNA) 1, Resident 9 and Resident 11's shared room had a wall mounted thermometer that indicated 64 degrees Fahrenheit (degrees F - a method of measuring temperature). CNA 1 stated, the room temperature was 64-66 degrees and [this temperature] could be too cold for the residents. CNA (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 stated, having the proper room temperature was important for Resident 9 and Resident 11 so the residents would not have hypothermia and if it's too cold or too hot, might not be comfortable [for the residents]. During an interview on 11/20/2025 at 4:11 PM with the Stationary Engineer (SE), the SE stated resident room temperatures needed to be between 68 and 72 degrees F for the safety and comfort of the residents. The SE stated facility staff were responsible for checking room temperatures and called the maintenance [department] if there were any problems. During an interview on 11/21/2025 at 11:15 AM with the Lead Engineer ([NAME]), the [NAME] stated the maintenance department was not responsible for checking room temperatures and the facility staff contacted maintenance if there was something wrong, it's too hot or too cold. The [NAME] stated maintenance did not keep a work order log [and this communication was] only verbal. During an interview on 11/21/2025 at 11:36 AM with the Director of Nursing (DON), the DON stated resident rooms had thermometers to check for room temperature and to ensure the room was not too hot or too cold and the engineer was responsible for checking the room temperatures. The DON stated, room temperature should be above 68 degrees F and shouldn't go too low. The DON stated staff should be checking room temperatures more when the weather changes. The DON stated the right room temperature was important for the residents to be comfortable. During an interview on 11/21/2025 at 12:24 PM with the Director of Facilities (DF), the DF stated, room temperatures should be between 68 and 75 degrees F for patient comfort. The DF stated engineering was not responsible for daily room temperature check. The DF stated the facility staff notified engineering if the room temperature was not within range for engineering to adjust the temperature. During a review of the facility's policy and procedures (P&P) titled, Temperature and Humidity Monitoring, approved date 5/2023, the P&P indicated, the purpose was to provide appropriate methods of monitoring and adjusting the temperature and relative humidity levels in sensitive areas or rooms. The P&P indicated, in all sensitive areas designed to control airborne contaminants, the ventilation system provided appropriate pressure relationships, air-exchange rates, filtration efficiencies, temperature and humidity within acceptable standards in order to inhibit bacterial growth and prevent infection, as well as promote patient comfort and safety. The P&P indicated, temperature range from 68-75 degrees. During a review of the facility's undated Patient Guide (the admission packet provided to the residents and/or family members), the Patient Guide included a Mission Statement (MS). The MS indicated, Our mission is to provide quality healthcare in a safe environment that is sensitive and supportive to the physical, emotional, spiritual, and diverse multicultural needs our patients and their loved ones. The MS indicated the facility advocated the preservation of human dignity in the delivery of services and programs. c. During a review of Resident 10's AR, the AR indicated the facility admitted Resident 10 on 10/15/2025, with diagnoses including chronic respiratory failure, chronic obstructive pulmonary disorder (COPD - a chronic lung disease causing difficulty in breathing), and cerebrovascular disorder (CVA - stroke, loss of blood flow to a part of the brain). During a review of Resident 10's MDS, dated [DATE], the MDS indicated Resident 10's cognition was (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	severely impaired. The MDS indicated Resident 10 was dependent on staff with ADL and mobility. During an observation on 11/19/2025 at 11 AM in Resident 10's room, the wall-mounted, red-indicator, liquid-in-glass thermometer (a wall thermometer with a red liquid line that rises to show the temperature) showed a room temperature of 60 degrees degrees F. The thermometer displayed temperature using a vertical degrees F scale with a red indicator line. During an interview on 11/19/2025 at 11:30 AM, with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 10's room thermometer showed 60 degrees F and this temperature was too low for Resident 10's comfort. LVN 1 stated resident rooms (in general) should have been set at 70 degrees F and stated lower temperatures can cause discomfort and health risks for residents. LVN 1 stated staff were responsible for notifying the engineering department when room temperatures were below the acceptable range. During an interview on 11/20/2025 at 4 PM with the SE, the SE stated resident room temperatures should be maintained between 68 &ndash; 75 degrees F. The SE stated the facility did not typically monitor room temperatures daily and nursing along with floor staff were responsible for identifying room temperature issues and submitting work orders or notifying engineering when there were problems with room temperatures. During a review of the facility's P&P titled, Temperature and Humidity Monitoring, dated 5/2023, the P&P indicated that in all sensitive areas designed to control airborne contaminants. The P&P indicated a relative humidity that is too high can result in damp or moist supplies with added opportunity for mold and microbial growth. The P&P indicated it can also contribute to excess perspiration and occasional sweat through when combined with high temperatures. The P&P indicated a relative humidity that is too low can result is excessive bacteria-carrying dust; it also increases the risk of electrostatic charges which pose a fire hazard in an oxygen rich environment or when flammable agents are present. During a review of the facility's Job Description and Performance Standards (JDPS) titled, Stationary Engineer, dated 6/27/2025, the JDPS mission statement indicated the mission was to provide quality healthcare in a safe environment that is sensitive and supportive to the physical, emotional, spiritual, and diverse multi-cultural needs of our patients and their loved ones. The JDPS indicated we advocate the preservation of human dignity in the delivery of our services and programs.		

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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 ensure food was stored, prepared, and distributed under sanitary conditions for all the residents in the facility by failing to:A. Ensure two damaged canned goods were removed from the usable food-inventory shelf, resulting in unsafe food items stored with products intended for resident consumption.B. Ensure two (2) of four (4) sanitation buckets located in the main kitchen had adequate amount of quaternary sanitizing solution (an ammonium solution used for sanitizing surfaces) for the disinfection of key areas in the kitchen utilized to prepare residents food.These failures had the potential to expose residents to foodborne illnesses (illness caused by food contaminated with bacteria) and contamination due to inadequate sanitation of food-contact surfaces and improper storage of compromised canned goods.Findings:A. During an observation on 11/19/2025 at 8:45 AM, with the Head [NAME] (HC), two dented cans of enchilada sauce were observed stored on the facility's dry-storage area and on shelving designated for usable food items. Both cans had dents along the sides. The cans were not labeled or placed in the designated area for compromised or damaged cans.During an interview on 11/19/2025 at 9:10 AM with the Purchasing Staff (PS), the PS stated the PS inspected all food deliveries upon arrival at the facility. The PS stated the PS's practice was to separate any dented cans from intact canned goods before stocking items in the dry-storage area. The PS stated dented cans were placed in a designated holding area and were not used for meal service. The PS stated serving food from dented cans could pose a contamination risk [for the residents consuming the food]. The PS stated two dented cans observed on the dry-goods shelf should not have been stored there and stated the PS would remove them.B. During an observation on 11/19/2025 at 9:15 AM, the HC checked the quaternary sanitizing solution in four sanitation buckets located in the main kitchen using quaternary test strips. The HC placed a test strip in Bucket #1 for 10 seconds, per the manufacturer's instructions, and the test strip indicated below 150 ppm (ppm - parts per million, unit of measurement, orange in color). The HC then placed a test strip in Bucket #2 for 10 seconds, according to the manufacturer's instructions, and the test strip also indicated below 150 ppm.During an interview on 11/19/2025 at 9:20 AM, the HC stated 2 of the 4 sanitation buckets were below the required sanitizing concentration [as indicated in] the manufacturer's instructions. The HC stated maintaining sanitation buckets at the proper disinfectant strength was essential to prevent cross contamination (process by which bacteria can be transferred from one area to another). The HC verified the 2 sanitation buckets were reading below 150 ppm and stated they must remain between 150 ppm and 400 ppm [olive green in color] to be effective. The HC stated that when the sanitation solution fell below the required concentration, the solution would not adequately kill bacteria on food-contact surfaces, which increased the risk of foodborne illnesses and contamination during meal preparation.During an interview on 11/19/2025 at 09:30 AM, the Dietary Supervisor (DS) stated that dented food cans were not used for meal preparation because dents could compromise the can's integrity, leading to rust, contamination, and an increased risk of botulism (A rare, but serious, muscle-paralyzing illness caused by a powerful toxin produced by the bacteria Clostridium botulinum). The DS stated dented cans were separated from usable stock and kept in a designated holding area to prevent accidental use and stated dented cans should not have been stored in the dry storage area. The DS stated that maintaining sanitation buckets at the proper sanitizing concentration was essential to ensure food-contact surfaces were effectively disinfected and to prevent cross-contamination during meal service.During a review of undated Ecolab manufacturer's instructions, used by the facility, indicated the acceptable sanitizing concentration range for the solution was 150 ppm to 400 ppm.During a review of the facility's policy and procedure (P&P) titled, Infection Control - Food and Nutrition Services revision date 4/2024, the P&P indicated:1. All foods are of good quality and are procured from sources considered satisfactory by federal, state, and local (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	authorities. Foods that are damaged in any way, such as unlabeled, dented, rusty, leaking or broken containers are reported and discarded. Cans with rim dents or which are swollen are discarded.2. All utensils and equipment are cleaned and sanitized with diluted Ecolab Oasis 146 Multi-Quat Sanitizer daily. Sanitizer concentration should be between 150-400 ppm. Strips are used to determine the proper sanitation range of the sanitizer. Sanitizer needs to be changed every 2 hours.3. Food contact surfaces (example: cutting boards, food preparation tables) are cleaned and sanitized with diluted Ecolab Oasis 146 Multi-Quat Sanitizer (concentration should be between 150-400ppm) once every four (4) hours or as required.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review the facility failed to provide comprehensive care plans (CP) for one of four residents (Resident 2) when Resident 2 did not have a care plan for diabetes mellitus (DM, a disease characterized by high blood sugar levels due to insufficient insulin [a hormone which regulates the amount of sugar in the blood] production). This failure had the potential to result in Resident 2's individualized medical needs not being met. Findings: During a review of Resident 2's admission Record (AR), the AR indicated the facility originally admitted Resident 2 on 4/25/2025 with a diagnosis that included acute chronic respiratory failure (a worsening of a long-term lung problem where the lungs cannot provide enough oxygen [colorless, odorless gas] to the body). During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 8/6/2025, the MDS indicated Resident 2 had an active diagnosis of DM. During a review of Resident 2's History and Physical (H&P), dated 10/9/2025, the H&P indicated Resident 2 was unable to complete the review of systems (a series of questions about symptoms the resident may be experiencing). During a concurrent interview and record review on 11/20/2025 at 12:27 PM with Registered Nurse (RN) 1, Resident 2's CPs were reviewed. RN 1 stated Resident 2 did not have a CP for DM. RN 1 stated it was important for Resident 2 to have comprehensive CPs to help direct the care of Resident 2. During an interview on 11/21/2025 at 10:59AM with the Director of Nursing (DON), the DON stated it was important for Resident 2 to have a CP that addressed DM to ensure the facility addressed the disease process for Resident 2. Additionally, the DON stated a DM CP would aid in communication with the doctor regarding Resident 2's medical progress. During a review of the facility's Policy and Procedure (P&P) titled, Care Planning, reviewed 11/2024, the P&P's purpose indicated, To assure a coordinated and comprehensive written plan is developed based on the resident assessment instrument and on the individual needs of the resident. The P&P's procedure indicated, Each diagnosis will be listed and updated as necessary.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide preventive care, for one of one sampled resident (Resident 6), who was at risk for the development of pressure injuries (PU/PI - refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) by failing to: 1. Conduct an Interdisciplinary Team Meeting (IDT - a group of healthcare professionals from various disciplines who collaborate, assess, coordinate, and manage each resident's comprehensive health care, including his or her medical, psychological, social, and functional needs) when Resident 6 developed a stage 2 (partial-thickness loss of skin, presenting as a shallow open sore or wound) PU/PI at the facility. 2. Consult with the Clinical Nutrition Manager (CNM - Registered Dietician) to obtain nutrition or hydration interventions when Resident 6 developed a stage 2 PU/PI. 3. Follow Resident 6's care plan (CP) for PU/PI on 11/21/2025, indicating always apply a left heel protector. These deficient practices had the potential to result in worsening of existing PU/PI or result in the development of new PU/PIs for Resident 6. Findings: During a review of Resident 6's admission Record (AR), the AR indicated Resident 6 was admitted to the facility on [DATE] with multiple diagnoses including cerebrovascular disease (CVA - a group of conditions that affect blood flow to your brain) and encounter for attention to tracheostomy (a surgically created hole, also called a stoma, in the windpipe). During a review of Resident 6's RD - Nutritional Assessment (NA), dated 10/7/2025, the NA indicated one of the nutritional goals was improved skin integrity. During a review of Resident 6's Patient Progress Notes (PN) dated 10/19/2025, the PN indicated open skin [on the] sacrum (a triangular bone located at the base of the spine) was noted on Resident 6 during morning care. During a review of Resident 6's CP, titled Actual altered skin integrity related [to the] presence of pressure ulcer, Site: sacrum, stage: 2 dated 10/19/2025, the CP indicated, one of the multiple approach/plan was to assess nutritional needs to promote wound healing (protein, calories, vitamins and mineral supplement) by [the] dietician. During a review of Resident 6's Minimum Data Set [MDS - an assessment and screening tool], dated 10/21/2025, the MDS indicated Resident 6's cognition (ability to understand and process information) was severely impaired. The MDS indicated was dependent (helper does all of the effort) for activities of daily living and to roll left and right (the ability to roll from lying on back to left and right side and return to lying on back on the bed). The MDS indicated Resident 6 had hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) or hemiparesis (weakness or the inability to move on one side of the body) and was at risk [for the development] of PU/PI. The MDS indicated, Resident 6 had one unhealed stage 2 PU. During a review of Resident 6's PN dated 10/22/2025, the PN indicated, a stage 2 PU on Resident 6 measuring a length of two (2) centimeters (cm - a metric unit of measurement used for measuring the length) x (by) a width of two and half (2.5) cm with a depth of one (1) cm. The PN indicated, the sacrum stage 2 PU had a red wound bed (the base or open area of a wound) and slight exudate (drainage that seeps out of wounds)/odor. The PN indicated, Resident 6 was noted to have a new deep tissue injury (DTI - a type of PU/PI that occurs under intact skin, affecting the soft tissues and bone) on the left heel measuring 1.5 cm x 1.5 cm. During a review of Resident 6's CP, titled Actual altered skin integrity related presence of pressure ulcer, Site: l (left) heel, stage: DTI dated 10/29/2025, the CP indicated, one of the multiple approach/plan was to use pillows to relieve pressure off heel and foot and to apply protector to the left heel at all times. During a review of Resident 6's undated Physician's Nursing Orders Report (PNOR), printed 11/18/2025, the PNOR indicated, an order to elevate both heels on pillows at all times. During a concurrent interview and record review on 11/20/2025 at 11:33 AM with the Registered Nurse (RN) 1, Resident 6's medical records were reviewed. RN 1 stated, an open skin stage 2 PU was identified on Resident 6's sacrum on 10/18/2025 and the dietician was not consulted. RN 1 stated, a consultation with a dietician was important when residents developed a new PU so the dietician could give recommendations to prevent (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further deterioration and the development of another skin breakdown. RN 1 stated, the dietician could add supplements, like protein, vitamin C to help heal the wound [PU]. RN 1 stated, conducting an IDT was important because the IDT discussed the resident's (in general) care and current condition. RN 1 stated there was no IDT conducted in October 2025. RN 1 stated, Resident 6 developed a new DTI PU on the left heel on 10/29/2025. During an interview on 11/20/2025 at 1:42 PM with the CNM, the CNM stated a dietician should be consulted for residents who were at risk of developing PUs or after developing a PU to prevent the PU from worsening and for the dietician to recommend wound healing supplements. The CNM stated, the facility did not notify the CNM regarding Resident 6's PUs that developed on 10/18/2025 and 10/29/2025, I was not made aware of it. During a concurrent observation and interview on 11/21/2025 at 8:17 AM with RN 2, Resident 6 was asleep lying in bed. Resident 6 had two pillows underneath Resident 6's legs with the left foot (heel) resting on the fitted sheet while the right foot was resting on top of the left foot. Resident 6 did not have heel protector on Resident 6's left foot. RN 2 stated, Resident 6's feet should be offloading [the process of reducing or removing pressure from the affected area to promote healing] to prevent the PU from getting worse. During an interview on 11/21/2025 at 10:25 AM with Certified Nursing Assistant (CNA) 2, CNA 2 stated, one of the interventions for Resident 6's left heel PU was to put pillows to elevate Resident 6's left heel. During an interview on 11/21/2025 at 11:36 AM with the Director of Nursing (DON), the DON stated, the discovery of Resident 6's stage 2 PU was not considered a significant change, only anything above stage 2, but an IDT should have been conducted, yes, of course, to be on the same page for the plan of care of Resident 6. The DON stated the dietician was involved in the IDT. During an observation on 11/21/2025 at 10:30 AM with RN 1 and Licensed Vocational Nurse (LVN) 3, Resident 6's PU/PI located on the sacrum was closed, pale in color and scarring. Resident 6's left heel DTI had a pale colored center and surrounded with a dark reddish purplish colored area. During a review of the facility's policy and procedure (P&P) titled, Pressure/Vascular Ulcer Management, revised date 4/12/2005, the P&P's purpose indicated to ensure a system of evaluation, assessment, and monitoring of residents for pressure/vascular ulcer management that promoted the healing of pressure ulcers that were present, including prevention of infection to the extent possible. The P&P indicated, an assessment of care needs for pressure/vascular ulcer management would be made with emphasis on but not limited to treatment, pressure reducing devices and nutritional status. The P&P indicated, if pressure/vascular areas were present, the licensed nurse would notify appropriate disciplines for referrals (i.e., dietary.). During a review of the facility's 2025 Facility Assessment [FA], the FA indicated, the facility offered services and care based on the residents' needs that included general care for skin integrity with specific care or practices such as pressure injury prevention and care, skin care, wound care (surgical, other skin wounds).		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 5) who had a urinary catheter (a flexible plastic tube inserted into the bladder to provide continuous urinary drainage) received proper care and services when Resident 5's urinary catheter was not flushed (the use of a sodium chloride solution to clean out a catheter) as indicated by the Order Information Report, dated 9/25/2025. This failure had the potential to result in blockage to Resident 5's urinary catheter resulting in discomfort or a urinary tract infection (an infection in any part of the urinary system: kidneys, bladder, or urethra [tube through which the urine leaves the body]). Findings: During a review of Resident 5's admission Record (AR), the AR indicated the facility originally admitted Resident 5 on 8/11/2025 with diagnoses including chronic (persistent or long-lasting) respiratory failure (a medical condition that happens when your lungs cannot get enough oxygen [colorless, odorless gas]) and hypertension (high blood pressure). During a review of Resident 5's History and Physical (H&P), dated 9/24/2025, the H&P indicated Resident 5 had a diagnosis of benign prostatic hyperplasia (enlargement of the prostate gland that can lead to urinary problems). During a review of Resident 5's Order Information Report, dated 9/25/2025, the order information report indicated sodium chloride (NaCl) Irrigation (solution used to prevent blockage one to one ratio of sodium and chloride ions) for an increase in sediments (particles that settle at the bottom), cloudiness, and hematuria (blood in the urine) was ordered for Resident 5 with a start date of 9/25/2025. During a review of Resident 5's Care Plan (CP) titled Required Indwelling Foley Catheter, initiated 9/25/2025, the CP indicated to monitor and maintain patency and placement of the suprapubic (a surgically created connection between the urinary bladder and the skin) or indwelling catheter. During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool), dated 10/6/2025, the MDS indicated Resident 5's cognitive (the ability to think and process information) skills for daily decision making were severely impaired. During a concurrent observation and interview on 11/19/2025 at 10:35 AM with Registered Nurse (RN) 1 in Resident 5's room, bloody sediment was observed in Resident 5's urinary catheter tubing. RN 1 stated Resident 5's urinary catheter should be flushed with normal saline to prevent the catheter from occluding (blockage) causing an infection. During an observation on 11/20/2025 at 2:23 PM in Resident 5's room, cloudy sediments were noted in Resident 5's urinary catheter tubing. During an interview on 11/20/2025 at 3:28 PM with Licensed Vocational Nurse (LVN) 2, LVN 2 stated LVN 2 was aware that the catheter had sediments in Resident 5's urinary catheter tubing and LVN 2 had not flushed the catheter tubing today. LVN 2 stated it was important to flush Resident 5's urinary catheter tubing to prevent the catheter from occluding. During a review of the facility's Policy and Procedure (P&P) titled, Catheter Care, Routine Daily, revised 11/2024, the P&P's purpose indicated, To maintain resident hygiene and to reduce the risk of urinary tract infection. The P&P's policy indicated, It is the policy of this facility that routine catheter care will be provided twice daily as a part of daily nursing care and as a measure of good nursing practice.		

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NAME OF PROVIDER OR SUPPLIER Greater El Monte Community Hos		STREET ADDRESS, CITY, STATE, ZIP CODE 1701 Santa Anita Avenue El Monte, CA 91733	
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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure, for one of four sampled residents (Resident 11), the enteral feeding (nutrition taken through the mouth or through a tube that goes directly to the stomach or small intestine) water flush bag (bag of fluid used to keep medical tubing clear and free from blockages) was labeled and dated as indicated in the facility's Policy and Procedure (P&P) titled, Administration of Formula Via Feeding Tube, Gravity, Bolus Pump. This failure had the potential to result in medical complications such as infections (the invasion and growth of germs in the body) for Resident 11. Findings: During a review of Resident 11's admission Record (AR), the AR indicated the facility admitted Resident 11 on [DATE]. During a review of Resident 11's History and Physical (H&P), dated [DATE], the H&P indicated Resident 11 had diagnoses including chronic (persistent or long-lasting) respiratory failure (a medical condition that happens when your lungs cannot get enough oxygen [colorless, odorless gas]), was on a ventilator (a machine used to support or replace the breathing of a person), and had a gastrostomy tube (a feeding tube that goes directly into the stomach). The H&P indicated Resident 11 was unable to complete the review of systems (a series of questions about symptoms the resident may be experiencing). During a review of Resident 11's Physician's Nursing Orders Report (PNOR), dated [DATE], the PNOR indicated an order to flush Resident 11's gastrostomy tube with 50 milliliters (ml-a unit of measurement) of water before medication administration and 20 ml of water after [medication administration]. During an observation on [DATE] at 9:56 AM in Resident 11's room, Resident 11's water flush bag was observed without a date indicating when the water flush bag was first used. During an interview on [DATE] at 11:05 AM with Registered Nurse (RN) 2, RN 2 stated Resident 11's water flush bag should be dated to indicate when the water flush bag was first used. RN 2 stated it was important to indicate the date of first use to prevent Resident 11 from receiving old or expired fluids which could lead to infections. During an interview on [DATE] at 10:57 AM with the Director of Nursing (DON), the DON stated it was the policy of the facility to date the water flush bag to ensure the safety of the residents (in general). During a review of the facility's P&P titled, Administration of Formula Via Feeding Tube, Gravity, Bolus Pump, revised 7/2019, the P&P's purpose indicated, To administer nutrients to residents who are unable to eat orally without complications. To assure proper absorption of nutrients by proper administration, without untoward side effects. The P&P's procedure indicated, Pump bags, syringe and tubing are to be changed every 24 hours and properly labeled with date, time, and nurse's initials.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to provide necessary respiratory care services for one of four sampled residents (Resident 11), as indicated by the facility's Policy and Procedure (P&P) titled, Tracheostomy Site Care, when Resident 11's tracheostomy tube (a breathing tube placed through a surgical opening in the neck) was left soiled on 11/19/2025. This failure had the potential for Resident 11 to develop medical complications such as infections (the invasion and growth of germs in the body). Findings: During a review of Resident 11's admission Record (AR), the AR indicated the facility admitted Resident 11 on 12/12/2023. During a review of Resident 11's History and Physical (H&P), dated 7/3/2025, the H&P indicated Resident 11 had diagnoses including chronic (persistent or long-lasting) respiratory failure (a medical condition that happens when your lungs cannot get enough oxygen [colorless, odorless gas]), was on a ventilator (a machine used to support or replace the breathing of a person), and had a gastrostomy tube (a feeding tube that goes directly into the stomach). The H&P indicated Resident 11 was unable to complete the review of systems (a series of questions about symptoms the resident may be experiencing). During a review of Resident 11's Physician's Nursing Orders Report (PNOR), dated 11/18/2025, the PNOR indicated an order to change/clean Resident 11's inner cannula (a removable tube that sits inside the tracheostomy tube) and trach [tracheostomy] tie daily and as needed if soiled. During a review of Resident 11's Care Plan (CP) titled Potential for infection related to long-term tracheostomy tube status and colonization [presence of a microorganism on/in a host with growth and multiplication of the organism but without interaction between host and organism], initiated 12/13/2023, the CP's approach plan indicated Resident 11 should receive tracheostomy care as ordered to help prevent infections. During an observation on 11/19/2025 at 9:56 AM in Resident 11's room, the inner part of Resident 11's tracheostomy tube was observed to be soiled with old bloody residue. During an interview on 11/19/2025 at 10:40 AM with Respiratory Therapist (RT) 1, RT 1 stated Resident 11's tracheostomy was soiled and [the bloody drainage] should be cleaned as ordered [by the physician]. RT 1 stated RT 1 had not had a chance to clean the bloody drainage in Resident 11's tracheostomy tube. RT 1 stated the bloody residue in Resident 11's tracheostomy could cause an infection if left in the tube. During an interview on 11/21/2025 at 10:54 AM with the Director of Nursing (DON), the DON stated the bloody residue in Resident 11's tracheostomy tube should have been cleaned to help prevent Resident 11 from developing infections. During a review of the facility's P&P titled, Tracheostomy Site Care, reviewed 11/2024, the P&P's purpose indicated, To prevent loss of skin integrity and prevent infection at the tracheostomy site. The P&P's policy indicated, Tracheostomy site care will be performed every shift, and as needed.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure a tube-feeding syringe containing gastric contents was discarded after use and was not left at the bedside for one of two sampled residents (Resident 10). This failure had the potential to result in bacterial contamination and infections to Resident 10, staff, and visitors who could have encountered the contaminated tube feeding syringe. Findings: During a review of Resident 10's admission Record (AR), the AR indicated the facility admitted Resident 10 on 10/15/2025, with diagnoses including chronic (persistent or long-lasting) respiratory failure (a condition where there's not enough oxygen [colorless, odorless gas] or too much carbon dioxide in the body), chronic obstructive pulmonary disorder (COPD - a lung disease causing difficulty in breathing), and gastrostomy tube (G-tube - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 10's Minimum Data Set (MDS - a resident assessment tool), dated 10/27/2025, the MDS indicated Resident 10's cognition (the ability to think and process information) was severely impaired. The MDS indicated Resident 10 was dependent (helper does all of the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and was dependent with mobility. The MDS indicated Resident 10 received tube feeding. During an observation on 11/19/2025 at 10:28 AM, in Resident 10's room, a tube-feeding syringe containing gastric contents was observed on Resident 10's bedside table. The syringe was left inside a wrapper packaging, and the syringe was filled with gastric contents. During an interview on 11/19/2025 at 11:30 AM, with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the syringe [left on Resident 10's bedside] should have been discarded immediately after checking Resident 10's gastric residuals (remaining contents) and stated that leaving a used syringe with gastric contents at the bedside was not consistent with infection-control practices. LVN 1 stated syringes with gastric content can harbor bacteria and should not remain in a resident-care environment. During an interview on 11/21/2025 at 1:32 PM, with the Director of Nursing (DON), the DON stated that the tube feeding syringe for Resident 10 should have been discarded immediately after use. The DON confirmed used syringes with gastric content must be removed from the bedside to prevent contamination. The DON stated in-services would be conducted to remind staff of the importance of discarding gastric-content syringes promptly and ensuring they were never left in the resident care area. During a review of the facility's P&P titled, Infection Prevention & Control Plan, review date 7/2025, the P&P indicated the goals of the infection control program included, but are not necessarily limited to: A. Minimizing the risk of transmitting infections with the use of procedures, medical equipment and medical devices. B. Maintaining a sanitary environment to avoid sources and transmission of infections and communicable diseases.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 10's) room environment was maintained in safe, comfortable, and sanitary condition by failing to:A. Ensure no active roof leak was present in Resident 10's room during active rain season on 11/20/2025.B. Prevent and repair visible wall damage caused by wall moisture and due to the leak in Resident 10's room.This deficient practice placed Resident 10 at risk for respiratory irritation, exacerbation of underlying health conditions, and physical decline. Additionally, there was a potential for discomfort to Resident 10, environmental contamination, increased risk of mold growth, and further structural damage. Findings:During a review of Resident 10's admission Record (AR), the AR indicated the facility admitted Resident 10 on 10/15/2025, with diagnoses including chronic (persistent or long-lasting) respiratory failure (a condition where there's not enough oxygen [colorless, odorless gas] or too much carbon dioxide in the body), chronic obstructive pulmonary disorder (COPD - a lung disease causing difficulty in breathing), and cerebrovascular disorder (CVA - stroke, loss of blood flow to a part of the brain).During a review of Resident 10's Minimum Data Set (MDS - a resident assessment tool), dated 10/27/2025, the MDS indicated Resident 10's cognition (the ability to think and process information) was severely impaired. The MDS indicated Resident 10 was dependent (helper does all of the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and was dependent with mobility.During an observation on 11/20/2025 at 3:30 PM in Resident 10's room, heavy rain was observed from inside the room and through Resident 10's room window. There was moisture on the upper wall located above the window, the wall was stained, discolored, and had visible deterioration, including peeling and separation of wall material. Additionally, there were water drops observed at the top of the window blinds.During an interview on 11/20/2025 at 4 PM with the Stationary Engineer (SE), the SE stated the SE was aware of the water leak [in Resident 10's room] for about one week. The SE stated staff had reported the water leak and the damaged wall in Resident 10's room approximately one week ago. The SE stated repairs were completed on the rooftop to prevent further water penetration [into Resident 10's room]. However, the SE stated the interior wall was never repaired or properly aired out, and the wall should have been [repaired] because moisture created mold, and mold could affect the resident's safety [health]. The SE stated that based on the current appearance of the wall, there was still a water leak, and the issue needed to be addressed immediately.During an interview on 11/21/2025 at 11:25 AM with the Lead Engineer ([NAME]), the [NAME] stated the leak in Resident 10's room had occurred due to recent rain within the last week. The [NAME] stated there was a drainage system that ran along the exterior wall directly adjacent to Resident 10's window, and this system tended to become backed up during heavy rain season. The [NAME] stated the area was previously sealed off, but based on the continued water intrusion, it appeared the seal was not properly installed. The [NAME] stated the ongoing water leak was evident by the appearance of the wall and the continuous wall damage. The [NAME] stated this condition posed a hazard to Resident 10 and needed to be corrected immediately to prevent further damage that could potentially affect Resident 10's health.During a review of the facility's Job Description and Performance Standards (JDPS) titled, Lead Engineer, revision date 7/3/2013, the JDPS mission statement indicated it was the facility's mission to provide quality healthcare in a safe environment that is sensitive and supportive to the physical, emotional, spiritual and diverse multi-cultural needs of our patients and their loved ones. We advocate the preservation of human dignity in the delivery of our services and programs. During a review of the facility's Policy and Procedure (P&P) titled, Work Orders - Engineering, reviewed 5/2022, the P&P indicated:A. It is the policy of [the facility] to maintain the Hospital in [a] safe operating condition.B. It is the responsibility of the Engineering Department to keep the hospital in a (continued on next page)		

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

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	safe and efficient operating condition at all times, and to establish a P&P for requesting repairs to the facility and its equipment. During a review of the facility's JDPS titled, Stationary Engineer, dated 6/27/2025, the JDPS mission statement indicated it was the facility's mission to provide quality healthcare in a safe environment that is sensitive and supportive to the physical, emotional, spiritual, and diverse multi-cultural needs of our patients and their loved ones. The P&P indicated we advocate the preservation of human dignity in the delivery of our services and programs.		