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 02/14/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46779 Based on observation, interview and record review, the facility failed to promote respect and dignity to one of one resident reviewed for dignity (Resident 19) who was observed with jeans tied with elastic gloves on the belt loop and was falling off, exposing his buttocks and groin area. This deficient practice has the potential to affect the resident's self image, sense of self-worth/ self-esteem and negatively affect the psychosocial being of the resident. Findings: During a review of Resident 19's Admission Record indicated the facility initially admitted Resident 19 on 6/2/2008 and readmitted her on 5/24/2022 with diagnoses that included paranoid schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions) and hyperlipidemia (a condition in which there are abnormally high levels of fats in the blood). During a review of Resident 19's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 1/31/2025, indicated Resident 19 had intact cognition (ability to think and reasonably) and memory. The MDS indicated Resident 19 was independent with eating, oral hygiene, toileting hygiene, shower/bathe self, personal hygiene and chair/bed-to-chair transfer. During an observation on 2/11/25 at 12:10 PM, in the Television (TV) Room of East Wing, Resident 19 was walking in and out from his room to the TV Room where other residents were watching TV and staff passing through. Resident 19 was wearing a pair of blue jeans with an elastic glove tied on the two belt loops to hold the jeans up on the waist. Resident 19 ' s jeans was loose and kept falling down and he kept pulling the jeans up to his waist. During an observation on 2/12/25 at 11:16 AM, during the resident counsel meeting in the dining room, Resident 19 was wearing the blue jeans with an elastic glove tied on the two belt loops to hold the jeans up to his waist. Resident 19 stood up from a chair and pants fell below his waist, showing his groin areas, then resident turned around to move a chair, showing his crack of his buttocks crack. Resident 19 pulled up his pants and tucked his sweater inside the jeans. (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

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 02/14/2025
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/12/25 PM at 12:04 PM, in the TV Room of the East Wing, Resident 19 was wearing the blue jeans with an elastic glove tied on the two belt loops holding the jeans up to his waist. Resident 19 ' s jeans was loose and felt below his waist, showing his buttocks crack. Resident 19 kept pulling up his jeans when walking. During an observation on 2/12/25 at 2:42 PM, Resident 19 stated he his jeans were falling off and he had to keep pulling them up in place. Resident 19 stated he wanted his pants to be properly fit. During an interview 02/12/25 at 2:43 PM, Certified Nursing Assistant (CNA) 1 stated Resident 19 likes to wear the same blue jeans every day and they were aware that his jeans was loose and does not fit well on him. CNA 1 stated because of the unfitted jeans, Resident 19 was prone to expose his private body parts in front of other residents, staff and visitors. CNA 1 stated they should do something to alter the waist of pants to ensure it was properly fit for the resident. CNA 1 stated they should not use a glove to tie the waist of the jeans to promote Resident 19 ' s dignity. During an interview on 2/14/25 at 12:16 PM with the Assistant Director of Nursing (ADON), the ADON stated the staff should provide properly fit clothing for the residents to preserve their dignity. During a review of the facility ' s policy and procedure (P&P) titled, Resident Rights-Quality of Life, dated 3/2017, indicated Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being.

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50012 Based on observation, interview, and record review, the facility failed to be fully informed by the physician or other professional in a language that he can understand for one of three residents reviewed for resident's rights (Resident 56) who signed a consent to receive psychotropic medications (medications that affects mood and behavior) when: 1.The Health & Physical (H&P) assessment by physician indicated Resident 56 does not have the mental capacity to make medical decisions. 2. Psychiatric notes indicated Resident 56 had cognitive impairments such as loose associations (a thought disorder characterized by a lack of logical connection between ideas or thoughts) and distractibility (the tendency to be easily distracted by external or internal stimuli). The facility allowed the Resident 56 to making medical decision and signed informed consent without a surrogate decision-maker (a person that advocate for the resident) or an interdisciplinary team (IDT) meeting was not conducted to assist the resident with the decision about his healthcare. This deficient practice violated the resident ' s rights and placed Resident 56 to potentially put the resident at risk for receiving inappropriate medical care and lead to irreversible or serious harm. Findings: During a review of Resident 56 ' s Admission Record (Face Sheet), the facility admitted Resident 56 on 11/10/2023 and readmitted on [DATE] with diagnoses including schizoaffective disorder a (mental health condition including schizophrenia and mood disorder symptoms), psychosis (severe mental disorder that cause abnormal thinking and perceptions) and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). During a review of Resident 56 ' s History and Physical (H&P), dated 11/16/2025 indicated, Resident 56 does not have the mental capacity to make medical decisions. During a review of Resident 56's Medical Doctor (MD) notes, dated 1/13/2025, the MDs ' note indicated Resident 56 does not have the capacity to understand and make decisions. During a review of Resident 56's psychiatric notes, dated 1/22/2025, the psychiatric note indicated Resident 56 was easily distracted, loose associations (a mental process in which a person speaking quickly from one idea to an unrelated one) and positive for hallucinations (hearing voices when no one is there). During a review of Resident 56's Order Summary Report, dated 2/1/2025, the Order Summary Report indicated an order on 12/21/2024 to give Resident 56 Depakote (a medication used as mood stabilizer) 500 milligrams (mg) by mouth two times a day for bipolar disorder m/b (manifested by) mood liability. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Seroquel Oral Tablet ([Quetiapine Fumarate- medication that treats schizophrenia and bipolar disorder]) Give 200 mg by mouth two times a day for schizoaffective disorder, bipolar type m/b auditory hallucination telling him to hurt others. During a review of Resident 56's informed consent dated 2/6/2025, indicated the Physician obtained an informed consent from Resident 56 for the use of Divalproex sodium. During a review of Resident 56's informed consent dated 2/6/2025, indicated the Physician obtained an informed consent from Resident 56 for the use of Seroquel. During a review of the Minimum Data Set (MDS, a standardized assessment and care planning tool) indicated Resident 56's Brief Interview for Mental Status (BIMS) Evaluation, dated 2/8/2025, indicated a total score of 8 indicating a cognitive (the ability to think and process information) impairment). During a review of Resident 56's psychological notes dated 02/11/2025, indicated Insight/Judgment was moderately impaired. During a concurrent interview and record review on 2/13/2025 at 1:30PM with the Social Service Director (SSD), SSD stated Resident 56 ' s mental status assessment was not verified by the physician prior to obtaining informed consent. SSD stated that failing to verify accuracy in the mental status assessment before obtaining consent placed the resident at risk of making medical decisions without the ability to fully comprehend the consequences. SSD stated that if the resident lacks capacity and has no surrogate decision-maker, an Interdisciplinary Team (IDT) meeting must be arranged to determine the next steps. SSD stated there should have been a clear and consistent assessment of capacity across all medical documentation. SSD also stated that there was any doubt, a neuropsychological evaluation should have been ordered before obtaining informed consent. SSD was not able to locate the neurophysiological evaluation for Resident 56. During a review of Resident 56's neuropsychological evaluation (an assessment on how well your brain is functioning) notes, dated 2/14/2025, the Neurophysiological evaluation indicated Resident 56 does not have the capacity to make independent healthcare or financial decisions at this time given his major neurocognitive disorder. During a review of the facility's policy and procedure (P&P) titled, Informed Consent, revised 2024, indicated the facility: Initial Determination of the Resident ' s Capacity and Identification of a Decision-maker a. The Resident ' s physician will determine the Resident ' s capacity to make decisions. b. If the Resident is determined to have capacity, the Resident may provide informed consent c. If the resident lacks capacity to provide informed consent, the surrogate decision maker will provide informed consent. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. If the resident lacks capacity to provide informed consent and does not have a surrogate decision-maker, the Facility will convene a Surrogate interdisciplinary team, IDT (refer to Procedure P-NP67B)

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779 Based on observation, interview and record review, the facility failed to accommodate the needs of one of three residents reviewed for resident's rights, (Resident 119) in accordance with the facility ' s policy and procedure by failing to ensure the call light (a device used by residents to signal his or her needs for assistance) was within reach of the resident in Shower room [ROOM NUMBER] in the west wing. This deficient practice had the potential for residents who shared Shower room [ROOM NUMBER] in the west wing not able to call the facility staff to ask for help or assistance specially during emergency. Findings: During a review of Resident 119 ' s Admission Record indicated the facility admitted Resident 119 on 9/11/2024 and readmitted him on 2/5/2025 with diagnoses that included schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions) and hypertension (high blood pressure). During a review of Resident 119's MDS, dated [DATE], indicated Resident 119 had intact cognition (ability to think and reasonably) and memory. The MDS indicated Resident 119 required setup or clean-up assistance with eating, and supervision or touching assistance with oral hygiene, toileting hygiene, shower/bathe self, personal hygiene and chair/bed-to-chair transfer. During a concurrent observation and interview on 2/12/2025 at 2:25 PM with Certified Nursing Assistant (CNA) 1, in Shower room [ROOM NUMBER] of the west wing, a call light switch lever was on the wall at the level of the head of door frame of Shower room [ROOM NUMBER]. CNA 1 was standing on the ground and stretched her left arm trying to reach the call light switch, but she could not reach. CNA 1 stated the call light switch was too high, and it was unreachable for residents who needed to use call light to ask for help. During a concurrent observation and interview on 2/12/2025 at 2:36 PM with the Maintenance Staff, in Shower Rom 2 of the west wing, the Maintenance Staff stated the string or cord was supposed to attached to the call light switch lever and hanging down along the wall, so the residents could pull the string to activate the call light.The Maintenance Staff stated a short length of string should be attached to the call light switch lever or move the call light switch lever lower to make sure call light was reachable for residents. The Maintenance s Staff stated it was important to keep call lights, including the ones in the shower rooms, within reach for the residents, so they could ask for assistance in case of accident and emergency. During an interview on 2/13/2025 at 7 AM with Resident 119, Resident 119 stated he could feel safe if the call light was within reach in the shower room incase he needed help and he could call for help. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/14/25 at 12:21 PM with the Assistant Director of Nursing (ADON), the ADON stated all call lights, including the ones in the residents ' rooms, restrooms and shower rooms, should be within reach at all times to ensure residents ' needs and safety were met, especially during emergency. During a review of the facility ' s policy and procedure titled, Communication-Call System, dated 10/9/2024, indicated The Facility will maintain a communication system to allow residents to call for staff assistance from their rooms and toileting/bathing facilities and The Call alert device will be placed within the resident's reach.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779 Based on observation, interview and record review, the facility failed to ensure two of two residents reviewed for right to privacy (Resident 41 and 119) were provided with privacy when using the common restroom and common shower room by failing to ensure: The window in Shower room [ROOM NUMBER] in the [NAME] Wing had stained-glass window film peeling off which let other people in the patio look thorough the window and see the residents when in the shower room. The window in Restroom [ROOM NUMBER] in the East Wing ' s had stained-glass window film that were peeling off which let other residents, staffs and visitors from the patio see the residents when using the restroom. This failure violated the resident ' s rights for privacy and the potential to result in Resident 41 not wanting to shower because she was feeling unsafe and exposed when showering, and Resident 119 feeling uncomfortable using the restroom. This practice also had the potential for other residents ' privacy to be violated. Findings: 1. During a During a review of Resident 41 ' s Admission Record indicated the facility admitted Resident 41 on 12/17/2024 with diagnoses that included schizoaffective disorder (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions) and hyperlipidemia (a condition in which there are abnormally high levels of fats in the blood). During a review of Resident 41's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 12/24/2024, indicated Resident 41 had intact cognition (ability to think and reasonably) and memory. The MDS indicated Resident 41 required setup or clean-up assistance with eating, and supervision or touching assistance with oral hygiene, toileting hygiene, shower/bathe self, personal hygiene and chair/bed-to-chair transfer. During an observation on 2/11/2025 at 12:30 PM, in the Shower room [ROOM NUMBER] in the [NAME] Wing, the stained-glass window film on window next to the front patio were peeling off, which let the window become see through from the front patio. Some residents were observed walking in the front patio, passing by the window. During a concurrent observation and interview on 2/12/25 2:29 PM with Certified Nursing Assistant (CNA) 1, in the Shower room [ROOM NUMBER] in the [NAME] Wing, CNA 1 stated the privacy window film on the window were peeling off and she did not remember for how long the film had been peeled off. CNA 1 stated female residents in the west wing used this shower room to shower. CNA 1 stated the Maintenance painted the windows yesterday. CNA 1 stated the window to the shower rooms and restrooms should not be see through to ensure residents ' privacy. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a During a review of Resident 119 ' s Admission Record indicated the facility admitted Resident 119 on 9/11/2024 and readmitted him on 2/5/2025 with diagnoses that included schizophrenia and hypertension (high blood pressure). During a review of Resident 119's MDS, dated [DATE], indicated Resident 119 had intact cognition (ability to think and reasonably) and memory. The MDS indicated Resident 119 required setup or clean-up assistance with eating, and supervision or touching assistance with oral hygiene, toileting hygiene, shower/bathe self, personal hygiene and chair/bed-to-chair transfer. During an observation on 2/11/2025 at 12:33 PM, patches of the privacy window film on the Restroom [ROOM NUMBER] in the East Wing ' s window were peeling off, which let the window become see through from the front patio. Some residents were observed walking in the front patio, passing by the window. During an interview on 2/12/2025 at 2:39 PM with the Maintenance, the Maintenance stated the residents shared Shower room [ROOM NUMBER] and Restroom [ROOM NUMBER] regularly. The Maintenance stated privacy window films on the windows of Shower room [ROOM NUMBER] in the [NAME] Wing and Restroom [ROOM NUMBER] in the East Wings were peeling off and he did not know for how long the privacy films had been peeled off, which caused these windows to become see through. The Maintenance stated the Housekeeper (HSKP) told him to paint over the privacy windows with paints yesterday, so he just painted them yesterday. The Maintenance stated the staff should fix the peeling privacy windows earlier to ensure residents ' privacy when they were showering and using the restroom. During an interview on 2/12/2025 at 4:34 PM with the HSKP, the HSKP stated to paint over the peeling privacy windows had been the facility's ongoing project since the privacy issue that was identified from the survey last year. The HSKP stated she just reminded the maintenance to paint over these windows yesterday. The HSKP stated they were aware that the privacy window films were peeling off for the windows in the restrooms and shower rooms before, but she did not know for how long it had been like that. The HSKP stated the staff should fix these windows in the restrooms and shower rooms earlier and make sure these windows were covered at all times to ensure residents' privacy. During an interview on 2/13/2025 at 6:58 AM with Resident 41, Resident 41 stated she always closed the window when she was showering so no one could see her naked. Resident 41 stated she could not see well and did not know the privacy film on the window in Shower room [ROOM NUMBER] in the [NAME] Wing was peeling off and anyone passing by could see through. Resident 41 stated if she knew it, she would not shower if someone could see through the window from the front patio when she was showering. Resident 41 stated she wanted her privacy. During an interview on 2/13/2025 at 6:59 AM with Resident 119, Resident 119 stated he would not be comfortable if other residents were able to peek through the window and watching him using the restroom. During an interview on 2/14/25 at 12:18 PM with the Assistant Director of Nursing (ADON), the ADON stated the windows in the restrooms and shower rooms should be covered and not seeing through at all times to protect residents ' privacy. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P&P) titled, Resident Rights, dated 1/2012, indicated State and federal laws guarantee certain basic rights to all residents of the Facility. These rights include, but are not limited to, a resident ' s right to .D. Privacy and confidentiality. During a review of the facility ' s P&P titled, Resident Rights-Quality of Life, dated 3/2017, indicated Facility Staff promotes, maintains, and protects resident privacy, including bodily privacy, when assisting with personal care and during treatment procedures.

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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.

46779

Based on interview and record review, the facility failed to develop and implement a comprehensive resident specific care plan for two of twelve residents reviewed (Resident 68 and 11) by failing to ensure:

1. Resident 68's care plan was developed to address discharge planning before discharged from the facility on 12/2/2024.

These deficient practices had the potential to result in confusion of Resident 68 ' s care and discharge process and negatively affect the resident's psychosocial wellbeing.

2. Resident 11's care plan was developed to address management and triggers for the Post-Traumatic Stress Syndrome (PTSD, a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event).

As a result of this deficient practice the resident did not received interventions to prevent and aggressive behaviors towards staffs and residents that could result in futher decline in psychosocial wellbeing.

Findings:

1. During a review of Resident 68's Record of Admission indicated the facility originally admitted Resident 68 on 10/10/2024 with diagnoses that included schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions) and depression (a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities).

During a review of Resident 68's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 12/2/2024, indicated Resident 68 had intact cognition (ability to think and reasonably) and memory. The MDS indicated Resident 68 was independent with eating, oral hygiene, toileting hygiene, shower/bathe self, personal hygiene and chair/bed-to-chair transfer.

During a review of Resident 68's Baseline Care Plan, dated 10/11/2024, indicated social services goals was to maintain medication management and assist with safe discharge planning, and Resident 68 ' s placement assessment and social services to follow up and support as needed.

During a review of Resident 68's Physician Order, dated 12/2/2024, indicated the physician ordered to discharge Resident 68 from the facility on 12/2/2024.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/14/2025 at 4:01 PM with the Assistant Director of Nursing (ADON), Resident 68 ' s care plan was reviewed. The ADON stated Resident 68 was discharged from the facility to a transition care facility on 12/2/2024, but the staff did not develop a comprehensive care plan to address his discharge planning before his discharge. The ADON stated the Social Services Director (SSD) was responsible to initiate the discharge care plan. The ADON stated the care plan for discharge planning was important because all the interdisciplinary team members could review it and intervene as the discharge plan indicated to ensure a smooth discharge process for the resident. During an interview on 2/14/2024 at 4:10 PM with the SSD, the SSD stated she only developed a baseline care plan when Resident 68 was admitted to the facility, but there were no specific interventions for his discharge. The SSD stated she did not develop a comprehensive care plan to address Resident 68 ' s discharge planning. The SSD stated it was important to develop a discharge planning care plan with specific goals and interventions for the resident to avoid confusion in the resident's care and discharge process. During a review of the facility's policy and procedure titled, Comprehensive Person-Centered Care Planning, dated 9/7/2023, indicated All goals, objectives, interventions, etc. from the current baseline care plan will be included in the resident's comprehensive care plan. 50203 2. A review of Resident 11 ' s Admission Record, the facility admitted Resident 11 on 6/20/2023 and readmitted Resident 11 on 1/17/2025 with diagnoses which included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), schizophrenia (a mental illness that was characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression [mental health condition that caused persistent feelings of sadness and loss of interest in activities] to elevated periods of emotional highs), and PTSD. During a review of Resident 11 ' s Letter of Conservatorship (a legal document that appointed a conservator to make decisions on behalf of another person), dated 12/16/2024, the Letter of Conservatorship indicated, Resident 11 was gravely disabled due to a mental health disorder and reappointed Family member (FM) 1 and FM 2 as Resident 11 ' s conservator. During a review of Resident 11 ' s care plans, initiated on 1/17/2025, the care plan indicated resident had a behavior problem related to schizophrenia, schizoaffective disorder, bipolar disorder, and PTSD. The care plan ' s interventions included to anticipate the resident ' s needs, assist the resident in developing healthy coping skills, and monitor behavior episodes and attempt to determine underlying cause. During a review of Resident 11 ' s H&P, dated 1/18/2025, the H&P indicated Resident 11 did not have the capacity to understand and make decisions. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 11 ' s Baseline Care Plan document, dated 1/20/2025, the document indicated Resident 11 was admitted with diagnoses that included schizophrenia, schizoaffective disorder, bipolar disorder, PTSD, anxiety (increase feelings of fear, dread, and uneasiness), depression, auditory and visual hallucination, suicidal ideation (SI, intrusive thoughts about death and dying oneself), homicidal ideation (HI, intrusive thoughts of harming another person), and substance abuse. During a review of Resident 11 ' s Minimum Data Set (MDS, a resident assessment tool), dated 1/24/2025, the MDS indicated Resident 11 was cognitively intact and hallucinated. The MDS indicated Resident 11 had anxiety disorder, depression, bipolar disorder, schizophrenia, and PTSD. The MDS indicated Resident 11 was taking antipsychotics and antidepressants on a routine basis. During a review of Resident 11 ' s care plan, initiated on 1/24/2025, the care plan indicated resident prefers to keep type of trauma private to avoid re-traumatization. The care plan ' s interventions included encourage resident ' s family ' s involvement, report psychological distress to the nurse, and to review resident ' s coping skills as much as possible. During a telephone interview on 2/14/2025 at 9:39AM with Family Member (FM) 1, FM 1 stated Resident 11 had a history of childhood trauma and PTSD. FM 1 stated, the facility never asked her about Resident 11 ' s history of PTSD and childhood trauma. FM 1 stated, Resident 11 has serious deep trauma and fear of particular gender. FM 1 stated, the facility only treated Resident 11 for the voices in his head but never addressed the deep trauma Resident 11 experienced. During an interview on 2/14/2025 at 3:33PM with Registered Nurse (RN) 1, RN 1 stated any resident within the facility could have experienced some type of trauma in their past that may trigger the resident and re-traumatize them. During a concurrent record review and interview on 2/14/2025 at 3:33PM with RN 1, Resident 11 ' s care plan regarding Resident 11 ' s behavioral problems related to his schizophrenia, schizoaffective disorder, bipolar disorder, and PTSD was reviewed. RN 1 stated, Resident 11 did not need another care plan related to his PTSD diagnosis because his PTSD has already been addressed in the care plan related to his behavioral problems. During an interview on 2/14/2025 at 4:07PM with the Assistant Director of Nursing (ADON), the ADON stated, it was expected that the staff create a separate care plan that addressed Resident 11 ' s PTSD. The ADON stated, the care plan created a guideline of how to care for the resident. The ADON stated, a care plan was important for a resident with PTSD because a care plan helps dictate the resident ' s care, how to deal with the resident ' s behaviors, and identify possible triggers that may re-traumatize the resident. During a review of the facility ' s policy and procedures titled Comprehensive Person-Centered Care Planning, dated 8/24/2023, the P&P indicated the baseline care plan should address resident-specific health and safety concerns to prevent decline or injury and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living, as necessary. During a review of the facility ' s P&P titled Comprehensive Person-Centered Care Planning, dated 8/24/2023, the P&P indicated the baseline care plan must reflect the resident ' s objectives and include interventions that address their needs to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s P&P titled Comprehensive Person-Centered Care Planning, dated 8/24/2023, the P&P indicated additional changes or updates to the resident comprehensive care plan will be made based on the assessed needs of the resident.

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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50203 Based on observation, interview, and record review, the facility failed to provide one of four residents that was reviewed for trauma informed care, (Resident 11) who was diagnosed with Post-Traumatic Stress Syndrome (PTSD, a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event) with culturally competent (cultural competence involves valuing diversity, conducting self-assessments, avoiding stereotypes, managing the dynamics of difference, acquiring and institutionalizing cultural knowledge, and adapting to diversity and cultural contexts in communities), trauma-informed care (an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma) according to professional standards of practice and accounting for the resident ' s experience and preferences to eliminate or mitigate triggers that may cause the resident ' s re-traumatization. This failure resulted in Resident 11 experiencing re-traumatization and increased visual and auditory hallucinations (perceptual experiences in the absence of real external sensory stimuli) and paranoid delusions (misconceptions or beliefs that were firmly held, contrary to reality) of homophobia (irrational fear, hatred, or intolerance of people who are homosexual, lesbian community) that resulted in multiple hospitalization transfers to the General Acute Care Hospital (GACH). This failure had the potential to endanger the health, safety, welfare, dignity, and respect of Resident 11, other residents, and all staff members of the facility. Findings: During a review of Resident 11 ' s Admission Record, the facility admitted Resident 11 on 6/20/2023 and readmitted Resident 11 on 1/17/2025 with diagnoses which included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), schizophrenia (a mental illness that was characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression [mental health condition that caused persistent feelings of sadness and loss of interest in activities] to elevated periods of emotional highs), and PTSD. During a review of Resident 11 ' s Minimum Data Set (MDS, resident assessment tool), dated 6/27/2023, Resident 11 ' s cognitive (a person ' s mental process of thinking, learning, remembering, and using judgement) skills were slight impaired. The MDS indicated Resident 11 experienced hallucinations. The MDS indicated Resident 11 ' s active diagnoses included schizophrenia, and there was no documented evidence Resident 11 had an active diagnosis of PTSD. The MDS indicated Resident 11 received antipsychotic (medications used to treat mental health conditions such as schizophrenia, bipolar disorder, and depression) medication on a routine basis. During a review of Resident 11 ' s Social Services Assessment document, dated 6/27/2023, the document indicated Resident 11 did have a history of recent trauma in the form of grief, separation, or death. This document indicated there was no documented evidence Resident 11 ' s triggers. (continued on next page)

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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 11 ' s Psychiatric Evaluation and Assessment document, dated 7/25/2023, written by Psychiatrist 1, indicated Resident 11 had paranoid delusions of someone putting a penis up his rectum (the final section of the large intestine that stored stool until it passed out of the body through the anus). The document indicated Resident 11 had auditory and visual hallucinations of cartoon bugs saying, he is going to take his manhood. During a review of Resident 11 ' s Psychological Consultation document, dated 8/11/2023, written by Psychologist 1, the document indicated Resident 11 recounted several events varying from childhood abuse, exposure to domestic violence, and chopping up people with [NAME] when I was five. During a review of Resident 11 ' s Application for Assessment, Evaluation, and Crisis Intervention or Placement for Evaluation and Treatment (MH 302 NCR) document, dated 1/9/2024, Resident 11 ' s conservator (a legally chosen person to act or make decisions for another person who needs help) had contacted the police due to Resident 11 ' s increased aggressive behaviors. The document indicated the conservator stated Resident 11 paced around the house, slamming doors, breaking household items, and was paranoid his family was stealing his money. The document indicated the conservator stated Resident 11 had hit a family member in the face. During a review of Resident 11 ' s MH 203 NCR, dated 1/9/2024, the document indicated Resident 11 denied hitting anyone and stated, I am being persecuted by men, gay (a person who was sexually or romantically attracted to people of the same gender or sex) men are trying to rape me every day. The document indicated Resident 1 stated men are troubling me; they are racist against straight people. During a review of Resident 11 ' s GACH 1 Inpatient Psych Progress Note (Final Report), dated 1/12/2024, this Final Report was written by Psychiatrist 2, indicated during the Resident 11 ' s examination, Resident 11 complained to the staff that men outside of the hospital think he is gay. The Final report indicated Resident 11 stated men accuse me of looking and dressing like I am gay and denied that anyone in his family molested (unwanted or improper sexual advances towards someone) Resident 11. The Final Report indicated Resident 11 stated all gay men want to do is have sex with men. During a review of Resident 11 ' s GACH 1 Psych Inpatient Progress Note (Progress Note), dated 4/10/2024, written by Medical Student 1 under Psychiatrist 3, the Progress Note indicated Resident 11 self-reported he was molested by his father (mother not sure if patient as in fact molested by father, but does describe father as a pedophile [a person who was sexually attracted to children]), patient frequently reports delusions and visual hallucinations surrounding sexual assault (sexual contact or behavior without the explicit consent of the other person) and being targeted by homosexual men, raising concern for complex PTSD. The Progress Note indicated, Resident 11 reported daily substance use, but Resident 11 continued to have delusions and hallucinations even when not using substances, which decreased the likelihood of Resident 11 having purely substance-induced psychotic disorder. During a review of Resident 11 ' s Multidisciplinary Care Conference document, dated 4/18/2024 and 7/18/2024, the document indicated Resident 11 ' s non-pharmacological intervention were activities. During a review of Resident 11 ' s Baseline Care Plan document, dated 4/19/2024, the document indicated Resident 11 was admitted with diagnoses that included schizophrenia, schizoaffective disorder, bipolar disorder, PTSD, auditory and visual hallucinations, and polysubstance abuse (the use of multiple drugs or substances at the same time). The document indicated the Social Services goals included Resident 11 maintaining psychosocial well-being. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 11 ' s Trauma Inform Care Assessment document, dated 4/19/2024, the document indicated Resident 11 did not experience any event that was unusually or especially frightening, horrible, or traumatic. During a review of Resident 11 ' s Social Services Assessment document, dated 4/21/2024, the document indicated Resident 11 did not have a history of recent trauma. During a review of Resident 11 ' s MDS, dated [DATE], Resident 11 ' s was cognitively intact, and Resident 11 had hallucinations. The MDS indicated Resident 11 had bipolar disorder, schizophrenia, and PTSD. The MDS indicated Resident 11 was taking antipsychotics. During a review of Resident 11 ' s Initial Psychiatric Evaluation, dated 4/25/2024, written by Psychiatrist 1, the document indicated Resident 11 had paranoid schizophrenia, schizoaffective disorder, bipolar disorder, and psychotic disorder with auditory and visual hallucinations. During a review of Resident 11 ' s Psychological Consultation document, dated 5/31/2024, written by Psychologist 1, the document indicated Resident 11 self-reported he had traumatic history. During a review of Resident 11 ' s Interdisciplinary Team (IDT, a collaborative approach from multiple medical disciplines who work together towards the goal of the residents) Note, dated 6/24/2024, the IDT note indicated Resident had been having visual and auditory hallucinations, and Resident 11 stated that he was heterosexual and did not want to be perceived as a different sexual orientation (the emotional, romantic, or sexual attract a person feels towards another person). During a review of Resident 11 ' s Psychological Evaluation and Consultation (Psychology Evaluation), dated 6/25/2024, written by Psychologist 1, the Psychology Evaluation indicated Resident 11 self-reported a history of trauma-related symptoms. The Psychology Evaluation indicated Resident 11 vaguely endorsed past childhood emotional abuse directed at by him family members. During a review of Resident 11 ' s Quarterly Social Services Progress Notes, dated 7/17/2024 and 10/13/2024, the progress notes indicated Resident 11 did not experience any trauma. During a review of Resident 11 ' s Multidisciplinary Care Conference document, dated 10/22/2024, the document indicated Resident 11 will attend the activities of his choice and use his headphones as a non-pharmacological intervention. During a review of Resident 11 ' s Letter of Conservatorship (a legal document that appointed a conservator to make decisions on behalf of another person), dated 12/16/2024, the Letter of Conservatorship indicated, Resident 11 was gravely disabled due to a mental health disorder and reappointed Family member (FM) 1 and FM 2 as Resident 11 ' s conservator. During a review of Resident 11 ' s Change in Condition Evaluation (CoC), dated 1/2/2025, the CoC indicated Resident 11 was experiencing an increase of delusions and auditory hallucinations manifested by Resident 11 yelling that people were stealing his money and trying to make him gay. The CoC indicated the Psychiatrist 1 was notified and recommended Risperdal (antipsychotic medication that treats mental health conditions such as schizophrenia and bipolar disorder) 4 milligrams (mg, unit of mass) twice a day. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 11 ' s CoC, dated 1/9/2025, the CoC indicated Resident 11 continued to have increase hallucinations and physical aggression. The CoC indicated Resident 11 ' s Primary Care Physican (PMD) 1 was notified and recommended Resident 11 be transferred to GACH 2. During a review of Resident 11 ' s care plans, initiated on 1/17/2025, the care plan indicated resident had a behavior problem related to schizophrenia, schizoaffective disorder, bipolar disorder, and PTSD. The care plan ' s interventions included anticipate the resident ' s needs, assist the resident in developing healthy coping skills, and monitor behavior episodes and attempt to determine underlying cause. During a review of Resident 11 ' s History and Physical (H&P, a comprehensive physician ' s note regarding the assessment of the resident ' s health status), dated 1/18/2025, the H&P indicated Resident 11 did not have the capacity to understand and make decisions. During a review of Resident 11 ' s Social Services Progress Notes, dated 1/20/2025, the progress notes indicated Resident 11 did not experience any trauma. During a review of Resident 11 ' s Baseline Care Plan document, dated 1/20/2025, the document indicated Resident 11 was admitted with diagnoses that included schizophrenia, schizoaffective disorder, bipolar disorder, PTSD, anxiety (increase feelings of fear, dread, and uneasiness), depression, auditory and visual hallucination, suicidal ideation (SI, intrusive thoughts about death and dying oneself), homicidal ideation (HI, intrusive thoughts of harming another person), and substance abuse. During a review of Resident 11 ' s Multidisciplinary Care Conference document, dated 1/20/2025, the document indicated Resident 11 will be encouraged to attend the activities of his choice as his non-pharmacological intervention. During a review of Resident 11 ' s MDS, dated [DATE], the MDS indicated Resident 11 was cognitively intact and hallucinated. The MDS indicated Resident 11 had anxiety disorder, depression, bipolar disorder, schizophrenia, and PTSD. The MDS indicated Resident 11 was taking antipsychotics and antidepressants on a routine basis. During a review of Resident 11 ' s care plan, initiated on 1/24/2025, the care plan indicated resident prefers to keep type of trauma private to avoid re-traumatization. The care plan ' s interventions included encourage resident ' s family ' s involvement, report psychological distress to the nurse, and to review resident ' s coping skills as much as possible. During a review of Resident 11 ' s CoC, dated 1/30/2024, the CoC indicated Resident 11 had increased agitation and physical and verbal aggression towards staff. The CoC indicated PMD 1 was notified and recommended to continue monitoring Resident 11. During an observation on 2/11/2025 at 11:09AM in the facility ' s locked front patio, Resident 11 was wearing personal clothes standing still, arguing and talking to himself, and leaning forward. (continued on next page)

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F 0699

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During and observation on 2/12/2025 at 1:20PM in the facility ' s hallway connecting the enclosed locked front patio and the enclosed locked back patio, Resident 11 was seen yelling at the Assistant Director of Nursing (ADON). The ADON attempted to de-escalate and redirect Resident 11 back to his room. Resident 11 yelled, you probably just want to fuck me in the ass (impolite term that may refer to the buttocks) you faggot (a slur used to refer to gay men or other people of the queer community)!, while Resident 11 walked down the hallway back to his room with other staff members following him.

During an observation on 2/13/2025 at 8:30AM in the facility ' s television room, Resident 11 was standing calmly and quietly in line waiting to receive his morning medications from the Licensed Vocational Nurse (LVN, unable to identify).

During a telephone interview on 2/14/2025 at 9:39AM with FM 1, FM 1 stated Resident 11 had a history of childhood trauma and PTSD. FM 1 stated, the facility never asked her about Resident 11 ' s history of PTSD and childhood trauma. FM 1 stated, Resident 11 had serious deep trauma and homophobia. FM 1 stated, the facility only treated Resident 11 for the voices in his head but never addressed the deep trauma Resident 11 experienced.

During an interview on 2/14/2025 at 3:00PM with Certified Nurse Assistant (CNA) 2, CNA 2 stated that she did not know about any residents with PTSD. CNA 5 stated, if a resident became aggressive, she would try to redirect the resident, call for the charge nurse, and ask for help. CNA 5 stated, Resident 11 was normally quiet but if someone asked him to do something and he was in a bad mood, Resident 11 would respond in an agitated tone and loud voice and ask to be left alone. CNA 5 stated, Resident 11 would yell fuck and other curse words when he was angry towards the CNAs and LVNs.

During an interview on 2/14/2025 at 3:33PM with Registered Nurse (RN) 1, RN 1 stated, any of the residents within the facility could have experienced some type of trauma in their past that would trigger and re-traumatize them. RN 3 stated, he would redirect, provide reassurance, and adopt a calm and assertive voice for any resident within the facility. RN 3 stated, he was unaware of any resident who had PTSD as a diagnosis.

During a concurrent interview and record review on 2/14/2025 at 3:33PM with RN 1, Resident 11 ' s Admission Record was reviewed. The Admission Record indicated Resident 11 was diagnosed with PTSD on 4/17/2024. RN 3 stated, Resident 11 had an official diagnosis of PTSD but cannot recall if Resident 11 had any triggers. RN 3 stated, Resident 11 would make homophobic comment such as you faggot, you like to take it in the ass, and you ' re a fucking homo (slur for a gay person), and curse words such as fuck and fuck you when he was angry towards male staff members.

During a concurrent interview and record review on 2/14/2025 at 3:33PM with RN 3, Resident 11 ' s CoC, dated 2/12/2025 was reviewed. The CoC indicated, Resident 11 was having behavioral changes. RN 3 stated, Resident 11 was verbally aggressive, making himself bigger, and attempted to hit staff members and other residents. RN 3 stated, the PMD 1 recommended Resident 11 to be transferred to GACH 2.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/14/2025 at 3:45PM with the Administrator (ADM), the ADM stated, the staff should assess the resident with a PTSD diagnosis for their triggers. The ADM stated, if a resident refused to disclose their trauma and if the resident had a family member or a conservator, the staff should contact the resident ' s family members or conservator to assess the resident ' s trauma and their triggers. The ADM stated, if there was no available family member or conservator, it was the responsibility of the facility to continue to assess for the resident ' s triggers and to prevent exposure to the resident. During an interview on 2/14/2025 at 4:07PM with the ADON, the ADON stated, it was important to assess a PTSD resident for their triggers. The ADON stated, it was important to know the resident ' s triggers to prevent the resident from harming himself, other residents, and staff members. During a review of the facility ' s policy and procedures (P&P) titled Trauma Informed Care - Screening, Training, and Care Integration Program, revised 7/10/2019, the P&P indicated the facility will ensure PTSD residents will receive culturally competent trauma informed care and consider the resident ' s experience and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident. The P&P indicated the types of traumas included but were not limited to traumatic grief or separation and witness to domestic or community violence. During a review of the facility ' s P&P titled Trauma Informed Care - Screening, Training, and Care Integration Program, revised 7/10/2019, the P&P indicated if the resident or responsible party does not want to disclose the traumatic event or circumstances, the IDT will not proceed to care planning, but Social Services will discuss it with the resident or responsible party during their quarterly or change of condition review. During a review of the facility ' s P&P titled Trauma Informed Care - Screening, Training, and Care Integration Program, revised 7/10/2019, the P&P indicated the IDT will implement a plan of care to address potential trauma triggers and prevent re-traumatization. The P&P indicated that trauma - informed interventions were interdisciplinary and must look at all aspects of care; including the environment, relationship, and care delivery. The P&P indicated, if the resident refused to talk about their traumatic experience, the IDT must focus on triggers and interventions.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 50203 Based on interview and record review, the facility failed to provide appropriate competencies in skills and techniques necessary to care for one of one resident (Resident 11) reviewed for competent nursing staff to care for resident with a diagnosis of Post-Trauma Stress Syndrome (PTSD, a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event) that was identified through the resident assessments. This failure resulted in Resident 11 not receiving the appropriate skills related to his trauma and PTSD as identified through his resident assessments. This failure resulted in the staff not receiving the appropriate competencies and skill set needed to care for residents with trauma or PTSD to ensure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident. Findings: During a review of Resident 11 ' s Admission Record, the facility admitted Resident 11 on 6/20/2023 and readmitted Resident 11 on 1/17/2025 with diagnoses which included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), schizophrenia (a mental illness that was characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression [mental health condition that caused persistent feelings of sadness and loss of interest in activities] to elevated periods of emotional highs), and PTSD. During a review of Resident 11 ' s History and Physical (H&P, a comprehensive physician ' s note regarding the assessment of the resident ' s health status), dated 1/18/2025, the H&P indicated Resident 11 did not have the capacity to understand and make decisions. During a review of Resident 11 ' s Minimum Date Set (MDS, a resident assessment tool), dated 1/24/2025, the MDS indicated Resident 11 was cognitively intact and hallucinated. The MDS indicated Resident 11 had anxiety disorder, depression, bipolar disorder, schizophrenia, and PTSD. The MDS indicated Resident 11 was taking antipsychotics and antidepressants on a routine basis. During an interview on 2/14/2025 at 2:38PM with the Director of Staff Development (DSD), the DSD stated she did not have any in-services related to trauma or PTSD. The DSD stated, their behavioral management in-services did not include PTSD. The DSD stated, the list of topics to for Certified Nurse Assistants (CNAs) in-services did not include PTSD. The DSD stated, she did not bring up the topic of PTSD or trauma-informed care to the Administrator (ADM) or the Director of Nursing (DON). The DSD stated, if the corporate specialist requested for PTSD in-services, she would provide the in-service. During an interview on 2/14/2025 at 3:00PM with CNA 2, CNA 2 stated she cannot recall if she received an in-service on trauma or PTSD. CNA 2 stated she does not know any resident diagnosed with PTSD. CNA 2 stated, when Resident 11 was in a bad mood and talking to himself, she would report Resident 11 ' s behavior to the Licensed Vocational Nurse (LVN) Charge Nurse. (continued on next page)

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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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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/14/2025 at 3:10PM with CNA 3, CNA 3 stated she had not been trained how to care for a resident with trauma or PTSD. CNA 3 stated, she was not aware of any resident diagnosed with trauma or PTSD. During an interview on 2/14/2025 at 3:15PM with CNA 4, CNA 4 stated she did not receive any in-services or related to trauma or PTSD. CNA 4 stated, she was not aware of any resident who had trauma or PTSD within the facility. CNA 4 stated, it was very important to know how to care for residents with PTSD to avoid triggering their trauma. During an interview on 2/14/2025 at 3:33PM with Registered Nurse (RN) 1, RN 1 stated there are always in-services related to behavioral symptoms. RN 1 stated, he may have received an in-service maybe once in the past year related to trauma and PTSD. During an interview on 2/14/2025 at 4:07PM with the Assistant Director of Nursing (ADON), the ADON stated it was important to learn how to handle with a PTSD resident ' s behavior when their trauma has been triggered. During a review of the facility ' s policy and procedures (P&P) titled Trauma-Informed Care - Screening, Training, and Care Integration Program, revised 7/10/2019, the P&P indicated staff will be educated as to the specific needs of the residents who have experienced trauma. The P&P indicated that re-traumatization means unintentionally causing harm through practice, policies, and/or activities that are incentive to the needs of the resident. During a review of the facility ' s P&P titled Trauma-Informed Care - Screening, Training, and Care Integration Program, revised 7/10/2019, the P&P indicated, the staff will received trauma-informed care training regarding the core principles of trauma-informed care. These principles include, but are not limited to: -What and how of Trauma Care -The impact of Trauma on the Brain -Understanding Trauma; Chronic vs. Acute -Creating an Environment of Safety and Security -Strategies for Early Identification of Trauma -PTSD and Psychiatric Disorders -Approaches to minimize triggers -Relationship between trauma and substance abuse. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s Facility Assessment, revised 12/18/2024, the Facility Assessment indicated common psychiatric, or mood disorders diagnoses included PTSD. The Facility Assessment indicated, specific care practices related to mental health and behavior included identifying and implementing interventions to help support residents with issues such as trauma or PTSD. The Facility Assessment indicated the Staffing training/education and competencies section included competencies specific for caring for residents who have mental and psychosocial disorders, as well as residents with a history of trauma and/or PTSD and implementing non-pharmacological interventions.

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	555897	A. Building B. Wing	02/14/2025

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 47467 Based on observation, interview and record review, the facility failed to post nurse staffing information daily in a prominent location that was readily accessible to residents and visitors for viewing in accordance with the facility's policy and procedure titled Nursing Department - Staffing, Scheduling & Postings. This deficient practice resulted in inaccessibility of the accurate daily number of clinical staff giving direct care to the residents. Findings: During a concurrent observation and interview in the presence with the Assistant Director of Nurses (ADON) on 2/13/2025 at 9:50 AM, there was no visible daily nurse staffing information posted. The ADON stated, there should be Nurse Staffing Postings readily accessible and visible for the residents and visitors. The ADON stated, the Director of Staff Development (DSD) was responsible for posting the staff information daily at the beginning of the shift. During an interview on 2/13/2025 at 10 AM with the DSD, the DSD stated, she posted the nurse staffing information on the visiting window for only the visitors to view. The DSD stated, the facility ' s residents did not have access to the window so they would not be able to view it. The DSD stated, she did not know that the residents should have access to the nurse staffing information. During an interview on 2/14/2025 at 3:50 AM with the Administrator (ADM), the ADM stated, it was the resident right to be informed about the nurse staffing information so the postings should be accessible for viewing in the residents ' area. During a review of the facility ' s policy and procedure (P&P) titled, Nursing Department - Staffing, Scheduling & Postings, revised 2018, the P&P indicated, Nurse Staffing Postings must be in a prominent place readily accessible to residents and visitors.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 50203 Based on observation, interview, and record review, the facility failed to provide the necessary behavioral health care and services for one of four residents reviewed (Resident 11) to attain or maintain the highest practicable physical, mental, and psychosocial well-being which encompassed the resident's whole emotional and mental well-being. This failure resulted in Resident 11's, who was diagnosed with Post-Traumatic Stress Syndrome (PTSD, a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), continued behavior of agitation, yelling, and attempts to hit staff members. Cross reference with F699 and F726 Findings: During a review of Resident 11 ' s Admission Record, the facility admitted Resident 11 on 6/20/2023 and readmitted Resident 11 on 1/17/2025 with diagnoses which included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), schizophrenia (a mental illness that was characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression [mental health condition that caused persistent feelings of sadness and loss of interest in activities] to elevated periods of emotional highs), and PTSD. During a review of Resident 11 ' s Social Services Assessment document, dated 6/27/2023, the document indicated Resident 11 did have a history of recent trauma in the form of grief, separation, or death. This document indicated there was no documented evidence Resident 11 ' s triggers. During a review of Resident 11 ' s Letter of Conservatorship (a legal document that appointed a conservator to make decisions on behalf of another person), dated 12/16/2024, the Letter of Conservatorship indicated, Resident 11 was gravely disabled due to a mental health disorder and reappointed Family member (FM) 1 and FM 2 as Resident 11 ' s conservator. During a review of Resident 11 ' s care plans, initiated on 1/17/2025, the care plan indicated resident had a behavior problem related to schizophrenia, schizoaffective disorder, bipolar disorder, and PTSD. The care plan ' s interventions included anticipate the resident ' s needs, assist the resident in developing healthy coping skills, and monitor behavior episodes and attempt to determine underlying cause. During a review of Resident 11 ' s History and Physical (H&P, a comprehensive physician ' s note regarding the assessment of a resident ' s health status), dated 1/18/2025, the H&P indicated Resident 11 did not have the capacity to understand and make decisions. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 11 ' s Baseline Care Plan document, dated 1/20/2025, the document indicated Resident 11 was admitted with diagnoses that included schizophrenia, schizoaffective disorder, bipolar disorder, PTSD, anxiety (increase feelings of fear, dread, and uneasiness), depression, auditory and visual hallucination, suicidal ideation (SI, intrusive thoughts about death and dying oneself), homicidal ideation (HI, intrusive thoughts of harming another person), and substance abuse. During a review of Resident 11 ' s Minimum Data Set (MDS, a resident assessment), dated 1/24/2025, the MDS indicated Resident 11 was cognitively intact and had hallucinations. The MDS indicated Resident 11 had anxiety disorder, depression, bipolar disorder, schizophrenia, and PTSD. The MDS indicated Resident 11 was taking antipsychotics and antidepressants on a routine basis. During a review of Resident 11 ' s care plan, initiated on 1/24/2025, the care plan indicated resident prefers to keep type of trauma private to avoid re-traumatization. The care plan ' s interventions included encourage resident ' s family ' s involvement, report psychological distress to the nurse, and to review resident ' s coping skills as much as possible. During an observation on 2/11/2025 at 11:09AM in the facility ' s locked front patio, Resident 11 was wearing personal clothes standing still, arguing and talking to himself, and leaning forward. During and observation on 2/12/2025 at 1:20PM in the facility ' s hallway connecting the enclosed locked front patio and the enclosed locked back patio, Resident 11 was seen yelling at the Assistant Director of Nursing (ADON). The ADON attempted to de-escalate and redirect Resident 11 back to his room. Resident 11 yelled, you probably just want to fuck me in the ass (impolite term that may refer to the buttocks) you faggot (a slur used to refer to gay men or other people of the queer community)!, while Resident 11 walked down the hallway back to his room with other staff members following him. During a telephone interview on 2/14/2025 at 9:39AM with FM 1, FM 1 stated Resident 11 had a history of childhood trauma and PTSD. FM 1 stated, the facility never asked her about Resident 11 ' s history of PTSD and childhood trauma. FM 1 stated, Resident 11 had serious deep trauma and homophobia. FM 1 stated, the facility only treated Resident 11 for the voices in his head but never addressed the deep trauma Resident 11 experienced. During an interview on 2/14/2025 at 3:00PM with Certified Nurse Assistant (CNA) 2, CNA 2 stated that she did not know about any residents with PTSD. CNA 5 stated, Resident 11 was normally quiet but if someone asked him to do something and he was in a bad mood, Resident 11 would respond in an agitated and loud voice and ask to be left alone. CNA 5 stated, Resident 11 would yell fuck and other curse words when he was angry towards the CNAs and Licensed Vocational Nurses (LVNs). During a concurrent interview and record review on 2/14/2025 at 3:33PM with Registered Nurse (RN) 1, Resident 11 ' s Admission Record was reviewed. The Admission Record indicated Resident 11 was diagnosed with PTSD on 4/17/2024. RN 3 stated, Resident 11 had an official diagnosis of PTSD. RN 3 stated, Resident 11 would make homophobic comment such as you faggot, you like to take it in the ass, and you ' re a fucking homo (slur for a gay person), and curse words such as fuck and fuck you when he was angry towards male staff members. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/14/2024 at 3:45PM with the Administrator (ADM), the ADM stated, it was important to assess a resident with a diagnosis of PTSD for their triggers to prevent exposure to the resident and to prevent re-traumatization. During an interview on 2/14/2025 at 4:07PM with the ADON, the ADON stated, it was important to identify a PTSD resident ' s triggers to prevent re-traumatization. The ADON stated, it was important to identify a PTSD resident ' s triggers because if the resident was re-triggered, the resident may be harmful to himself, other residents, and the staff members. During a review of the facility ' s policy and procedure (P&P) titled Behavior/Psychoactive Medication Management, revised 1/25/2025, the P&P indicated if a resident exhibits mood or behavior problems upon admission, assessment will be conducted to address the resident ' s mood or behavioral status. The P&P indicated, the facility will identify the contributing factors related to the resident ' s mood/behavior and the non-medication interventions to be implemented. The P&P indicated, the Behavior Management/Psychoactive Review Committee will review the effectiveness of non-medication interventions.

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F 0757

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident’s drug regimen must be free from unnecessary drugs.

50012

Based on observation, interview and record review, the facility failed to ensure one of three residents (Resident 28) does not receive Bactrim (Sulfamethoxazole-Trimethoprim an antibiotics or medication used to treat infection) unnecessarily by indicating in the physician's order how long the medication should be administered.

This deficient practice had the potential for Resident 28 to develop antibiotic resistance (medication not effective to treat infection) and results in adverse reaction (undesirable effect) health outcomes.

Findings:

During a review of Resident 28 ' s Admission Record (Face Sheet), the facility admitted Resident 28 on 5/30/2024 with diagnoses that included heart failure (failure of the heart to meet the body ' s demand), asthma (a chronic lung condition that causes inflammation and narrowing of the airways, making it difficult to breathe), schizophrenia (is a serious mental health condition that affects how people think, feel and behave) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).

During a review of Resident 28 ' s History and Physical (H&P), dated 6/2/2024 indicated, Resident 28 does not have the mental capacity to make medical decisions.

During a review of Resident 28's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 12/3/2024, indicated the resident ' s cognitive (the ability to think and process information) skills for daily decisions making was moderately impaired, and needed Setup or clean-up assistance from the staff for the activities of daily living.

During a review of Resident 28's Order Summary Report (a physician ' s order), dated 2/14/2025, the Order Summary Report indicated an order on 5/31/2024 to give Resident 28 Bactrim DS Oral Tablet 800-160 MG (Sulfamethoxazole-Trimethoprim a medication used to treat infection) give 1 tablet by mouth one time a day for HIV (Human Immunodeficiency Virus. It is a virus that attacks the body's immune system) without the stop date or how long the medication will be administered.

During a concurrent interview and record review on 2/14/25 at 12:21 PM, with the Infection Preventionist Nurse (IPN), IPN stated Resident 28 had been receiving Bactrim since admission to the facility due to a diagnosis of HIV. IPN stated, she was not aware that the resident was still receiving the antibiotic, as there was no documented end date for the prescription. IPN stated that Resident 28 remained on the antibiotic for an extended period, significantly exceeding the recommended 14-day course for Bactrim. IPN stated prolonged use of antibiotic can cause resistance to the antibiotic. IPN stated she will contact the physician to discontinue the antibiotic, as it had been prescribed for nearly a year without reassessment.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship , revised 2021, indicated The Facility will implement an Antibiotic Stewardship Program (ASP) to promote appropriate use of antibiotics optimizing the treatment of infection, reducing the threat of antibiotic resistance, reducing adverse events associated with antibiotic use and improve outcomes for Residents.

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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. 50012 Based on observation, interview and record review, the facility failed to follow the facility ' s proper sanitation and food handling practices by failing to ensure the Dietary Aide 1 (DA 1) adhere to properly securing hair with the hairnet without any hair exposed when assisting tray line (process of preparing meals for the residents from the food preparation area to the meal trays) for 69 out of 69 residents residing in the facility. This deficient practice had the potential to result in foodborne illnesses (also called food poisoning caused by eating contaminated food (transfer of bacteria, viruses, toxins [poisons] from the environment to the food ingested). Findings: During a dining observation on 2/13/25 12:19 PM, the DA 1 had hair exposed outside and visible outside of the hairnet while assisting the cook with the preparation of the meal rays. In a concurrent interview DA 1 stated it was important to secure all hair within the hairnet to prevent contamination and the risks of infection or illness associated with exposed hair that could contaminate the food being prepared. During an interview on 2/13/25 12:29 PM, [NAME] 1 stated that while DA 1 wore a hairnet, they had not the kitchen staffs had to ensured that all the hair was properly contained, allowing some no hair to be exposed. The cook stated the risks associated with this deficiency, including the potential for contamination in food preparation areas and the facility ' s compliance with health and safety regulations. During an interview on 2/14/25 2:29 PM with the Assistant Director of Nursing (ADON), the ADON stated whoever enters the kitchen should be wearing hair net and to ensure no hair was exposed. During a review of the facility's policy and procedures titled, Dietary Department - Infection Control, revised in 2024, indicated Cover hair, beard, and mustache with an effective hair restraint, such as hats, hair coverings, or nets while in any kitchen and food storage areas.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50203 Based on observation, interview, and record review, the facility failed to provide proper infection control practices for 69 of 69 sampled resident by failing to ensure the facility's Water Management Program followed the approved national, state, and local measures to prevent and monitor the growth of Legionella (water-borne opportunistic bacteria) These failures had the potential to contribute to poor infection control, improper cleaning and disinfection of the resident's clothing and linens, growth of Legionella within the facility's water system which can lead to Legionnaires' disease (a serious pneumonia [lung infection] that can be fatal) which would affect all the residents and staff within the facility, and potential to cause a facility fire by not tracking when lint screens were cleaned out from the clothes dryer. Findings: During an interview on 2/13/2025 at 10AM with the IP, the IP stated the facility does not test for Legionella unless there were 10 or more cases of pneumonia in the facility because testing for Legionella was very costly. The IP stated, there were five water heaters throughout the facility and the water heaters were flushed once a month, usually at the beginning of the month. During a concurrent record review and interview on 2/13/2025 at 10:00AM with the IP, the facility ' s Water Heater Legionella Management Plan for November 2024, December 2024, and January 2025 were reviewed. The Water Heater Legionella Management Plan indicated the water heaters by the Breakroom, East Wing, [NAME] Wing, Laundry, and Kitchen were documented evidence under good and there was no documented evidence bad. The IP stated she did not know what good or bad meant. The IP stated the last time the facility ' s water heaters were checked was in January 2025. The IP stated it looked like the facility ' s water heaters had not been flushed for February 2025. During a concurrent record review and interview on 2/13/2025 at 3:30PM with the IP, the facility ' s Water Management Plan, revised 2/6/2024, was reviewed. The IP indicated the facility ' s Water Management Plan did not have anything specific to legionella water management. The IP stated, she did not know if the Legionella Water Management Plan was based on a national standard. The IP stated, she did not know what Maintenance meant by flush the boilers. The IP stated, I go by what Maintenance and MS tell me. During a record review of Direct Supply TELS. Work History Report, dated for January and February 2025, the document indicated on 11/30/2024, 12/31/2024, and 1/31/2025, Maintenance marked the task description of water heater: flush to remove impurities, test pressure relief valve was marked done. During a concurrent interview and record review on 2/13/2025 with the IP, the facility ' s policy and procedure (P&P) titled, Water Management, revised 5/25/2023, was reviewed. The P&P indicated the facility will survey the facility using a risk assessment to determine its risk for Legionella growth and spread. The IP stated, she did not know about a risk assessment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s P&P titled Water Management, revised on 5/25/2023, the P&P indicated the facility will develop and utilize water management strategies, using the Core Elements of a Water Management Plan, to reduce the risk of growth and spread of Legionella and other opportunistic water-borne pathogens in facility water systems. The P&P indicated the facility will follow national, state, and local guidelines to determine control measures based on the risk assessment and how to monitor them. During a review of the facility ' s P&P titled Water Management, revised on 5/25/2023, the P&P indicated physical and chemical measures recommended by the American Association of Heating Refrigeration and Air-Conditioning Engineers (ASRAE) that may be applied for the prevention and control of Legionella include, but are not limited to: Quarterly measurement of water quality throughout the system to ensure charges that may lead to Legionella growth are not occurring. Quarterly maintenance and monitor of disinfectant and other chemical levels in cooling towers and hot tubs. During a review of the Centers of Disease Control and Prevention (CDC) document titled Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings, dated 6/24/2021, the document indicated it was important to: Identify building water systems for which Legionella control measures are needed Assess how much risk the hazardous conditions in those water systems pose Apply control measures to reduce the hazardous conditions, whenever possible, to prevent Legionella Growth and spread. Make sure the program is running as designed and is effective. During a review of the State Operational Manual (SOM), revised 8/8/2024, the SOM indicated the facility must be able to demonstrate its measures to minimize the risk of Legionella and other opportunistic pathogens in building water system such as by having a documented water management program. The SOM indicated the water management plan must be based on national accepted standards, for example the American Society of Heating, Refrigerating, and Air Conditioning Engineers, the CDC, and the U.S Environmental Protection Agency. The SOM indicated, the control measures may include visible inspections, use of disinfectant, and temperature. The SOM indicated, monitoring such controls include testing protocols for control measures, acceptable range, and documenting the results of testing and should also include established ways to intervene when control limits are not met.

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 02/14/2025
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 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview, and record review, the facility failed to ensure four (4) out of twenty-two (22) resident's rooms (room [ROOM NUMBER], 5, 20, and 26) accommodated no more than four residents in each room. The 4 resident rooms consisted of 2 (two) - twelve (12) bed capacity rooms, 1 (one), seven (7) bed capacity room, and 1 (one), six (6) bed capacity rooms. This deficient practice had the potential adversely affect the delivery of care, quality of life, safety and violate the resident's rights for privacy. Findings: During the entrance conference interview, the Administrator (ADM) on 2/11/2025 at 9:20 AM, the ADM stated there were four rooms in the facility that occupied more than four residents in each room, but the facility had a waiver (a permit approved by Centers for Medicare & Medicaid Services for rooms that did not meet the regulation requirement) in place and would like to request an additional waiver this year. The ADM stated, the multiple beds per room had no impact on care of the residents. During a concurrent observation and interview on 2/11/2025 at 10:30 AM with Resident 51 in room [ROOM NUMBER], Resident 51 was observed walking around with his front wheel walker (a device that gives additional support to maintain balance or stability while walking) with no restriction. Resident 51 stated he had no concern with resident's space or the number of residents in his room. During an interview on 2/12/2025 at 11 AM with Resident 65, Resident 65 stated he was sharing a room (room [ROOM NUMBER]) with other residents. Resident 65 stated, he had no concerns with the number of the residents in his room. During a review of the facility ' s Client Accommodations Analysis form, dated 2/12/2025, indicated the facility had 4 rooms (room [ROOM NUMBER], 5, 20, and 26) that had more than four residents per room. During a review of the facility's request for additional room waiver dated 2/12/2025, indicated the arrangement of the rooms provided adequate space for nursing care, for wheelchair (a chair fitted with wheels for use as a means of transport by a person who is unable to walk as a result of illness, injury, or disability) access. The multiple beds per room and did not adversely affect the health and safety of the residents. The request indicated the following resident bedrooms were: room [ROOM NUMBER] (12 beds) 12 residents, 79.1 sq. ft per resident. room [ROOM NUMBER] (6 beds) 6 residents, 92.8 sq. ft per resident. room [ROOM NUMBER] (12 beds) 12 residents, 87.1 sq. ft per resident. room [ROOM NUMBER] (7 beds) 7 residents, 79.8 sq. ft per resident. (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	02/14/2025

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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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 2/13/2025 at 2:06 PM with Resident 119 in room [ROOM NUMBER], Resident 119 stated he was sharing room [ROOM NUMBER] with other residents. Resident 119 stated the room size was okay and stated that the wheelchair and other equipment were used for other residents without any restrictions. Resident 119 stated, he did not have any issue with the room size. During the survey, from 2/11/2025 to 2/14/2025, there were no observed adverse effects as to the adequacy of space, nursing care, comfort, and privacy to the residents. The residents residing in the affected rooms (Rooms 1, 5, 20, and 26) with an application for variance were observed to have enough space to move freely inside the rooms. Each resident inside the affected rooms had beds and lockers. There was adequate room for the operation and use of the wheelchairs, walkers, or canes. The room variance did not affect the care and services provided to the residents when nursing staff were observed providing care to the residents. During a review of the facility's Resident Census from the last Health Recertification Survey with exit date of 3/15/2024 indicated the residents that occupied Rooms 1, 5, 20, and 26 were not the same residents that occupies Rooms 1, 5, 20, and 26 during this current Health Recertification Survey from 2/11/2025 to 2/14/2025.

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 02/14/2025
NAME OF PROVIDER OR SUPPLIER Monterey Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview and record review, the facility failed to provide a minimum of 80 square feet (sq. ft., unit of measurement) per resident for twelve (12) out of twenty-two (22) resident rooms (room [ROOM NUMBER], 2, 3, 4, 6, 9, 21, 26, 27, 28, 30, and 31). The 12 resident rooms consisted of 1 (one), twelve (12) bed capacity room, 1 (one), seven (7) bed capacity room, 2 (two), four (4) bed capacity rooms, 2 (two), three (3) bed capacity rooms, and 6 (six), two (2) bed capacity rooms. This deficient practice had the potential to negatively impact the quality-of-care and the ability to of the nursing care to safely provide care and privacy to the residents. Findings: During an entrance conference with the Administrator (ADM) on 2/11/2025 at 9:20 AM, the ADM stated multiple rooms in the facility did not have the required 80 square feet of space per resident, but the facility had a room waiver (a permit approved by Centers for Medicare & Medicaid Services for rooms that did not meet the regulation requirement) in place and would like to request an additional waiver this year. The ADM stated, the room size had no impact on the care of the residents. During a concurrent observation and interview on 2/11/2025 at 10:30 AM with Resident 51 in room [ROOM NUMBER], Resident 51 was observed walking around with his front wheel walker (a device that gives additional support to maintain balance or stability while walking) with no restriction. Resident 51 stated he had no concern with resident's space in his room. During a concurrent observation and interview on 2/11/2025 at 10:51 AM with Resident 29 in room [ROOM NUMBER], Resident 29 was observed moving around the room in her wheelchair (a chair fitted with wheels for use as a means of transport by a person who is unable to walk as a result of illness, injury, or disability) with no restriction. Resident 29 stated, she had no issue with the space in the room. During an interview on 2/12/2025 at 9:55 AM with Resident 56, Resident 56 stated, he was sharing room [ROOM NUMBER] with other residents and had no concerns with his room size. During a review of the facility ' s Client Accommodations Analysis form, dated 2/12/2025, indicated the facility had 12 rooms (room [ROOM NUMBER], 2, 3, 4, 6, 9, 21, 26, 27, 28, 30, and 31) that measured less than the required 80 square footages per resident in multiple bed capacity rooms. During a review of the facility's request for room waiver, dated 2/12/2025, indicated the arrangement of the rooms provided adequate space for nursing care, for wheelchair access, and did not adversely affect the health and safety of the residents. The request indicated the following resident bedrooms were: room [ROOM NUMBER] (12 beds) 12 residents 56x20 sq. ft., 79.1 sq. ft per resident. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Monterey Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	room [ROOM NUMBER] (2 beds) 2 residents 11x12 sq. ft., 63 sq. ft per resident. room [ROOM NUMBER] (2 beds) 2 residents 11x12 sq. ft., 63 sq. ft per resident. room [ROOM NUMBER] (2 beds) 2 residents 11x12 sq. ft., 63 sq. ft per resident. room [ROOM NUMBER] (2 beds) 2 residents 12x13 sq. ft., 75 sq. ft per resident. room [ROOM NUMBER] (2 beds) 2 residents 12x12 sq. ft., 70 sq. ft per resident. room [ROOM NUMBER] (4 beds) 4 residents 12x23 sq. ft., 67 sq. ft per resident. room [ROOM NUMBER] (7 beds) 7 residents 25x23 sq. ft., 79.8 sq. ft per resident. room [ROOM NUMBER] (2 beds) 2 residents 12x14 sq. ft., 66.5 sq. ft per resident. room [ROOM NUMBER] (4 beds) 4 residents 12x25 sq. ft., 72 sq. ft per resident. room [ROOM NUMBER] (3 beds) 3 residents 12x20 sq. ft., 78 sq. ft per resident. room [ROOM NUMBER] (3 beds) 3 residents 12x20 sq. ft., 78 sq. ft per resident. During an interview on 2/13/2025 at 2:06 PM with Resident 119 in room [ROOM NUMBER], Resident 119 stated he was sharing room [ROOM NUMBER] with other residents. Resident 119 stated the room size was okay and stated that the wheelchair and other equipment were used for other residents without any restrictions. Resident 119 stated, he did not have any issues with the room size. During the survey, from 2/11/2025 to 2/14/2025, there was no observed adverse effects related to the inadequate room size during nursing care. The residents residing in the affected rooms (room [ROOM NUMBER], 2, 3, 4, 6, 9, 21, 26, 27, 28, 30, and 31) with an application for variance were observed to have enough space to move freely inside the rooms. Each resident inside the affected rooms had beds and lockers. There was adequate room for the operation and use of the wheelchairs, walkers, or canes. The room variance did not affect the care and services provided to the residents when nursing staff were observed providing care to the residents. During a review of the facility's Resident Census from the last Health Recertification Survey with exit date of 3/15/2024 indicated the residents that occupied Rooms 1, 2, 3, 4, 6, 9, 21, 26, 27, 28, 30 and 31 were not the same residents that occupies Rooms 1, 2, 3, 4, 6, 9, 21, 26, 27, 28, 30 and 31 during this current Health Recertification Survey from 2/11/2025 to 2/14/2025.

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 02/14/2025
NAME OF PROVIDER OR SUPPLIER Monterey Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 50203 Based on observation, interview, and record review, the facility failed to provide a safe, functional, and sanitary environment for 69 or 69 residents, staff and the public by failing to: 1. Ensure the facility's washing machine Lint Cleaning Log for 2/12/2025 and 2/13/2025 were completely filled out to indicate the facility's lint screens (lint trap, a device that catches lint and debris from laundry) were cleaned from the clothes dryer. These failures had the potential to cause a facility fire by not tracking when lint screens were cleaned out from the clothes dryer. Findings: During a concurrent interview and record review on 2/13/2025 at 8:50AM with Laundry Services (LS), the facility's Lint Cleaning Log for 2/10/2025 to 2/12/2025 was reviewed. The Lint Cleaning Log indicated on 2/12/2025 at 4:00PM there was no documented evidence the lint screens were cleaned for two of three dryer machines. The LS stated, on 2/13/2025 at 8:30AM, there was no documented evidence the lint screens were cleaned for three of three dryer machines. The LS stated the lint screens were cleaned every 2 hours on at 8AM, 10AM, 12PM, 2PM, 4PM, and 6PM schedule. The LS stated it was important to clean the lint screens because of the possibility of a fire. During a concurrent interview and record review at 2/13/2025 at 8:50AM with the Infection Preventionist (IP), the facility's Lint Cleaning Log for 2/10/2025 to 2/12/2025 was reviewed. The IP stated, according to the lint cleaning log, the last dryer lint screen check was done on 2/12/2025 at 4PM for one dryer machine. The IP stated, she cannot be sure the last schedule person on 2/12/2025 cleaned the lint screens because it was not documented. The IP stated, if the lint screens were not cleaned regularly, there was a potential for a fire throughout the facility. During a review of the facility's policies and procedures (P&P) titled Laundry - Safety, revised 1/1/2012, the P&P indicated all machines and appliances are checked daily to make sure they are clean, operating correctly free of defects .