STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555897	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monterey Healthcare & Wellness Centre, LP	1267 San Gabriel Blvd Rosemead, CA 91770

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 interview and record review, the facility failed to notify the physician of a resident exhibiting new behaviors of verbal threats for one of two sampled residents (Resident 35) when Licensed Vocational Nurse (LVN) 1 observed Resident 35 regularly saying, I want to hit you to staff but did not notify Resident 35's physician of this new behavior. On 3/24/26, Resident 35 was witnessed throwing coffee toward Resident 58 during activities and Resident 35 was transferred to a general acute care hospital (GACH) for medical and psychiatric evaluation. This failure to report Resident 35's new behavior of verbal threats toward others did not allow Resident 35's physician to evaluate Resident 35 and apply new interventions such as making changes to Resident 35's medications or ordering new nursing interventions. This had the potential for Resident 35 to escalate his behavior and physically attack staff or other residents. [Cross reference F656] Findings: During a review of Resident 35's admission Record, the record indicated Resident 35 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and auditory hallucinations (perceptual experiences in which an individual hears sounds, often voices, with no external auditory stimulus present). During a review of Resident 35's Minimum Data Set (MDS- a resident assessment tool) dated 1/27/26, the MDS indicated Resident 35 had moderately impaired cognition (the mental process of how a person learns, remembers, understands, and uses information) and required supervision or touch assistance for most cares such as personal hygiene and toileting. The MDS also indicated Resident 35 did not exhibit verbal behavioral symptoms directed towards others such as threatening others, screaming at others, or cursing at others. During a review of Resident 35's care plan initiated on 1/21/26, the care plan indicated Resident 35 had a mood disorder with interventions to monitor/record/report to physician the risk of Resident 35 harming others: increased anger, labile mood or agitation, threatened by others or thoughts of harming someone. During a review of Resident 35's provider progress notes dated 2/9/26 at 4:02 PM and signed by NP 1, the notes indicated Resident 35 denied / expressed no suicidal ideations, homicidal ideations, and violent behavior. During a review of Resident 35's Change in Condition (CIC- a communication tool used by healthcare workers when there is a change of condition among the residents) Form dated 3/24/26 at 9:50 AM, the CIC indicated, During scheduled coffee social activities in the dining room, [Resident 35] started exhibiting physical aggression [related to] throwing coffee at another resident unprovoked. [Resident 35] was sitting down and stood up from his chair while speaking loudly. [Resident 35] threw a cup of coffee in the direction of another resident. The CIC also indicated Nurse Practitioner (NP) 1 was notified of this incident and ordered to transfer Resident 35 to a GACH on a 5150 hold (a 72 hour hold for psychiatric evaluation when a resident is a danger to themselves, a danger to others, or are unable to care for their basic needs due to a mental health condition) for evaluation. During an interview with LVN 1 on 3/27/26 at 10:28 AM and concurrent record review of Resident 35's progress notes, CICs, and care plans from 1/2026 to 3/2026, LVN 1 stated there was no documentation of Resident 35 making verbal threats to staff. LVN (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 stated Resident 35 was known to easily be triggered when he did not get what he wanted and expressed his frustrations at staff by verbalizing, I want to hit you. LVN 1 further explained Resident 35's verbal threats to hit staff was new and he did not exhibit threatening behaviors until 2/2026, around a month after being admitted to the facility. LVN 1 stated she did not update Resident 35's care plan with Resident 35's verbal threats toward staff because Resident 35 was already known to be verbally aggressive and required frequent redirection. LVN 1 stated she should have created a CIC and notified Resident 35's physician of Resident 35's new behavior of making verbal threats to staff so that Resident 35 and his medications could have been reassessed by the physician. LVN 1 also stated that when residents stated they want to harm themselves or others, the facility's protocol is to place that resident on one-to-one supervision for safety to protect the resident or others from harm. During an interview with the Director of Registered Nursing (DON) on 3/27/26 at 11:20 AM, the DON stated she was not aware that Resident 35 was making verbal threats to hit staff. The DON stated that when a resident expressed verbal threats toward others such as, I want to hit you, staff should create a CIC to communicate the change in the resident's behavior to the rest of the staff, update the care plan to implement interventions, and notify the resident's physician in order to have the resident's medications reevaluated or sent to a GACH for further evaluation. The DON further explained that a CIC should have been created when Resident 35 first made verbal threats to harm others. During a review of the facility's Policy and Procedure (P&P) titled, Change in Condition and dated 8/25/22, the P&P indicated the licensed nurse will notify the resident's physician and legal representative when there is: An incident involving the resident A significant change in the residents' mental or psychosocial status

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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 observation, interview, record review, the facility failed to develop and implement a comprehensive-person centered care plan for three of three sample residents (Resident 9, 35, and 5) by failing to ensure: 1. The care plan was not implemented for Resident 9 with a history of hemolytic anemia (a blood disorder where the red blood cells [RBC] are destroyed faster than the bone marrow can replace them, leading to fatigue, jaundice [yellowing of skin], and dark urine) to monitor the resident for signs and symptoms of anemia (a blood condition where there is not enough healthy RBC or hemoglobin [HGB, protein that carries blood to the tissues; normal range 11 - 16 grams per deciliter (g/dL)]). This deficient practice had the potential for Resident 9 not to receive the necessary care and interventions for her history of hemolytic anemia that could lead to a decline in the resident's physical and psychosocial well-being that may lead to foreseeable risks, including unrecognized progression of anemia, severe weakness, hypoxia, and the need for emergency blood transfusions and hospitalizations. [Cross Reference to F684] 2. A care plan was created for Resident 35 who exhibited new behaviors of making verbal threats to others after Licensed Vocational Nurse (LVN) 1 observed Resident 35 regularly saying, I want to hit you to staff. This failure had the potential for Resident 35 to not receive the proper interventions and necessary care related to his behaviors and had the potential for Resident 35 to escalate his behavior and physically attack staff or other residents. On 3/24/26, Resident 35 was witnessed throwing coffee toward Resident 58 during activities and Resident 35 was transferred to a general acute care hospital (GACH) for medical and psychiatric evaluation. [Cross reference F580] 3. A care plan was created when Resident 5 was admitted to the facility with poor vision and required assistance with activities. This failure had the potential for Resident 5 to decline psychosocially from not participating in group activities and physically from not being able to perform his activities of daily living (ADLs). Findings: 1.During a review of Resident 9's admission Record (AR), the facility admitted Resident 4/17/2025 and readmitted Resident 9 on 11/17/2025 with diagnoses of acquired hemolytic anemia, hypertension (HTN, high blood pressure), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 9's care plan, initiated on 11/17/2025, the care plan indicated Resident 9 had hemolytic anemia with interventions, initiated on 11/17/2025, that included to educate Resident 9 and their caregivers to expect her stool to change from dark green to black and to monitor/document/report the following signs and symptoms of anemia such as pallor (unhealthy pale color), fatigue, dizziness, syncope (faint), headache, palpitations, weakness, feelings of cold, low hemoglobin and hematocrit, shortness of breath upon activity, sore tongue, chest pain, tinnitus (ringing in ears), headache, and changes in condition. Durning a review of Resident 9's Minimal Data Set (MDS, a resident's assessment) dated 1/23/2026, the MDS indicated that Resident 9's cognitive (a resident's thought process) was intact. The MDS indicated that Resident 9's active diagnoses include anemia, heart failure (chronic condition where the heart cannot effectively pump blood to the rest of the body), HTN, and renal insufficiency (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(condition where the kidneys cannot effectively filter the blood of impurities). During a review of Resident 9's Change of Condition Evaluation (CoC) record, dated 2/18/2026 timed at 7:57 PM, the CoC indicated Resident 9's had abnormal blood pressure of 94/43, heart rate of 99, respiratory rate of 16, and temperature of 98.8 degrees Fahrenheit (F, unit of temperature). The record indicated that Resident 9's had a critical laboratory result and blood pressure. Physician 1 (Primary Care Physician) recommended to transfer Resident 9 to the GACH via 911. During a review of Resident 9's care plan, initiated on 11/17/2025, revised on 2/24/2026, indicated that Resident 9 had low HGB of 3.8 and low HCT of 14% on 2/18/2026. The care plan did not indicate any new interventions related to hemolytic anemia after Resident 9's hospitalization on 2/18/2026 and readmission to the facility on 2/23/2026. During a review of Resident 9's HP, dated 2/25/2026, the HP indicated that Resident 9 did not have the capacity to understand and make decisions. During an interview on 3/26/2026 at 3:20 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, Resident 9 had routine laboratory orders and her HGB results would sometimes be low. LVN 4 stated, she did not know if Resident 9 had a diagnosis of anemia, but Resident 9 was hospitalized recently for low HGB. During a concurrent interview and record review on 3/26/2026 at 6:15 PM with the ADON, Resident 9's care plans and physician orders were reviewed. The ADON stated, the facility monitored Resident 9's anemia through routine laboratory orders every three (3) months but there was no monitoring conducted to ensure that Resident 9 was monitored for signs and symptoms of hemolytic anemia such as pallor, fatigue, dizziness, syncope, headache, palpitations, weakness, feelings of cold, low hemoglobin and hematocrit, shortness of breath upon activity, sore tongue, chest pain, tinnitus, and changes in condition. During a concurrent interview and record review on 3/26/2026 at 6:15 PM with the Assistant Director of Nursing (ADON), Resident 9's care plans and active orders were reviewed. The ADON stated that Resident 9's care plan indicated to monitor, document, and report if Resident 9 experienced any physical signs and symptoms of anemia. The ADON stated that there was no documented evidence to monitor if Resident 9 experienced any physical signs and symptoms of anemia. During an interview on 3/27/2026 at 10:40 AM with Registered Nurse (RN) 1, RN 1 stated it was important follow Resident 9's care plan to monitor for signs and symptoms of anemia such as pallor, dark tarry stool, and bleeding because if Resident 9 was not monitored, the signs and symptoms of anemia may be missed, which may result in hospitalization. During an interview on 3/27/2026 at 11 AM with the Director of Nursing (DON), the DON stated it was (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	important to specifically monitor any signs and symptoms of anemia to identify any changes in Resident 9's condition and to notify Physician 1 as soon as possible. During a review of the facility's policies and procedures (P&P) titled Comprehensive—Person Centered Care Planning, revised 8/24/2023, the P&P indicated the facility must develop and implement a comprehensive person-centered care plan for each resident rights and provide services that are to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being. During a review of the same facility's P&P titled Comprehensive—Person Centered Care Planning, revised 8/24/2023, the P&P indicated that the comprehensive care plans must be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. 2. During a review of Resident 35's admission Record, the record indicated Resident 35 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and auditory hallucinations (perceptual experiences in which an individual hears sounds, often voices, with no external auditory stimulus present). During a review of Resident 35's Minimum Data Set (MDS- a resident assessment tool) dated 1/27/26, the MDS indicated Resident 35 had moderately impaired cognition (the mental process of how a person learns, remembers, understands, and uses information) and required supervision or touch assistance for most cares such as personal hygiene and toileting. The MDS also indicated Resident 35 did not exhibit verbal behavioral symptoms directed towards others such as threatening others, screaming at others, or cursing at others. During a review of Resident 35's care plan initiated on 1/21/26, the care plan indicated Resident 35 had a mood disorder with interventions to monitor/record/report to physician the risk of Resident 35 harming others: increased anger, labile mood or agitation, threatened by others or thoughts of harming someone. During a review of Resident 35's provider progress notes dated 2/9/26 at 4:02 PM and signed by NP 1, the notes indicated Resident 35 denied / expressed no suicidal ideations, homicidal ideations, and violent behavior. During a review of Resident 35's Change in Condition (CIC- a communication tool used by healthcare workers when there is a change of condition among the residents) Form dated 3/24/26 at 9:50 AM, the CIC indicated, During scheduled coffee social activities in the dining room, [Resident 35] started exhibiting physical aggression [related to] throwing coffee at another resident unprovoked. [Resident 35] was sitting down and stood up from his chair while speaking loudly. [Resident 35] threw a cup of coffee in the direction of another resident. The CIC also indicated Nurse Practitioner (NP) 1 was notified of this incident and ordered to transfer Resident 35 to a GACH on a 5150 hold (a 72 hour hold for psychiatric evaluation when a resident is a danger to themselves, a danger to others, or are unable (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to care for their basic needs due to a mental health condition) for evaluation. During an interview with LVN 1 on 3/27/26 at 10:28 AM and concurrent record review of Resident 35's progress notes, CICs, and care plans from 1/2026 to 3/2026, LVN 1 stated there was no documentation of Resident 35 making verbal threats to staff. LVN 1 stated Resident 35 was known to easily be triggered when he did not get what he wanted and expressed his frustrations at staff by verbalizing, I want to hit you. LVN 1 further explained Resident 35's verbal threats to hit staff was new and he did not exhibit threatening behaviors until 2/2026, around a month after being admitted to the facility. LVN 1 stated she did not update Resident 35's care plan with Resident 35's verbal threats toward staff because Resident 35 was already known to be verbally aggressive and required frequent redirection. LVN 1 stated she should have created a CIC and notified Resident 35's physician of Resident 35's new behavior of making verbal threats to staff so that Resident 35 and his medications could have been reassessed by the physician. LVN 1 also stated that when residents stated they want to harm themselves or others, the facility's protocol is to place that resident on one-to-one supervision for safety to protect the resident or others from harm. During an interview with the Director of Registered Nursing (DON) on 3/27/26 at 11:20 AM, the DON stated she was not aware that Resident 35 was making verbal threats to hit staff. The DON stated that when a resident expressed verbal threats toward others such as, I want to hit you, staff should create a CIC to communicate the change in the resident's behavior to the rest of the staff, update the care plan to implement interventions, and notify the resident's physician in order to have the resident's medications reevaluated or sent to a GACH for further evaluation. The DON further explained that a CIC should have been created when Resident 35 first made verbal threats to harm others. 3. During a review of Resident 5's admission Record, the record indicated Resident 5 was admitted to the facility 9/2/25 with diagnoses including schizophrenia, lack of coordination, depression, and anxiety. During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5 had intact cognition and impaired vision (resident could see large print, but not regular print in newspapers/books). During an observation on 3/26/26 at 3:46 PM in the facility's dining room, Resident 5 was observed participating in the facility's karaoke activity. Resident 5 was observed to be sitting close to the TV, holding a microphone, and looking down at the floor but not singing. Resident 5 was observed telling the activity staff that he wanted to hear the song but could not sing along because he could not read the words on the TV. Resident 5 was observed squinting his eyes at the TV and squinting his eyes when looking at staff. During an interview with Resident 5 on 3/24/26 at 10:33 AM, Resident 5 stated that he had difficulty seeing because he was partially blind. Resident 5 stated he wanted to participate in more activities but could not due to his impaired vision. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During another interview with Resident 5 on 3/26/26 at 1:59 PM, Resident 5 stated that he told the facility's staff of his vision impairment but did not feel the heard by the facility. Resident 5 stated he was frustrated and further stated, I feel like they [the facility] don't care. During an interview with Activity Staff (AS) 1 on 3/26/26 at 2:04 PM, AS 1 stated that Resident 5 often complained about not being able to see well and stated that Resident 5 did not participate in some activities due to his poor vision. AS 1 stated that Resident 5 would not attend group activities that could not accommodate his poor vision. During an interview with the activities director (AD) on 3/26/26 at 2:30 PM, the AD stated that Resident 5 required one-to-one activity visits because the activity staff noticed that Resident 5 was not actively participating in group activities. The AD stated Resident 5 presented with low self-esteem and would state he felt like a burden when he could not participate in activities. During an interview with the DON on 3/27/26 at 12:35 PM and concurrent record review of Resident 5's care plan, the DON stated there should have been a care plan for Resident 5's poor vision so that proper interventions could have been in place and Resident 5 could perform his ADLs. The DON further stated that if Resident 5 continued to refuse activities, he could isolate and his psychosocial and mental wellbeing could decline. During a review of the facility's Policy and Procedure (P&P) titled, Person-Centered Care Planning dated 5/22/25, the P&P indicated the facility must develop and implement a comprehensive person-centered care plan for each resident rights and provide services that are to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being.ˆ

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide interventions to one of three sample residents (Resident 54) with increased verbal aggression towards other staffs or residents and increased episodes of delusion (misconceptions or beliefs that are firmly held, contrary to reality) to ensure safety to other residents by implementing interventions to prevent Resident 54 from aggression towards residents and staffs. As a result, Resident 54 hit Resident 25 on the right cheek without major injury. In addition, Resident 54 had the potential to emotionally and physically harm other residents and staff due to aggression and delusional thoughts.Findings: During a review of Resident 25's admission Record (AR), the facility admitted Resident 25 on 6/30/2021 and readmitted Resident 25 on 2/13/2026 with diagnoses that included paranoid schizophrenia (mental health disorder where a resident experiences intense, irrational suspicion, paranoia, and hallucinations [perceptual experiences in the abuse of real external sensory stimuli]), dementia (a progressive state of decline in mental abilities), and blindness in one eye. During a review of Resident 25's Minimal Data Set (MDS, a resident assessment), dated 2/5/2026, the MDS indicated that Resident 25's cognitive (a resident's thought process) skills were intact. The MDS indicated that Resident 25 had delusions. The MDS indicated that Resident 25's active diagnoses included anxiety disorder (mental health condition characterized by excessive, persistent, and uncontrollable fear or worry that interferes with daily life), depression (mental health condition characterized by persistent sadness, loss of interest in activities, and low energy), bipolar disorder (manic-depressive disorder; mood swings that range from lows of depression to elevated periods of emotional highs), psychotic disorder (other than schizophrenia), and schizophrenia (a mental illness that is characterized by disturbances in thought). The MDS indicated that Resident 25 had routine antipsychotic (medication that affects mood and behavior) medication. During a review of Resident 54's admission Record (AR), the facility admitted Resident 54 on 2/23/2023 and readmitted Resident 54 on 2/13/2026 with diagnoses that include schizophrenia, anxiety disorder, and bipolar disorder. During a review of Resident 54's MDS, dated [DATE], the MDS indicated that Resident 54's cognitive was intact. The MDS indicated that Resident 54 had delusions. The MDS indicated that Resident 54's active diagnoses included anxiety disorder, depression, bipolar disorder, psychotic disorder, and schizophrenia. The MDS indicated that Resident 54 received routine antipsychotic medications. During a review of Resident 54's Conservatorship (legal order in which an appointed person makes decisions for another adult who cannot care for themselves) Letter record, filed 2/10/2026, the record indicated that Resident 54 remains gravely disabled as a result of mental disorder and is unable to provide for basic personal needs of food, clothing, and/or shelter and that the conservatorship of the person and estate should be granted. During a review of Resident 54's care plan, initiated on 2/13/2026, the care plan indicated that Resident 54 had the potential to be verbally aggressive related to ineffective coping skills, mental and emotional illness, and poor impulse control. The care plan's interventions included to analyze key times, places, circumstances, triggers, and what de-escalates behavior and document and assess resident's copying skills and support systems. During a review of Resident 54's care plan, initiated on 2/13/2026, indicated Resident 54 was physically aggressive, hitting others, related to poor impulse control and bipolar disorder. The goal of the care plan was for the resident to not harm herself or others. Interventions include analyzing triggers, circumstances, and effective deˆescalation strategies; anticipating and assessing the resident's needs; and identifying and addressing any contributing sensory deficits. During a review of Resident 54's Change of Condition Evaluation (CoC) record, dated 3/9/2026 timed at 5:30 PM, the CoC record indicated that Resident 54 was verbally aggressive, cursing, yelling, shouting [at] staff and other residents. The CoC record indicated the staff redirected Resident 54 and closely monitored her for safety. Physician 4 (Primary Care (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician) recommendation was to monitor [Resident 54] at this time. During a review of Resident 54's Nursing Progress Notes (PN), dated 3/9/2026 timed at 8:51 PM, 3/10/2026 timed at 6:21 AM and 2:14 PM, 3/11/2026 timed at 2:31 PM, and 3/12/2026 timed at 1 PM, were reviewed. The Nursing PN indicated that Resident 54 had multiple episodes of increase verbal aggression towards staff and residents, and there were times the staff was successful at redirect Resident 54 and other times the staff was unable to redirect Resident 54. During a review of Resident 54's Nursing PN written by the Assistant Director of Nursing (ADON), dated 3/10/2026 timed at 11:11 AM, the PN indicated that he spoke to Physician 5 (Psychiatrist) about Resident 54's medication and indicated that Physician 5 will visit the facility on Friday (3/13/2026) and evaluate the patient and review all medications. During a review of Resident 54's Dietary PN written by the Registered Dietitian (RD), dated 3/10/2026 at 1:43 PM, the PN indicated that during lunch time, Resident 54 had accused the RD that the RD was stealing her medication. During a review of Resident 54's Nursing PN written by the ADON, dated 3/13/2026 timed at 2 PM, the PN indicated that the ADON attempted to call Physician 5 regarding his visit with Resident 54, but the ADON was unable to get a hold of [Physician 5] at this time. During a review of Resident 54's Medication Administration Record (MAR), dated for March 2025, the MAR indicated there was documented evidence that Resident 54 had 13 - 16 episodes of increased delusions and aggression towards other staff members and residents between 3/9/2026 to 3/15/2026. During a review of Resident 54's CoC record, dated 3/16/2026 timed at 7 AM, the record indicated CNA 3 had witnessed Resident 54 have an episode of physical aggression by elbowing Resident 25 to the right check. The CoC record indicated that Resident 54 stated [Resident 25] flipped as I did a back flip and [Resident 25] saw my pubic area. Physician 4's recommendation was to transfer Resident 54 to the general acute care hospital (GACH) for psychiatric evaluation. During a review of the Certified Nurse Assistant (CNA) 3's written statement record (written statement of the facility's internal investigation), dated 3/16/2026, the record indicated that Resident 25 was reading her Bible quietly in her wheelchair in the alcove by Resident 25's room, and Resident 54 stood next to Resident 25 as she waited for CNA 3 to open her locker, then Resident 54 asked Resident 25 what are you going to do black bitch, and Resident 54 hit Resident 25 with an elbow to the right side of the face. During a review of the License Vocational Nurse (LVN) 1 written statement record (written statement of the facility's internal investigation), dated 3/16/2026, the record indicated in an interview Resident 54 stated she hit Resident 25 because [Resident 25] flipped her [Resident 54] as she [Resident 54] was walking by and [Resident 25] saw her public area. The record indicated that Resident 25 stated she was sitting in her wheelchair reading her Bible when Resident 54 came up to [Resident 25] had said what are you going to do black bitch? During an observation and interview on 3/24/2026 at 11:25 AM with Resident 25 in the hallway, Resident 25 was sitting forward in her wheelchair and stated Resident 54 touched her right cheek. Resident 25 stated, she did not know why Resident 54 had touched her cheek. During an interview on 3/26/2026 at 3:10 PM with CNA 4, CNA 4 stated that about one to two weeks before 3/16/2026, Resident 54 had increased episodes of verbal aggression towards staff members and other residents and had increased episodes of withdrawal and laying in her bed in her room. CNA 4 stated that the staff members' interventions were to calmly interact and redirect Resident 54 during her episodes of verbal aggression. During an interview on 3/26/2026 at 3:20 PM with LVN 4, LVN 4 stated, Resident 54 was had increased verbal aggressive with increased delusions from her baseline for the last three weeks. Resident 54 would claim multiple times that someone was stealing her medication. During a concurrent interview and record review on 3/26/2026 at 5:42 PM with the Assistant Director of Nursing (ADON), Resident 54's CoC record from 3/9/2026 and a nursing progress note from 3/10/2026 were reviewed. The ADON reported that Resident 54 had shown increased verbal aggression and notified Physician 5 on 3/10/2026 to discuss possible medication adjustments. Physician 5 stated he would conduct an inˆperson evaluation before making any changes. The ADON also explained that although the resident had a history of verbal aggression with interventions that included closely monitoring the resident's behavior, redirecting her, and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555897	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monterey Healthcare & Wellness Centre, LP	1267 San Gabriel Blvd Rosemead, CA 91770

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	encouraging participation in group or individual activities, the interventions were not effective, and the resident had the potential to harm others. During the same concurrent interview and record review on 3/26/2026 at 5:50 PM with the ADON, Resident 54's Nursing PN dated 3/13/2026 timed at 2 PM was reviewed. The ADON stated he attempted to follow up with Physician 5 on 3/13/2026 and was not able to contact the physician and he did not come to the facility on 3/10/26 to 3/13/26 to assess Resident 54. The ADON stated he did not notify Physician 5's Nurse Practitioner (NP) or the Psychiatric Medical Director because he expected the physician to come in to see the resident on 3/10/26 to 3/13/26. ADON further stated that Resident 54's physical aggression toward Resident 25 on 3/16/2026 could have been avoided if he continued to follow up with Physician 5 and informed the NP or the Psychiatric Medical Director to assess Resident 54 for further recommendations regarding increased hallucinations, delusions, and aggressions towards others. During an interview on 3/27/2026 at 9:35 AM with LVN 1, LVN 1 stated upon interviewing Resident 54, Resident 54 stated, she made an elbowing motion because she wanted Resident 25 to move out of the way out in the small alcove room by Resident 25's room. During the same interview on 3/27/2026 at 9:40 AM with LVN 1, LVN stated 1 Resident 54's baseline personality fluctuates between verbal aggression to being withdrawn and shutting people out. LVN 1 stated, there were times Resident 54 did not comply with redirection from the staff members and would ignore everyone around her and will not listen to what we say. During a review of the facility's policies and procedures (P&P) titled Resident Safety, dated 4/15/2021, the P&P indicated that residents will be evaluated when there is a change of condition to identify circumstances that pose a risk for the safety and welling of the resident.