

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555897	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2026
NAME OF PROVIDER OR SUPPLIER Monterey Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 1267 San Gabriel Blvd Rosemead, CA 91770	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to notify the physician (MD) of an accident involving a resident for one of two sampled residents (Resident 1) after Resident 1 was observed by staff walking head first into a door that resulted in a cut near his right eye during the nightshift on 3/7/26 around 3 AM. The facility's staff did not notify Resident 1's physician (MD) of the injury during the morning shift, on 3/7/26 at 9 AM, six (6) hours after the accident, when Resident 1 was sent to a general acute care hospital (GACH) for medical evaluation and treatment. This failure to notify Resident 1's physician at the time of Resident 1's accident delayed the MD from placing orders to evaluate Resident 1 for severe injury that potentially required medical intervention and to monitor Resident 1 for any change in condition and had the potential for Resident 1 to decline from his head injury. Findings: During a review of Resident 1's admission Record, the record indicated Resident 1 was originally admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), lack of coordination, and abnormalities of gait (walking) and mobility. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 1/29/26, the MDS indicated Resident 1 had severe cognitive impairment (a profound decline in memory, orientation, reasoning, and daily functioning) and required supervision for most cares such as personal hygiene and dressing. During a review of Resident 1's Change in Condition Evaluation form (CIC- a communication tool used by healthcare workers when there is a change of condition among the residents) dated 3/7/26 at 8:45 AM, the CIC indicated, Resident [1] was seen in the shower room getting ready to shower when he started rubbing his right eyebrow and started bleeding. Upon further assessment noted resident with a 1.2 cm (centimeter- a unit of measurement) cut on his right eyebrow and discoloration on right upper eyelid. Resident might need to go to acute hospital for evaluation. The CIC also indicated that Resident 1 had a skin change of a right eyebrow cut and right eyelid discoloration. The CIC also indicated a neurological assessment was relevant to the change in condition. The CIC also indicated Resident 1's physician was notified of the CIC on 3/7/26 at 9 AM and recommended to transfer Resident 1 to a GACH for medical clearance related to the right eyebrow cut and discoloration on the right upper eyelid. During a review of the facility's Investigation Report dated 3/13/26, the report indicated that Resident 1 was investigated for an injury of unknown origin for a cut and mild discoloration to the right eye after the ADM was informed of Resident 1's injury on 3/7/26 at 8:56 AM. The investigation indicated Certified Nursing Assistant (CNA) 1 witnessed Resident 1 turned a corner in the hallway and bumped into an open door on 3/7/26 shortly before 3 AM. The report further indicated CNA 1 noticed a small cut above Resident 1's right eye after he bumped into the door and Licensed Vocational Nurse (LVN) 1 and Registered Nurse (RN) 1 assessed Resident 1's cut and rendered first aid. During an interview with the ADM and concurrent observation on 3/20/26 at 8:45 AM of Resident 1, Resident 1 was observed walking and shuffling his feet with short strides and leaning forward with his head down as he walked. The ADM stated that Resident 1 sometimes did not watch where he was walking and could bump into things as he walked. During another interview with the ADM and concurrent observation on (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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3/20/26 at 9 AM, the door to the facility's room [ROOM NUMBER] was observed. The door to room [ROOM NUMBER] was opened and stuck out approximately 10 inches into the hallway. The ADM stated that Certified Nursing Assistant (CNA) 1 observed Resident 1 turn the corner of the hallway and bump into the edge of the door with his face. The ADM also stated the licensed nurses assessed Resident 1 and provided first aid and deemed [Resident 1] was fine. During a telephone interview with CNA 1 on 3/20/26 at 11:24 AM, CNA 1 stated that, on 3/7/26 around 3 AM, he observed Resident 1 turning a corner and then hit the end edge of the door to room [ROOM NUMBER] with his face. CNA 1 stated he noticed a cut on Resident 1's eyebrow with blood on his face and hand. CNA 1 further stated that he brought Resident 1 to the nurses station where LVN 1 and RN 1 cleaned Resident 1's wound. During an interview with the DON on 3/20/26 at 12:05 PM, the DON stated that Resident 1's right eye injury was initially considered an injury of unknown origin because no one during the day shift (7 AM to 3 PM) knew how Resident 1 got the injury. After further investigation by the facility, it was discovered that Resident 1 received the injury after bumping into the edge of a door during night shift (11 PM to 7 AM) around 3 AM on 3/7/26. The DON stated LVN 1 and RN 1 did not initiate a CIC to communicate to the rest of the facility how Resident 1 received his injury to the right eye. The DON stated LVN 1 and RN 1 should have initiated a CIC and notified Resident 1's MD of the accident so that the MD could place orders for proper interventions for Resident 1 such as medical evaluation from a GACH and monitoring. The DON stated she looked through Resident 1's Progress Notes and CIC documentation and did not see any documentation related to Resident 1's accident on 3/7/26 at 3 AM. During a review of the facility's policy and procedure (P&P) titled Change in Condition dated 8/25/22, the P&P indicated a licensed nurse will notify the resident's physician and legal representative or an appropriate family member when: There is an incident/accident involving the resident. An accident involving the resident which results in injury and has the potential for requiring physician intervention</p>		