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

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

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based observation, interview, and record review, the facility failed to implement proper infection control for 66 of 66 sample residents per the facility's Water Management Plan for the Prevention of Waterborne Pathogens (bacteria, viruses, or parasites found in contaminated water) by failing to ensure: 1. The Water Heater 1's mercury temperature gauge (a glass tube filled with mercury that can be used to measure changes in temperature) was not broken and functional. 2. The Water Heater 2's mercury temperature gauge reading was maintained at 110 degrees Fahrenheit (F, a unit of temperature), not at 145 F. 3. The water temperature reading at Nursing Station A ranged from 86 F - 105 F, which was below the 110 degrees Fahrenheit as indicated on the facility's Water Management Program. 4.The water temperature at Nursing Station B ranged from 116 F - 120 F, which was above the 110 F as indicated on the facility's Water Management Program. 5. A monitoring log indicated the visual checks of the facility's water heaters to monitor and identify any changes in the water appearance to indicate biofilm, rust, sediment, or contamination. These failures had the potential to result in waterborne pathogen (microorganisms-bacteria, viruses, and parasites that spread through contaminated drinking or recreational water) growth such as Legionella's (a bacteria that may grow in the water systems and can make people sick when they breathe in contaminated water droplets, which may result in Legionnaires' disease [severe form of pneumonia, where the Legionella bacteria infected the lungs]) and other virus and bacteria that could lead to a widespread infection in the facility. Findings: 1.During a concurrent observation and interview on 3/25/2026 at 8:20 AM with the Maintenance Supervisor (MS) behind the laundry room in a locked shed ,Water Heater 1 was observed. The MS stated Water Heater 1 distributed hot water to Nursing Station A's side of the facility. The MS stated the mercury temperature gauge on Water Heater 1 appeared broken and not working. The MS stated that he did not know how long it had been when the temperature gauge stopped working. During another concurrent observation and interview on 3/25/2026 at 8:30 AM with the MS, behind the kitchen in a locked shed, Water Heater 2 was observed. The MS stated Water Heater 2 distributed hot water to Nursing Station B's side of the facility. The MS stated the mercury temperature gauge of Water Heater 1 was at 110 F. The MS stated that the water heater temperature gauges should be 110 F. 2. During a concurrent observation and interview on 3/25/2026 at 8:41 AM with the MS, in Nursing Station A, the MS was observed checking the temperature of the sink with a digital thermometer (an electronic device used to measure temperature changes and convert to a digital reading). The MS stated, the water temperature of Nursing Station A's sink ranged between 86 F - 105 F. The MS stated the water temperature of Nursing Station A was too low. The MS stated the water temperature at the sinks should be at 110 F. During a concurrent observation and interview on 3/25/2026 at 8:43 AM with the MS, in Nursing Station B, the MS was observed checking the temperature of the sink with a digital thermometer. The MS stated, the water temperature of Nursing Station B's sink ranged between 116 F - 120 F. The MS stated the water temperature of Nursing Station B was too high. The MS stated the water temperature for all sinks, toilets, and showers should be at least 110 F. During an interview on 3/25/2026 at 8:50 AM with the MS, the MS stated it was important to maintain the correct temperature of the water heaters that distributed water to the facility. The MS stated that if the water temperature was below 110 F, it provided an opportunity for water borne pathogens such as (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Legionella to grow and potentially affect all residents, visitors, and staff of the facility. The MS stated that if the water temperature was above 110 F, it created a safety issue because too hot water may cause burns. 3.During an interview on 3/26/2026 at 9:30 AM with the MS, the MS stated, he performs a visual check of the facility's water heaters by draining the water heaters and inspecting the initial drained water for any crystal-like structures that may indicate potential growth of waterborne pathogens such as Legionella. The MS stated there was currently a log to indicate when and which water heaters were flushed, but there currently was no log to indicate the visual monitoring of the appearance of the drained water from the water heaters. During a concurrent record review and interview on 3/26/2026 at 4:30 PM with the Infectious Preventionist Nurse (IPN), the facility's Water Management Plan for the Prevention of Waterborne Pathogens (Water Management Plan), dated 2/2/2026, was reviewed. The IPN stated, according to the Water Management Plan, the water temperature of the water heaters should be 145 degrees F. The IPN stated that when the water was distributed to the sinks, toilets, and showers within the facility, the water temperature should be at least 110 degrees F.

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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 - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, the facility failed to develop and implement a comprehensive-person centered care plan for three of three sample residents (Resident 9, 35, and 5) by failing to ensure: 1. The care plan was not implemented for Resident 9 with a history of hemolytic anemia (a blood disorder where the red blood cells [RBC] are destroyed faster than the bone marrow can replace them, leading to fatigue, jaundice [yellowing of skin], and dark urine) to monitor the resident for signs and symptoms of anemia (a blood condition where there is not enough healthy RBC or hemoglobin [HGB, protein that carries blood to the tissues; normal range 11 - 16 grams per deciliter (g/dL)]). This deficient practice had the potential for Resident 9 not to receive the necessary care and interventions for her history of hemolytic anemia that could lead to a decline in the resident's physical and psychosocial well-being that may lead to foreseeable risks, including unrecognized progression of anemia, severe weakness, hypoxia, and the need for emergency blood transfusions and hospitalizations. [Cross Reference to F684] 2. A care plan was created for Resident 35 who exhibited new behaviors of making verbal threats to others after Licensed Vocational Nurse (LVN) 1 observed Resident 35 regularly saying, I want to hit you to staff. This failure had the potential for Resident 35 to not receive the proper interventions and necessary care related to his behaviors and had the potential for Resident 35 to escalate his behavior and physically attack staff or other residents. On 3/24/26, Resident 35 was witnessed throwing coffee toward Resident 58 during activities and Resident 35 was transferred to a general acute care hospital (GACH) for medical and psychiatric evaluation. [Cross reference F580] 3. A care plan was created when Resident 5 was admitted to the facility with poor vision and required assistance with activities. This failure had the potential for Resident 5 to decline psychosocially from not participating in group activities and physically from not being able to perform his activities of daily living (ADLs). Findings: 1.During a review of Resident 9's admission Record (AR), the facility admitted Resident 4/17/2025 and readmitted Resident 9 on 11/17/2025 with diagnoses of acquired hemolytic anemia, hypertension (HTN, high blood pressure), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 9's care plan, initiated on 11/17/2025, the care plan indicated Resident 9 had hemolytic anemia with interventions, initiated on 11/17/2025, that included to educate Resident 9 and their caregivers to expect her stool to change from dark green to black and to monitor/document/report the following signs and symptoms of anemia such as pallor (unhealthy pale color), fatigue, dizziness, syncope (faint), headache, palpitations, weakness, feelings of cold, low hemoglobin and hematocrit, shortness of breath upon activity, sore tongue, chest pain, tinnitus (ringing in ears), headache, and changes in condition. Durning a review of Resident 9's Minimal Data Set (MDS, a resident's assessment) dated 1/23/2026, the MDS indicated that Resident 9's cognitive (a resident's thought process) was intact. The MDS indicated that Resident 9's active diagnoses include anemia, heart failure (chronic condition where the heart cannot effectively pump blood to the rest of the body), HTN, and renal insufficiency (condition where the kidneys cannot effectively filter the blood of impurities). During a review of Resident 9's Change of Condition Evaluation (CoC) record, dated 2/18/2026 timed (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. 2. During a review of Resident 35's admission Record, the record indicated Resident 35 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and auditory hallucinations (perceptual experiences in which an individual hears sounds, often voices, with no external auditory stimulus present). During a review of Resident 35's Minimum Data Set (MDS- a resident assessment tool) dated 1/27/26, the MDS indicated Resident 35 had moderately impaired cognition (the mental process of how a person learns, remembers, understands, and uses information) and required supervision or touch assistance for most cares such as personal hygiene and toileting. The MDS also indicated Resident 35 did not exhibit verbal behavioral symptoms directed towards others such as threatening others, screaming at others, or cursing at others. During a review of Resident 35's care plan initiated on 1/21/26, the care plan indicated Resident 35 had a mood disorder with interventions to monitor/record/report to physician the risk of Resident 35 harming others: increased anger, labile mood or agitation, threatened by others or thoughts of harming someone. During a review of Resident 35's provider progress notes dated 2/9/26 at 4:02 PM and signed by NP 1, the notes indicated Resident 35 denied / expressed no suicidal ideations, homicidal ideations, and violent behavior. During a review of Resident 35's Change in Condition (CIC- a communication tool used by healthcare workers when there is a change of condition among the residents) Form dated 3/24/26 at 9:50 AM, the CIC indicated, During scheduled coffee social activities in the dining room, [Resident 35] started exhibiting physical aggression [related to] throwing coffee at another resident unprovoked. [Resident 35] was sitting down and stood up from his chair while speaking loudly. [Resident 35] threw a cup of coffee in the direction of another resident. The CIC also indicated Nurse Practitioner (NP) 1 was notified of this incident and ordered to transfer Resident 35 to a GACH on a 5150 hold (a 72 hour hold for psychiatric evaluation when a resident is a danger to themselves, a danger to others, or are unable to care for their basic needs due to a mental health condition) for evaluation. During an interview with LVN 1 on 3/27/26 at 10:28 AM and concurrent record review of Resident 35's progress notes, CICs, and care plans from 1/2026 to 3/2026, LVN 1 stated there was no documentation of Resident 35 making verbal threats to staff. LVN 1 stated Resident 35 was known to easily be triggered when he did not get what he wanted and expressed his frustrations at staff by verbalizing, I want to hit you. LVN 1 further explained Resident 35's verbal threats to hit staff was new and he did not exhibit threatening behaviors until 2/2026, around a month after being admitted to the facility. LVN 1 stated she did not update Resident 35's care plan with Resident 35's verbal threats toward staff because Resident 35 was already known to be verbally aggressive and required frequent redirection. LVN 1 stated she should have created a CIC and notified Resident 35's physician of Resident 35's new behavior of making verbal threats to staff so that Resident 35 and his medications could have been reassessed by the physician. LVN 1 also stated that when residents stated they want to harm themselves or others, the facility's protocol is to place that resident on one-to-one supervision for safety to protect the resident or others from harm. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Registered Nursing (DON) on 3/27/26 at 11:20 AM, the DON stated she was not aware that Resident 35 was making verbal threats to hit staff. The DON stated that when a resident expressed verbal threats toward others such as, I want to hit you, staff should create a CIC to communicate the change in the resident's behavior to the rest of the staff, update the care plan to implement interventions, and notify the resident's physician in order to have the resident's medications reevaluated or sent to a GACH for further evaluation. The DON further explained that a CIC should have been created when Resident 35 first made verbal threats to harm others. 3. During a review of Resident 5's admission Record, the record indicated Resident 5 was admitted to the facility 9/2/25 with diagnoses including schizophrenia, lack of coordination, depression, and anxiety. During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5 had intact cognition and impaired vision (resident could see large print, but not regular print in newspapers/books). During an observation on 3/26/26 at 3:46 PM in the facility's dining room, Resident 5 was observed participating in the facility's karaoke activity. Resident 5 was observed to be sitting close to the TV, holding a microphone, and looking down at the floor but not singing. Resident 5 was observed telling the activity staff that he wanted to hear the song but could not sing along because he could not read the words on the TV. Resident 5 was observed squinting his eyes at the TV and squinting his eyes when looking at staff. During an interview with Resident 5 on 3/24/26 at 10:33 AM, Resident 5 stated that he had difficulty seeing because he was partially blind. Resident 5 stated he wanted to participate in more activities but could not due to his impaired vision. During another interview with Resident 5 on 3/26/26 at 1:59 PM, Resident 5 stated that he told the facility's staff of his vision impairment but did not feel the heard by the facility. Resident 5 stated he was frustrated and further stated, I feel like they [the facility] don't care. During an interview with Activity Staff (AS) 1 on 3/26/26 at 2:04 PM, AS 1 stated that Resident 5 often complained about not being able to see well and stated that Resident 5 did not participate in some activities due to his poor vision. AS 1 stated that Resident 5 would not attend group activities that could not accommodate his poor vision. During an interview with the activities director (AD) on 3/26/26 at 2:30 PM, the AD stated that Resident 5 required one-to-one activity visits because the activity staff noticed that Resident 5 was not actively participating in group activities. The AD stated Resident 5 presented with low self-esteem and would state he felt like a burden when he could not participate in activities. During an interview with the DON on 3/27/26 at 12:35 PM and concurrent record review of Resident 5's care plan, the DON stated there should have been a care plan for Resident 5's poor vision so that proper interventions could have been in place and Resident 5 could perform his ADLs. The DON further stated that if Resident 5 continued to refuse activities, he could isolate and his psychosocial and mental wellbeing could decline. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled, Person-Centered Care Planning dated 5/22/25, the P&P indicated the facility must develop and implement a comprehensive person-centered care plan for each resident rights and provide services that are to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being.ˆ

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food safety for the facility's one of one kitchen used by 66 residents when the facility did not ensure the dishwasher machine thermometer was functioning properly. This deficient practice had the potential to spread foodborne illnesses throughout the facility through dishes that were not sanitized properly. Findings: During an interview with the Dietary Supervisor (DS) on 3/24/26 at 9:18 AM and concurrent observation of the facility's kitchen, the facility's dishwashing machine was observed. The DS stated the dishwashing machine was a low temperature dishwasher and the staff were required to check and log two temperatures when the dishwasher ran: the Wash Temperature and Rinse Temperature. The DS stated the wash temperature and rinse temperatures should both be at a minimum of 120 degrees Fahrenheit (F) to properly clean the dishware. The dishwashing machine was run three times and had the following temperatures: Run 1: Wash temp 100 F, Rinse temp 102 F Run 2: Wash temp 110 F, Rinse temp 112 F Run 3: Wash temp 110 F, Rinse temp 112 F The DS stated that the dishwashing machine's water temperatures had not reached the goal temperature of at least 120 F after running it three times. The DS stated that the staff would have to use the facility's three-compartment dishwashing sinks to handwash the facility's dishes while the dishwashing machine was out of order. During an interview with the facility's Dietitian on 3/24/26 at 9:25 AM, the Dietitian stated that if the dishwasher did not reach the goal temperatures of 120 F - 150 F, the dishes would not be cleaned and pathogens from dirty dishes could transfer to the residents. During another interview with the DS on 3/25/26 at 8:14 AM, the DS stated that the dishwashing machine's company sent a repair person to assess the machine and discovered that the dishwashing machine's thermometer was not reading accurately. The DS stated she did not know how long the thermometer was not working. During a review of the facility's policy and procedure (P&P) titled Dish Machine Temperature Recording revised 10/1/14, the P&P indicated the dish machine would be routinely monitored during use to ensure appropriate temperatures.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that staff provided assistance with dining in a manner that promoted and maintained resident dignity for one of one sampled resident (Resident 69) when Certified Nursing Assistant (CNA) 1 was observed feeding Resident 69 while standing, rather than sitting at eye level. This deficient practice did not promote a dignified, person-centered dining experience and had the potential to make Resident 69 feel rushed, disrespected, or less engaged during meals. Findings: During a review of Resident 69's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included schizophrenia (a mental illness that was characterized by disturbances in thought), anxiety disorder (feelings of fear, dread, and uneasiness that may occur as a reaction to stress), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which could cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 69's History and Physical (H&P) dated 12/6/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 69's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 3/17/2026, the MDS indicated the resident had severe cognitive impairment (Problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident's active diagnoses included schizophrenia, anxiety disorder, and depression. During a review of Resident 69's Order Summary Report dated 3/6/2026, the Order Summary Report indicated the resident had a regular - standard portion diet, level 6 - soft and bit sized textured (consisted of soft, tender, and moist foods cut into small 1.5 centimeter (cm, metric unit of length) by 1.5 cm pieces), level zero thin consistency (or thin liquid, representing natural, unmodified liquids that flowed quickly and easily like water), may have soft bread, sandwiches, cookies, and cakes. During a review of Certified Nursing Assistant (CNA) 1's Providing Assistance with Eating Competency Validation dated 4/10/2025, the Competency indicated the procedure to assist a resident with eating included sitting in a chair and facing the resident during the feeding. The Competency indicated CNA 1 met the procedure by providing a return demonstration. During a review of the facility's Assistance with Feeding an Adult Procedure dated 2021, the Procedure indicated assisting the resident into a comfortable sitting position in a chair at the table and for the facility staff assisting the resident to place a chair next to the resident to assist the resident comfortably. During an observation in the Facility's Dining Room on 3/25/2026 at 12:35 PM, Resident 69 was observed sitting in a chair at a dining table with CNA 1 standing over the resident. CNA 1 was observed spoon feeding the resident two times before another facility staff member whispered into CNA 1's ear. CNA 1 thereafter did not feed Resident 69 anymore and instead prompted the resident to eat different items on the meal tray. CNA 1 was observed staying with the resident until the resident was done with her meal and was observed standing the entire time. During an interview on 3/25/2026 at 1:05 PM, CNA 1 stated she should have been sitting down with the resident and not standing over her. CNA 1 stated she respected the resident even though she was standing over the resident and would bend her body over to try and communicate with the resident, but the dining room was only for the residents to sit down and not the facility staff. During an interview on 3/26/2026 at 11:43 AM, Licensed Vocational Nurse (LVN) 1 stated when assisting or prompting residents during feeding, facility staff should be seated next to the resident at eye level and should not stand over the resident. LVN 1 stated facility staff assisting a resident during mealtimes should not stand over the resident because facility staff were not trained to feed the resident while standing up and standing while assisting a resident during mealtimes could make the resident feel rushed to eat. LVN 1 stated sitting with the resident and communicating with them to see their verbal cues or facial expressions would provide the resident with comfort. LVN 1 stated when facility staff stand (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	over the resident while assisting with meals could make the resident feel uncomfortable if the spoon was too high when being fed or giving the resident a feeling of being rushed. During an interview on 3/27/2026 at 12:36 PM, the Director of Nursing (DON) stated when the facility staff assisted a resident during meals, the facility staff should be seated with the resident and not standing over them. The DON stated facility staff should not stand over resident's when feeding because of the resident's dignity and the resident might have felt like they were being hurried. During a review of the facility's policy and procedure (P&P) titled Resident Rights dated 1/1/2012, the P&P indicated, The Purpose: to promote and protect the rights of all residents at the facility. The P&P indicated, The Policy: Residents of skilled nursing facilities have a number of rights under state and federal law. The facility will promote and protect those rights. Residents have freedom of choice, as much as possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules and regulations and applicable state and federal laws governing the protection of resident health and safety. Employees are to treat all residents with kindness, respect, and dignity and honor the exercise of resident's rights.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 75) was provided with written information regarding Advance Directive (AD, a legal document indicating resident preference on end-of-life treatment decisions) upon admission in accordance with federal requirements and facility policy. This deficient practice had the potential for Resident 75 not to be informed about their rights to make an informed decision regarding their medical care.Findings: During a review of Resident 75's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included schizophrenia (a mental illness that was characterized by disturbances in thought), depression (constant feeling of sadness and loss of interest, which stopped you doing your normal activities), and cannabis use (a plant used for psychoactive effects which altered mood, perception, and consciousness). During a review of Resident 75's History and Physical (H&P) dated 3/22/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During an interview on 3/26/2026 at 3:41 PM, the Social Services Director (SSD) stated Resident 75 was admitted on [DATE] and the SSD provided the AD pamphlet on 3/26/2026 (six days after admission). The SSD stated the AD should have been provided to Resident 75 upon admission to the facility on 3/20/2026. During a concurrent interview and record review of the facility's policy and procedure (P&P) titled Advance Directive on 3/26/2026 at 3:55 PM, Admissions stated the facility was not following the policy that indicated written information regarding the AD should be provided upon admission. Admissions stated for Resident 75, if she did not have an AD, the facility staff would not know what the resident's wishes were in case there was a medical emergency. During an interview on 3/27/2026 at 10:47 AM, the SSD stated if a resident did not have capacity but was able to communicate, was verbal and able to read, the SSD would give an AD pamphlet to the resident. During a concurrent interview and record review of the facility's P&P titled Advance Directive on 3/27/2026 at 12:20 PM, the DON stated the facility staff were not following the facility's policy because the AD pamphlet was not provided to the resident upon admission. The DON stated the AD pamphlet should have been provided to the resident upon admission to the facility, so the resident was aware. The DON stated when a resident has an AD, the residents medical wishes would be provided, and the staff would be consistent and follow the residents' medical wishes. The DON stated without the AD pamphlet, the resident would not have the right to determine what they wanted in regard to medical care. During a review of the facility's P&P titled, Advance Directive dated 7/31/2024, the P&P indicated, Purpose: To include provisions to inform and provide written information to all adult residents concerning their right to accept or refuse medical and surgical treatment, and , at the resident's option, formulate an advance directive. The P&P indicated, Upon admission, the Admissions Staff or Designee will provide written information to the resident concerning his or her right to make decisions concerning medical care; including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives. During the Social Service Assessment Process, the Director of Social Services or Designee will also ask the resident if they have a written advance directive.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician of a resident exhibiting new behaviors of verbal threats for one of two sampled residents (Resident 35) when Licensed Vocational Nurse (LVN) 1 observed Resident 35 regularly saying, I want to hit you to staff but did not notify Resident 35's physician of this new behavior. On 3/24/26, Resident 35 was witnessed throwing coffee toward Resident 58 during activities and Resident 35 was transferred to a general acute care hospital (GACH) for medical and psychiatric evaluation. This failure to report Resident 35's new behavior of verbal threats toward others did not allow Resident 35's physician to evaluate Resident 35 and apply new interventions such as making changes to Resident 35's medications or ordering new nursing interventions. This had the potential for Resident 35 to escalate his behavior and physically attack staff or other residents. [Cross reference F656] Findings: During a review of Resident 35's admission Record, the record indicated Resident 35 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and auditory hallucinations (perceptual experiences in which an individual hears sounds, often voices, with no external auditory stimulus present). During a review of Resident 35's Minimum Data Set (MDS- a resident assessment tool) dated 1/27/26, the MDS indicated Resident 35 had moderately impaired cognition (the mental process of how a person learns, remembers, understands, and uses information) and required supervision or touch assistance for most cares such as personal hygiene and toileting. The MDS also indicated Resident 35 did not exhibit verbal behavioral symptoms directed towards others such as threatening others, screaming at others, or cursing at others. During a review of Resident 35's care plan initiated on 1/21/26, the care plan indicated Resident 35 had a mood disorder with interventions to monitor/record/report to physician the risk of Resident 35 harming others: increased anger, labile mood or agitation, threatened by others or thoughts of harming someone. During a review of Resident 35's provider progress notes dated 2/9/26 at 4:02 PM and signed by NP 1, the notes indicated Resident 35 denied / expressed no suicidal ideations, homicidal ideations, and violent behavior. During a review of Resident 35's Change in Condition (CIC- a communication tool used by healthcare workers when there is a change of condition among the residents) Form dated 3/24/26 at 9:50 AM, the CIC indicated, During scheduled coffee social activities in the dining room, [Resident 35] started exhibiting physical aggression [related to] throwing coffee at another resident unprovoked. [Resident 35] was sitting down and stood up from his chair while speaking loudly. [Resident 35] threw a cup of coffee in the direction of another resident. The CIC also indicated Nurse Practitioner (NP) 1 was notified of this incident and ordered to transfer Resident 35 to a GACH on a 5150 hold (a 72 hour hold for psychiatric evaluation when a resident is a danger to themselves, a danger to others, or are unable to care for their basic needs due to a mental health condition) for evaluation. During an interview with LVN 1 on 3/27/26 at 10:28 AM and concurrent record review of Resident 35's progress notes, CICs, and care plans from 1/2026 to 3/2026, LVN 1 stated there was no documentation of Resident 35 making verbal threats to staff. LVN 1 stated Resident 35 was known to easily be triggered when he did not get what he wanted and expressed his frustrations at staff by verbalizing, I want to hit you. LVN 1 further explained Resident 35's verbal threats to hit staff was new and he did not exhibit threatening behaviors until 2/2026, around a month after being admitted to the facility. LVN 1 stated she did not update Resident 35's care plan with Resident 35's verbal threats toward staff because Resident 35 was already known to be verbally aggressive and required frequent redirection. LVN 1 stated she should have created a CIC and notified Resident 35's physician of Resident 35's new behavior of making verbal threats to staff so that Resident 35 and his medications could have been reassessed by the physician. LVN 1 also (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that when residents stated they want to harm themselves or others, the facility's protocol is to place that resident on one-to-one supervision for safety to protect the resident or others from harm. During an interview with the Director of Registered Nursing (DON) on 3/27/26 at 11:20 AM, the DON stated she was not aware that Resident 35 was making verbal threats to hit staff. The DON stated that when a resident expressed verbal threats toward others such as, I want to hit you, staff should create a CIC to communicate the change in the resident's behavior to the rest of the staff, update the care plan to implement interventions, and notify the resident's physician in order to have the resident's medications reevaluated or sent to a GACH for further evaluation. The DON further explained that a CIC should have been created when Resident 35 first made verbal threats to harm others. During a review of the facility's Policy and Procedure (P&P) titled, Change in Condition and dated 8/25/22, the P&P indicated the licensed nurse will notify the resident's physician and legal representative when there is: An incident involving the resident A significant change in the residents' mental or psychosocial status

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise or update the care plan for one of one sampled residents (Resident 72) to address new interventions related to paranoid schizophrenia (chronic mental disorder characterized by intense, irrational paranoia, delusions [false beliefs], and auditory hallucinations [hearing voices]) due to increased hallucinations when readmitted to the facility on [DATE] after hospitalization. This deficient practice had the potential to result in Resident 72 not receiving appropriate interventions and treatment and/or services and negatively affect the resident's psychosocial wellbeing. Findings: During a review of Resident 72's admission Record (AR), the AR indicated the resident was readmitted on [DATE] with diagnoses that included paranoid schizophrenia (chronic mental disorder characterized by intense, irrational paranoia, delusions [false beliefs], and auditory hallucinations [hearing voices]), schizophrenia, and diabetes mellitus (chronic metabolic disorder characterized by high blood sugar [hyperglycemia] resulting from insufficient insulin [hormone produced by the pancreas that acts as a key, allowing cells to absorb glucose from the blood for energy, and lowering blood sugar levels] production [Type 1] or ineffective insulin use [Type 2]) due to underlying condition with diabetic chronic kidney disease (high blood sugar damages the kidney's filtering units causing them to leak protein into the urine and eventually reducing their function). During a review of Resident 72's History and Physical (H&P), dated 3/25/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 72's Order Summary Report dated 3/16/2026 indicated a physician order was made for transfer to General Acute Care Hospital (GACH) for psych evaluation and 7-day bed hold (resident's right to have their own bed held for seven days while they are in the hospital). During a review of Resident 72's Change in Condition Evaluation dated 3/11/2026 indicated Resident 72 complained of pain over the lower back and alleged that she had a fall from 50 feet elevator. The evaluation indicated Resident 72 was able to ambulate and move lower extremities without difficulty. The evaluation indicated resident denied numbness on lower extremities and denied head injury. The evaluation indicated resident was noted with increased hallucinations and delusions with recommendations from Resident's physician for transfer to hospital for psych evaluation. During a review of Resident 72's care plans, no care plan revision was indicated for resident's transfer to hospital on 3/11/2026 for increased hallucinations and delusion. During a concurrent interview and record review of Resident 72's care plans on 3/27/2026 at 12:45 PM, the Director of Nursing (DON) confirmed Resident 72 did not have a care plan for resident's transfer to the GACH on 3/11/2026. The DON stated should be a revised care plan for the resident's change of condition/transfer so they canˆfollow the resident's plan of care. The DON stated the care plan includes interventions that follow's MD orders and to help prevent whatever is going on with resident.ˆ A review of the facility's policy and procedure (P&P) titled Person-Centered Care Planning, dated 5/22/2025 indicated comprehensive care plans must be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. A review of the facility's P&P titled Discharge and Transfer of Residents, dated 3/21/2025 indicated in the case of the transfer or discharge being necessary for the resident's welfare because the resident's needs cannot be met in the facility, the following information should be included, if the information is not already included in the most current discharge care plan: (1) a written description of the specific resident's needs that cannot be met; (ii) facility attempts to meet the resident's needs; and (iii) the services available at the receiving facility that meet the resident's needs.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of six residents (Resident 9 and Resident 16) was informed of the name and purpose of each medication at the time of administration. This deficient practice had the potential to limit Resident 9 and Resident 16's ability to make informed decisions and participate in their care. Findings: a.During a review of Resident 9's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and re-admitted to the facility on [DATE], with diagnoses that included schizophrenia (a mental illness that was characterized by disturbances in thought), depression (constant feeling of sadness and loss of interest, which stopped you doing your normal activities), and anxiety disorder (feelings of fear, dread, and uneasiness that may have occurred as a reaction to stress). During a review of Resident 9's History and Physical (H&P) dated 2/25/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 9's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 1/23/2026, the MDS indicated the resident's cognition was intact (sufficient judgement and self-control to manage the normal demands of the environment). The MDS indicated the resident was receiving antipsychotic (prescription medications that helped manage psychosis - symptoms that was hard to tell what was real, such as hearing voices, severe paranoia, or delusions), antianxiety (prescription drugs designed to calm the nervous system, reduce intense fear, and alleviate worry, helping to make anxiety manageable), and antidepressant (prescription medication that helped improve mood, sleep, appetite, and concentration in people with depression or anxiety) medications. During a review of Resident 9's Physician's Order dated 2/23/2026 at 9:22 PM, The Physician's Order indicated an order for benztropine mesylate (a medication primarily used to treat still muscles, muscle spasms, and tremors) oral tablet one milligram (mg- a unit of measurement), give one tablet by mouth two times a day for extrapyramidal symptoms (EPS, involuntary, uncontrollable movement disorders that act as side effects of medications, particularly antipsychotics). During a review of Resident 9's Physician's Order dated 2/23/2026 at 9:22 PM, The Physician's Order indicated an order for Depakote (also known as divalproex sodium, a prescription medication primarily used to treat seizures [a sudden, temporary surge of uncontrolled electrical activity in the brain that caused temporary changes in behavior, movement, feelings, or consciousness], prevent migraine headaches, and manage manic episodes associated with bipolar disorder [a mental health condition characterized by severe, unpredicted shifts in mood, energy, and activity levels]) oral tablet delayed release 500 mg, give one tablet by mouth two times a day for bipolar disorder manifested by (m/b) fluctuation of mood from calm to anger. During a review of Resident 9's Physician's Order dated 2/23/2026 at 9:22 PM, The Physician's Order indicated an order for Keppra (a common prescription anti-seizure medication used to treat epilepsy [a chronic brain disorder characterized by recurrent, unprovoked seizures caused by sudden, abnormal electrical activity] by calming abnormal electrical activity in the brain) oral tablet 500 mg, give one tablet by mouth two times a day for seizure. During a review of Resident 9's Physician's Order dated 2/23/2026 at 9:22 PM, The Physician's Order indicated an order for vitamin B12 (an essential nutrient that helped keep your body's nerves and blood cells healthy, boosted emergency, and aided in creating DNA [molecule that carried the genetic instructions for the development, functioning, growth, and reproduction of all known living organisms]) oral tablet 500 microgram (mcg, a unit of weight), give one tablet by mouth one time a day for supplement. During a review of Resident 9's Physician's Order dated 2/23/2026 at 9:33 PM, The Physician's Order indicated an order for Lasix (a powerful prescription diuretic or water pill used to remove excess fluid from the body) oral tablet 20 mg, give one tablet by mouth one time a day for hypertension (HTN, a chronic condition where the force of blood pushing against artery walls was consistently too high), hold if systolic blood pressure (SBP, the top or first number in a blood pressure reading) was less (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	than 110. During a review of Resident 9's Physician's Order dated 2/23/2026 at 9:33 PM, The Physician's Order indicated an order for metoprolol tartrate (a beta-blocker medication that lowered blood pressure and heart rate, making the heart easier to pump blood) oral tablet 25 mg, give one tablet by mouth two times a day for HTN, hold if SBP less than 110 or heart rate was less than 60. During a review of Resident 9's Physician's Order dated 2/23/2026 at 9:37 PM, The Physician's Order indicated an order for folic acid (synthetic, man-made form of vitamin B9 used in supplements and fortified foods) oral tablet one mg, give on tablet one time a day for supplement. During a review of Resident 9's Physician's Order dated 2/27/2026 at 2:24 PM, The Physician's Order indicated an order for multivitamin-minerals (daily pill, capsule, or liquid containing a mix of essential vitamins and minerals designed to fill nutrient gaps in your diet) oral tablet, give one tablet by mouth one time a day for supplement. During a review of Resident 9's Physician's Order dated 2/27/2026 at 2:24 PM, The Physician's Order indicated an order for potassium chloride (KCL, salt-like mineral compound made of potassium and chlorine to treat low potassium levels in the body) tablet extended release 20 milliequivalent (MEQ, a unit used in medicine to measure the chemical activity of electrolytes in your body), give one tablet by mouth one time a day for supplement. During a review of Resident 9's Medication Administration Record (MAR) dated 3/1/2026 to 3/31/2026, the MAR indicated the resident received benztropine mesylate, Depakote, Keppra, vitamin B12, Lasix, metoprolol tartrate, folic acid, multivitamin-minerals, and potassium chloride's morning dose on 3/26/2026. During a medication observation on 3/26/2026 at 8:06 AM, Licensed Vocational Nurse (LVN) 4 was observed administering a medication to Resident 9. LVN 4 obtained the resident's blood pressure. LVN 4 sanitized hands and was checking each medication with the physician's order before placing the medication into a medicine cup. Upon gathering all medications, LVN 4 confirmed the residents name and date of birth and proceeded to hand the medication to the resident without explaining what the medications were or why the resident was receiving those medications. Resident 9 took the medication and LVN 4 checked the resident's mouth to ensure the resident swallowed all of the medication. During an interview on 3/26/2026 at 10:51 AM, LVN 4 stated when passing medication, she would inform the resident of each medication and why the resident was receiving the medication but forgot this morning. LVN 4 stated that if residents are not informed about the medications they are receiving, they would not know what they are taking or why, which could lead to confusion or anger. LVN 4 stated that the residents may have felt lost because staff were giving medications without explaining what the medications were or what they were for. During an interview on 3/27/2026 at 12:34 PM, the Director of Nursing (DON) stated that during medication pass, facility staff should be informing residents of their medications and providing a general explanation of what each medication is for. The DON stated that because of the resident population at the facility, informing the residents of the medication could trigger them so the staff were very careful in wording what the medications were. The DON stated the residents have the right to know what medications they were receiving and if they were not informed, the facility staff were not providing the residents with a choice. b. During a review of Resident 16's AR, the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included schizoaffective disorder (a chronic mental health condition combining symptoms of schizophrenia [such as hallucinations, delusions, or disorganized thinking) with a major mood disorder [depression or mania]), bipolar disorder (a mental health condition characterized by severe, unpredicted shifts in mood, energy, and activity levels), and major depressive disorder (a serious mental health condition characterized by persistent, overwhelming sadness and a loss of interest in activities, lasting at least two weeks). During a review of Resident 16's H&P dated 12/10/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 16's MDS dated [DATE], the MDS indicated the resident had moderate cognitive impairment (a person was experiencing noticeable and significant difficulties with thinking, learning, remembering, and other cognitive skills that impacted their daily life). The MDS indicated the resident was receiving antipsychotic medications. During a review of (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 16's Physician's Order dated 12/9/2025 at 11:40 AM, The Physician's Order indicated an order for divalproex sodium oral tablet delayed release 500 mg, give two tablet by mouth every morning and at bedtime for bipolar disorder m/b poor impulse control, easily getting agitated, two tablets equal 1000 mg. During a review of Resident 16's Physician's Order dated 12/9/2025 at 11:28 AM, The Physician's Order indicated an order for polyethylene glycol 3350 powder (also known as MiraLAX, a [NAME], over-the-counter white powder used to treat occasional constipation [having hard, dry bowel movements less than three times a week, or finding them difficult and painful to pass]), give 17 grams by mouth one time a day for bowel management, dissolve in four to eight ounces of beverage, hold for loose stools. During a review of Resident 16's Physician's Order dated 12/16/2025 at 11:36 AM, The Physician's Order indicated an order for gabapentin (a prescription medication primarily used to treat nerve pain and manage certain types of seizures) give 200 mg by mouth three times a day for neuropathic pain (pain caused by a direct lesion or disease affecting the somatosensory nervous system, either peripherally or centrally). During a review of Resident 16's Physician's Order dated 12/16/2025 at 11:36 AM, The Physician's Order indicated an order for multivitamin-minerals oral tablet, give one tablet by mouth one time a day for supplement. During a review of Resident 16's Physician's Order dated 1/26/2026 at 10:11 AM, The Physician's Order indicated an order for loxapine succinate (a conventional antipsychotic used primarily to treat schizophrenia by restoring balance to brain chemicals) oral capsule 25 mg, give three capsules by mouth every morning and at bedtime for schizoaffective disorder, bipolar type m/b responding to internal stimuli AEB mumbling to self, three capsules equal to 75 mg. During a review of Resident 16's Physician's Order dated 3/3/2026 at 1:27 PM, The Physician's Order indicated an order for Artane (a medication used to treat muscle stiffness, tremors, spasms, and poor muscle control) oral tablet two mg, give 0.5 tablet by mouth two times a day for EPS, give 0.5 tablet equals one mg. During a review of Resident 16's MAR dated 3/1/2026 to 3/31/2026, the MAR indicated the resident received divalproex sodium, polyethylene glycol 3350 powder, gabapentin, multivitamin-minerals, loxapine succinate, and Artane's morning dose on 3/26/2026. During an observation on 3/26/2026 at 8:21 AM, Licensed Vocational Nurse (LVN) 4 was observed giving medication to Resident 16. LVN 4 sanitized hands and was checking each medication with the physician's order before placing the medication into a medicine cup. Upon gathering all medication LVN 4 confirmed the residents name and date of birth and proceeded to hand the medication to the resident without explaining what the medications were or why the resident was receiving them. Resident 16 took the medication and LVN 4 checked the resident's mouth to ensure the resident swallowed all of the medication. During an interview on 3/26/2026 at 10:51 AM, LVN 4 stated when passing medication, she would inform the resident of each medication and why the resident was receiving the medication but forgot this morning. LVN 4 stated that if residents are not informed about their medications, they would not know what they were taking or why, which could lead to confusion or anger. LVN 4 stated the residents may have felt lost because they did not know what was happening, as staff were administering medications without explaining the purpose. During an interview on 3/27/2026 at 12:34 PM, the Director of Nursing (DON) stated during medication pass, the facility staff should have been informing the residents of their medication and roughly explain what each medication was. The DON stated that because of the resident population at the facility, informing the residents of the medication could trigger them so the staff were very careful in wording what the medications were. The DON stated the residents have the right to know what medications they are receiving, and if they were not informed, staff were not providing the residents with a choice. During a review of the facility's policy and procedure (P&P) titled Medication Administration dated 8/19/2025, the P&P indicated All medications shall be administered by licensed nursing staff according to physician's orders, current best practices, and federal and state regulations. The facility shall ensure residents receive the correct medications in a timely, safe, and documented manner. The P&P indicated Purpose: to establish standardized procedures for the safe, effective, and accurate administration of medications in compliance with state and federal regulations and best practice standards.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to assess and monitor one of three sample residents (Resident 9), diagnosed with hemolytic anemia (a blood disorder where the red blood cells [RBC] are destroyed faster than the bone marrow can replace them, leading to fatigue, jaundice [yellowing of skin], and dark urine) with symptoms of blood loss in accordance with the care plan and professional standards of practice by failing to: 1.Monitor and assess Resident 9 for any signs and symptoms of hemolytic anemia such as skin pallor, shortness of breath upon activity, sore tongue, chest pain, tinnitus (ringing in ears), palpitations, and changes in condition. 2.Follow up with Resident 9's Clinic 1 (Hematology Clinic) regarding the after visit care regarding the plan of care for resident's management of hemolytic anemia. These failures resulted in Resident 9 being transferred to the General Acute Care Hospital (GACH) 1 on 2/18/2026 with low blood pressure (BP, measure of the force of blood against artery walls; normal: 120/80 millimeters of mercury [mmHg]) of 94/43 mmHg, low hemoglobin (HGB, protein that carries blood to the tissues; normal range 11 - 16 (g/dL) results of 3.8 g/dL, and hematocrit (HCT, percentage of the total blood volume that consist of RBC; normal range 35 - 52%) of 14%. Resident 9 received a total of four (4) units of packed red blood cells and stayed in the GACH from 2/18/2026 to 2/23/2026. Findings: During a review of Resident 9's admission Record (AR), the facility admitted Resident 4/17/2025 and readmitted Resident 9 on 11/17/2025 with diagnoses of acquired hemolytic anemia, hypertension (HTN, high blood pressure), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 9's Minimal Data Set (MDS, a resident's assessment) dated 1/23/2026, indicated Resident 9's cognitive (a resident's thought process) was intact. During a review of Resident 9's care plan, initiated on 11/17/2025, indicated Resident 9 had hemolytic anemia with interventions, that included to educate Resident 9 and their caregivers to expect her stool to change from dark green to black and to monitor/document/report the following signs and symptoms of anemia such as pallor (unhealthy pale color), fatigue, dizziness, syncope (faint), headache, palpitations, weakness, feelings of cold, low hemoglobin and hematocrit, shortness of breath upon activity, sore tongue, chest pain, tinnitus (ringing in ears), headache, and changes in condition. During a review of Resident 9's Lab Result Report record, dated 2/18/2026, the record indicated Resident 9's blood specimen was collected on 2/18/2026 timed at 9:39 AM and the results were reported on 2/18/2026 at 7:30 PM. The record indicated Resident 9's red blood cells (RBC; normal RBC is 3.9-5.5 millions per microliter [million/mcL])) was 0.98 million/mcL (abnormally low) , hemoglobin (HGB, protein that carries oxygen to the tissues; normal HGB is 11-16 grams per deciliter [g/dL]) was 3.8 g/dL (abnormally low), and hematocrit (HCT, percentage of total blood volume; normal 35 - 52%) was 14% (abnormally low). During a review of Resident 9's Change of Condition Evaluation (CoC) record, dated 2/18/2026 timed at 7:57 PM, the CoC indicated Resident 9's had abnormal blood pressure of 94/43, heart rate of 99, respiratory rate of 16, and temperature of 98.8 degrees Fahrenheit (F, unit of temperature). The record indicated that Resident 9's had a critical laboratory result and blood pressure. Physician 1 (Primary Care Physician) recommended to transfer Resident 9 to the GACH via 911. During a review of Resident 9's GACH records, the laboratory results records dated 2/18/2026 timed at 9:10 PM, were reviewed. The records indicated that Resident 9's RBC levels were 0.76 million/mcL (abnormally low), HGB levels were 3.4 g/dL (abnormally low), and HCT levels were 10.5% (abnormally low). During a review of Physician 2 (GACH 1's Attending Physician) history and physical (HP) record, dated 2/19/2026 timed at 7:06 AM, the record indicated that Resident 9 had reported diffuse body aches while lying still, the facility checked Resident 9's blood pressure, and her systolic blood pressure (the top number of a blood pressure reading; the amount of force blood pushes against the vessels; normal systolic blood pressure is 120) was reported in the 80's, and 911 was activated. The record indicated that Resident 2's laboratory results indicated her HBG of 3.4 g/dL (abnormally low), and Resident 9 received a total of four (4) units of packed RBC during her admission to GACH 1 from 2/18/2026 to (continued on next page)

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	555897	A. Building B. Wing	03/27/2026

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/23/2026. During a review of Resident 9's HP, dated 2/25/2026, the HP indicated that Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 9's Order Summary Report record, the order, dated 2/25/2026, indicated that Resident 2 had an order for a hematology (physician who specializes in diagnosing, treating, and managing diseases of the blood) consult. During a review of Resident 9's Order Summary Report record, the order, dated 2/26/2026 and 3/2/2026, indicated Resident 9 was scheduled to have an appointment with Physician 3 (Hematologist) on 3/2/2026 and 3/16/2026, respectively. During a review of Clinic 1's note (untitled note from Clinic 1 after Resident 9's appointment), dated 3/2/2026 and 3/16/2026, the note indicated Physician 3 recommended blood laboratory orders and scheduled another appointment in two weeks. During an observation on 3/24/2026 at 10:36 AM in Resident 9's room, Resident 9 was observed sleeping in bed wearing a jacket and covered with a blanket and refused any interaction. During an interview on 3/24/2026 at 2:17 PM with Family Member (FM) 1, FM 1 stated, Resident 9 was transferred to the hospital for a HGB of 4 g/dL in February 2026. During an interview on 3/26/2026 at 3:20 PM with Licensed Vocational Nurse (LVN) 4, LVN 4 stated, Resident 9 had routine laboratory orders and her HGB results would sometimes be low. LVN 4 stated, she did not know if Resident 9 had a diagnosis of anemia, but Resident 9 was hospitalized recently for low HGB. During a concurrent interview and record review on 3/26/2026 at 6:02 PM with the Assistant Director of Nursing (ADON), Resident 9's Medical Chart was reviewed. The AODN stated, the only records from Clinic 1 were the notes that indicated Resident 9's diagnoses, recommended laboratory orders, and next scheduled visit. The ADON stated, Physician 3 did not have any assessment notes in Resident 9's chart, therefore the facility was not aware of Physician 3's assessments or plan of care related to monitoring Resident 9's hemolytic anemia. During a concurrent interview and record review on 3/26/2026 at 6:15 PM with the ADON, Resident 9's care plans and active orders were reviewed. The ADON stated, the facility monitored Resident 9's anemia through routine laboratory orders every three (3) months but the facility did not monitor or assess any possible changes of condition related to Resident 9's hemolytic anemia such as pallor, fatigue, shortness of breath upon activity, or syncope as indicated in her care plan. During a concurrent interview and record review on 3/27/2026 at 9:16 AM with the Medical Records Director (MRD), Clinic 1's notes, dated 3/2/2026 and 3/16/2026, were reviewed. The MRD stated, the two (2) notes only had Resident 2's diagnoses and laboratory that were required before the next clinic visit. The MRD stated that the two (2) notes did not contain a visit summary, Resident 9's assessment and baseline, or Physician 3's plan of care. During an interview on 3/27/2026 at 10:40 AM with Registered Nurse (RN) 1, RN 1 stated, it was important to monitor any signs and symptoms of anemia such as pallor, dark tarry stool, and bleeding because if Resident 9 was not monitored, the signs and symptoms of anemia may be missed, which may result in hospitalization. During an interview on 3/27/2026 at 11 AM with the Director of Nursing (DON), the DON stated it was important to specifically monitor any signs and symptoms of anemia to identify any changes in Resident 9's condition and to notify Physician 1 as soon as possible. During an interview on 3/27/2026 at 11:04 AM with Medical Assistant of Clinic 1 (MA) 1, MA 1 stated, the facility did not contact Clinic 1 to request Physician 3's assessment after the clinic visit to indicate the plan of care for management Resident 9's hemolytic anemia. During a review of the facility's policy and procedures (P&P) titled Resident Safety, revised 4/15/2021, the P&P indicated the interdisciplinary team will establish a person-centered observation or monitoring systems for the resident o address the identified risk factors identified. During a review of the facility's P&P titled Comprehensive Person-Centered Care Planning, revised 8/24/2023, the P&P indicated the facility will provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of resident in order to obtain or maintain the highest physical, mental, and psychosocial well-being. During a review of the same facility's P&P titled Comprehensive-Person Centered Care Planning, revised 8/24/2023, the P&P indicated that the baseline care plan will be developed and implemented, using the necessary (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	combination of problem specific care plans to promote continuity of care and communication among facility staff, increase resident safety, and safeguard against adverse events.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide interventions to one of three sample residents (Resident 54) with increased verbal aggression towards other staffs or residents and increased episodes of delusion (misconceptions or beliefs that are firmly held, contrary to reality) to ensure safety to other residents by implementing interventions to prevent Resident 54 from aggression towards residents and staffs. As a result, Resident 54 hit Resident 25 on the right cheek without major injury. In addition, Resident 54 had the potential to emotionally and physically harm other residents and staff due to aggression and delusional thoughts.Findings: During a review of Resident 25's admission Record (AR), the facility admitted Resident 25 on 6/30/2021 and readmitted Resident 25 on 2/13/2026 with diagnoses that included paranoid schizophrenia (mental health disorder where a resident experiences intense, irrational suspicion, paranoia, and hallucinations [perceptual experiences in the abuse of real external sensory stimuli]), dementia (a progressive state of decline in mental abilities), and blindness in one eye. During a review of Resident 25's Minimal Data Set (MDS, a resident assessment), dated 2/5/2026, the MDS indicated that Resident 25's cognitive (a resident's thought process) skills were intact. The MDS indicated that Resident 25 had delusions. The MDS indicated that Resident 25's active diagnoses included anxiety disorder (mental health condition characterized by excessive, persistent, and uncontrollable fear or worry that interferes with daily life), depression (mental health condition characterized by persistent sadness, loss of interest in activities, and low energy), bipolar disorder (manic-depressive disorder; mood swings that range from lows of depression to elevated periods of emotional highs), psychotic disorder (other than schizophrenia), and schizophrenia (a mental illness that is characterized by disturbances in thought). The MDS indicated that Resident 25 had routine antipsychotic (medication that affects mood and behavior) medication. During a review of Resident 54's admission Record (AR), the facility admitted Resident 54 on 2/23/2023 and readmitted Resident 54 on 2/13/2026 with diagnoses that include schizophrenia, anxiety disorder, and bipolar disorder. During a review of Resident 54's MDS, dated [DATE], the MDS indicated that Resident 54's cognitive was intact. The MDS indicated that Resident 54 had delusions. The MDS indicated that Resident 54's active diagnoses included anxiety disorder, depression, bipolar disorder, psychotic disorder, and schizophrenia. The MDS indicated that Resident 54 received routine antipsychotic medications. During a review of Resident 54's Conservatorship (legal order in which an appointed person makes decisions for another adult who cannot care for themselves) Letter record, filed 2/10/2026, the record indicated that Resident 54 remains gravely disabled as a result of mental disorder and is unable to provide for basic personal needs of food, clothing, and/or shelter and that the conservatorship of the person and estate should be granted. During a review of Resident 54's care plan, initiated on 2/13/2026, the care plan indicated that Resident 54 had the potential to be verbally aggressive related to ineffective coping skills, mental and emotional illness, and poor impulse control. The care plan's interventions included to analyze key times, places, circumstances, triggers, and what de-escalates behavior and document and assess resident's copying skills and support systems. During a review of Resident 54's care plan, initiated on 2/13/2026, indicated Resident 54 was physically aggressive, hitting others, related to poor impulse control and bipolar disorder. The goal of the care plan was for the resident to not harm herself or others. Interventions include analyzing triggers, circumstances, and effective deˆescalation strategies; anticipating and assessing the resident's needs; and identifying and addressing any contributing sensory deficits. During a review of Resident 54's Change of Condition Evaluation (CoC) record, dated 3/9/2026 timed at 5:30 PM, the CoC record indicated that Resident 54 was verbally aggressive, cursing, yelling, shouting [at] staff and other residents. The CoC record indicated the staff redirected Resident 54 and closely monitored her for safety. Physician 4 (Primary Care (continued on next page)

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

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure the drugs and biologicals stored in Medication Cart A, for one of six sample residents (Resident 46) was properly labelled and reflected the correct dose and frequency as indicated on the active order's summary list. Resident 46's prescribed medication-Clozaril (Clozapine, an antipsychotic medication) Oral Tablet 25 milligrams (mg, unit of weight) medication label on the unit dose packaging (bubble pack or blister pack, an organization way to store and dispense pill medication). This failure had the potential to result in Resident 46 receiving the wrong dose and wrong frequency of Clozaril which may result in a medication error and compromise the safety of the resident. Findings: During a review of Resident 46's admission Record (AR), the facility admitted Resident 46 on 5/16/2024 and readmitted Resident 46 pm 9/8/2026 with diagnoses that include bipolar disorder (manic-depressive disorder; mood swings that range from lows of depression to elevated periods of emotional highs), schizophrenia (a mental illness that is characterized by disturbances in thought), and bipolar type schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 46's Letter of Conservatorship (legal order in which an appointed person makes decisions for another adult who cannot care for themselves) record, filed 12/29/2025, the record indicated that Resident 46 was gravely disabled due to a mental health disorder. During a review of Resident 46's Minimal Data Set (MDS, a resident's assessment), dated 2/20/2026, the MDS indicated that Resident 46's cognitive (a resident's thought process) skills were intact. The MDS indicated that Resident 46 had hallucinations (perceptual experiences in the absence of real external sensory stimuli). The MDS indicated that Resident 46's active diagnoses included anxiety disorder (mental health condition characterized by excessive, persistent, and uncontrollable fear or worry that interferes with daily life), depression (mental health condition characterized by persistent sadness, loss of interest in activities, and low energy), bipolar disorder, psychotic disorder, and schizophrenia. The MDS indicated that Resident 46's routine medications included antipsychotics, antianxiety, and antidepressants. During a review of Resident 46's Order Summary Report the order, start date 3/2/2026, indicated that Resident 46 was taking Clozaril Oral Tablet (Clozapine) with instructions to give 37.5 mg by mouth one time a day for Schizophrenia manifested by the delusion that people was against him. During an interview on 3/26/2026 at 11:01 AM with Licensed Vocational Nurse (LVN) 3, LVN 3 stated that if there was a medication order change such as an increase or decrease in the medication dose, it was important to remove the discontinued medication bubble pack from the medication cart, properly dispose the medication, and wait for the pharmacy to deliver the new medication bubble pack with new medication order label with the correct dose and frequency. LVN 3 stated, it was important to remove the discontinued medication bubble pack from the medication cart to prevent giving the resident the wrong order, wrong dose, or wrong frequency of the medication, which may result in a medication error. During a concurrent record review and interview on 3/26/2026 at 12:11 PM with LVN 3, Resident 3's Active Order List and current Clozaril medication bubble pack were reviewed. LVN 3 stated, the current order indicated Resident 46 was receiving Clozaril 37.5 mg with a frequency of once a day but the current Clozaril medication bubble pack's label indicated Resident 46 was receiving Clozaril 37.5mg twice a day. LVN 3 stated, the Clozaril's active order frequency and dose were not the same order frequency and dose on the medication's bubble pack label. LVN 3 stated, he did not know why the old medication bubble pack was not properly disposed of and replaced with a new bubble pack with the correct medication, correct dose, and correct frequency. LVN 3 stated, there no Change of Directions: See chart sticker on the current bubble pack to indicate the physician's change in directional use. During a review of the facility's policy and procedures (P&P) titled Medication Ordering and Receiving from Pharmacy: Medication Labels, dated (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/2014, the P&P indicated that each prescription medication label includes but not limited to: resident's name, specific direction for use, including route of administration, medication name, and strength of medication. During a review of the same P&P titled Medication Ordering and Receiving from Pharmacy: Medication Labels, dated 4/2014, the P&P indicated improperly or inaccurately labeled medications are rejected and returned to the dispensing pharmacy. During a review of the same P&P titled Medication Ordering and Receiving from Pharmacy: Medication Labels, dated 4/2014, the P&P indicated that if the physician's direction for use change or the label is inaccurate, the nurse may place a change of order label on the container indicating there is a change in directions for use, taking care not to cover important label information. The P&P indicated that when such a label appears on the container, the medication nurse checks the resident's MAR or the physician's order for current information.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to accurately document the administration of medication for one of one sampled resident (Resident 4.)This failure had the potential to cause severe hypoglycemia (low blood sugar), unconsciousness, and death to the resident.Findings: During a review of Resident 4's face sheet, the face sheet indicated Resident 4 was readmitted on [DATE] (original admission date 6/2/2008), with a diagnosis including but not limited to metabolic encephalopathy (a brain dysfunction caused by illness), schizophrenia (a mental disorder), diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 4's order summary report (OSR), dated 3/25/2026, the order summary report indicated on 11/24/2025 to start administering pioglitazone (medication used to treat DM) 45 milligrams (mg - metric unit of measurement, used for medication dosage and/or amount) give one tablet orally (by mouth) one time a day for DM, hold if the blood sugar (BS) is less than 120 milligrams per deciliter (mg/dL). During a review of Resident 4's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated February 2026, the medication administration record indicated Resident 4 was administered pioglitazone 45mg by Licensed Vocational Nurse (LVN) 2 on 2/10/2026 at 9:00 a.m. by when Resident 4's BS was 89 mg/dL. During a review of Resident 4's MAR, dated February 2026, the medication administration record indicated Resident 4 was administered pioglitazone 45mg by Licensed Vocational Nurse (LVN) 3 on 2/22/2026) at 9:00 a.m. when Resident 4's BS was 110 mg/dL. During a review of Resident 4's MAR, dated February 2026, the medication administration record indicated Resident 4 was administered pioglitazone 45mg by LVN 2 on 2/27/2026) at 9:00 a.m. when Resident 4's BS was 77 mg/dL. During a review of Resident 4's MAR, dated March 2026, the medication administration record indicated Resident 4 was administered pioglitazone 45mg by LVN 2 on 3/10/2026) at 9:00 a.m. when Resident 4's BS was 84 mg/dL. During a review of Resident 4's MAR, dated March 2026, the medication administration record indicated Resident 4 was administered pioglitazone 45mg by LVN 2 on 3/13/2026) at 9:00 a.m. when Resident 4's BS was 114 mg/dL. During an interview on 3/25/2026 at 1:06 p.m., with LVN 2, LVN 2 stated on the Medication Administration Record (MAR), a check mark indicates a medication was administered, while a number indicates the medication was held, with the specific number identifying the reason for holding it. LVN 2 reported there was no way the medication was administered to Resident 4 on 3/10/2026 and stated the check mark on that date must have been a charting error on their part. LVN 2 confirmed they were fully aware of the order to hold pioglitazone HCL 45 mg if blood sugar (BS) is less than 120. LVN 2 stated -the BS documented for Resident 4 on 3/10/2026 was accurate and reiterated the check mark indicating administration was a mistake in charting. LVN 2 stated administering medications when a resident's BS is outside ordered parameters places the resident at risk for severely low blood sugar levels and potential hospitalization. During a review of the facility's policy and procedure (P&P) titled Completion and Correction medical records manual - general, dated 1/1/2012, the P&P indicated the facility will provide the highest quality and accuracy in documentation, and will make sure medical records are complete and correct. During a review of the facility's P&P titled, NP76 Medication Administration, dated 6/6/2025 the P&P indicated all medications must be administered by a licensed nurse according to physician's orders, and federal and state regulations.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 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 3/24/2026 at 9:21 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 review of the facility ' s Client Accommodations Analysis form, dated 3/25/2026, 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 3/25/2026, 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) 8 residents, 79.1 square (sq, unit of measure) feet (ft, unit of measure) 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. During an interview on 3/27/2026 at 10 AM with Resident 4 in room [ROOM NUMBER], Resident 4 stated he was sharing room [ROOM NUMBER] with other residents. Resident 4 stated the room size was okay and stated that the wheelchair and other equipment were used for other residents without any restrictions. Resident 4 stated, he did not have any issue with the room size. During the survey, from 3/24/2026 to 3/27/2026, 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 an interview on 3/27/2026 at 10:13 AM, certified nursing assistant (CNA) 5 stated residents do not complain of room size or having multiple roommates. CNA stated there was enough room for residents to move around with or without assistive devices like wheelchairs or walkers. During a review of the facility's Resident Census from the last Health Recertification Survey with exit date of 2/14/2025 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 3/24/2026 to 03/27/2026.

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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** 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 the entrance conference interview, the Administrator (ADM) on 3/24/2026 at 9:21 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 an interview onˆ3/27/2026ˆatˆ10 AMˆwith Residentˆ4ˆin room [ROOM NUMBER], Residentˆ4ˆstatedˆhe was sharing room [ROOM NUMBER] with other residents. Residentˆ4ˆstatedˆthe room size was okay andˆstatedˆthat the wheelchair and other equipment were used for other residents without any restrictions. Residentˆ4ˆstated, he did not have any issue with the room size. During an interviewˆon 3/27/2026 at 10:13 AM, certified nursing assistant (CNA) 5 stated residents do not complainˆofˆroom size or having multiple roommates. CNAˆstatedˆthere was enough room for residents to move around with or without assistive devices like wheelchairs or walkers.ˆˆ During a concurrent observation and interview on 3/27/2026 at 10:17 AM with Resident 13 in room [ROOM NUMBER], Resident 13 was observed walking around with no restriction. Resident 13 stated she had no concern with resident's space in his room. During a review of the facility' s Client Accommodations Analysis form, dated 3/25/2026, 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 footage per resident in multiple bed capacity rooms. During a review of the facility's request for room waiver, dated 3/25/2026, 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) 8 residents 56x20 sq. ft., 79.1 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 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 the survey, fromˆ3/24/2026ˆtoˆ3/27/2026, there were no observed adverse effects as to the adequacy of space, nursing care, comfort, and privacy to the residents. The residentsˆresidingˆin 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 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Survey with exit date of 2/14/2025 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 3/24/2026 to 3/27/2026.