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	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monterey Healthcare & Wellness Centre, LP	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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its policy and procedure (P&P) on abuse for one of two sampled residents (Resident 4) when Certified Nursing Assistant (CNA) 1 failed to report an alleged resident-to-resident altercation between Residents 4 and 5 on 4/28/26. This deficient practice had the potential to place Resident 4 at risk for unrecognized abuse, delayed assessment of injuries, and failure to ensure resident safety, protection, and timely reporting in accordance with the facility's Abuse and Neglect policy. Findings: During a review of Resident 4's admission Record, the record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety, and depression. During a review of Resident 4's History and Physical (H&P) dated 4/25/26, the H&P indicated Resident 4 could make his needs known but could not make medical decisions. During an interview with Resident 4 on 4/30/26 at 7:35 AM, Resident 4 stated that on 4/28/26, Resident 5 spat on him and threw a walker at him. Resident 4 stated that he told CNA 1 about the altercation and was separated from Resident 5 but was not assessed for injuries by a licensed nurse. During an interview with CNA 1 on 4/30/26 at 9:07 AM, CNA 1 stated that on 4/28/26 Resident 4 came to her and told her that another resident hit him with a walker. CNA 1 stated that she notified Licensed Vocational Nurse (LVN) 2 and Registered Nurse (RN) 2 at the nurses' station. CNA 1 stated she did not further investigate on who the alleged resident was who threw the walker at Resident 4 because she was busy helping another resident. During an interview with LVN 2 on 4/30/26 at 11:33 AM, LVN 2 stated he was never notified of a resident altercation that involved Resident 4. During an interview with RN 2 on 4/30/26 at 12:13 PM, RN 2 stated he was never notified of a resident altercation that involved Resident 4. During another interview with CNA 1 on 4/30/26 at 12:43 PM, CNA 1 stated that, on 4/28/26, Resident 4 came to CNA 1 near the nurses' station and said, Look, he hit me. He threw his walker and hit me. CNA 1 stated she observed a red scratch on Resident 4's right knee. CNA 1 stated she brought Resident 4 to the nurses' station where LVN 2 and RN 2 were working. CNA 1 stated she reported the allegation to LVN 2 then walked away. CNA 1 stated she was not sure if LVN 2 actually heard her because she walked away to help another resident. CNA 1 stated she did not follow up on the incident any further after that. During an interview with the Director of Registered Nursing (DON) on 5/1/26 at 3:27 PM, the DON stated that when a staff member was made aware of an alleged altercation between residents, the staff member was expected to notify the abuse coordinator (the facility's administrator [ADM]) so that the facility could investigate the alleged abuse and report to the proper agencies. The DON stated CNA 1 should have reported Resident 4's allegation of being spat at and struck by a walker so that the facility could have assessed Resident 4 for injuries and sent Residents 4 and 5 out for medical evaluation. During a review of the facility's Policy and Procedure (P&P) titled, Abuse and Neglect and dated 12/22/21, the P&P indicated that allegations of abuse, neglect, mistreatment, exploitation or reasonable suspicion of a crime were to be reported to the ADM or designated representative immediately. The P&P indicated the facility reported all allegations of abuse and criminal activity, as required by law and regulations, to the appropriate agencies.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary medical social services to one of two sampled residents (Resident 3) when the Social Service Coordinator (SSC) did not follow up or encourage Resident 3 to participate in dental care services, and did not explain the potential risk and benefits of declining dental treatments as indicated in the Resident's care plan after Resident 3 reportedly refused dental treatments on 4/1/26. This deficient practice had the potential to result in unmet dental needs, delayed identification and treatment of oral health issues, and a possible decline in Resident 3's overall health and quality of life due to lack of appropriate follow-up and support from facility staff. Findings: During a review of Resident 3's admission Record, the record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety, and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool) dated 2/20/26, the MDS indicated Resident 3 was cognitively intact and independent for most cares. During a review of Resident 3's Care Plan initiated on 9/8/25 and revised on 4/1/26, the care plan indicated Resident 3 was resistive to care related to schizoaffective disorder bipolar type and schizophrenia. The care plan also indicated that Resident 3 declined dental services on 4/1/26. The care plan indicated interventions to educate Resident 3 of the possible outcome of not complying with treatment or care, encourage as much participation/interaction as possible during care activities, and to give clear explanation of all care activities prior to and as they occur during each contact. During a review of the facility's Dental Visit Summary Log dated 4/1/26, the log indicated Resident 3 declined dental treatments and indicated for the dental consultant to try again in the next visit. During a concurrent interview and record review with the SSC on 5/1/26 at 12:37 PM, Resident 3's progress notes were reviewed. The SSC stated there was no documentation that indicated Resident 3 declined dental treatment on 4/1/26. The SSC stated she did not know why Resident 3 declined the dental visit. During an interview with Resident 3 on 5/1/26 at 12:47 PM, Resident 3 stated he had waited for the dentist on 4/1/26, but the dentist never came. Resident 3 stated he never declined dental visits or treatments and wanted continued evaluation for his broken tooth. During another interview with the SSC on 5/1/26 at 2:59 PM, the SSC stated that when a resident refused a consultation, the SSC was responsible for assessing and addressing the reason for the refusal. The SSC stated she should have followed up with Resident 3 on 4/1/26 to determine why, or whether Resident 3 declined his dental visit but did not do so. During an interview with the Director of Registered Nursing (DON) on 5/1/26 at 3:27 PM, the DON stated that when residents refused treatments, staff should explain the necessity of the treatment and the risk and benefits of declining a treatment. The DON also stated it was important to address the residents' reason for refusing care to ensure residents complied and received the care they needed. During a review of the facility's Policy and Procedure (P&P) titled, Referrals to Outside Services and dated 12/1/13, the P&P indicate The Director of Social Services coordinated the referral of residents to outside agencies/programs to fulfil residents' needs for services not offered by the facility. During a review of the undated Social Service Coordinator Job Description Manual, the job description indicated the SSC arranged ancillary services that have been determined necessary to maintain the residents' concrete needs.