

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055141	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Madera Post Acute Center			STREET ADDRESS, CITY, STATE, ZIP CODE 11900 RAMONA BOULEVARD , EL MONTE, California, 91732	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of two complaints. Complaint Numbers: 2585350 and 2593765 The inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for complaint number: 2585350 at F684 No deficiency was issued for complaint number: 2593765	F0000	The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is submitting this document in order to comply with its obligations as a provider participating in Medicare/ Medicaid program(s).	
F0684 SS = E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to provide necessary care and services to one of three sampled residents (Resident 1) by failing to: A. Ensure Resident 1's physician's orders were followed when Licensed Vocational Nurse 1 (LVN 1) held administration of Tresiba (a once-daily medication used to manage high blood sugar). B. Ensure accurate medication administration documentation for Resident 1, when LVN 2 did not document the Tresiba administration for Resident 1 on 8/9/2025.	F0684	F0684 Quality of Care How corrective action will be accomplished for those residents found to have been affected by the identified practice. Immediate Corrective action(s) for resident(s) found to have been affected by the deficient practice: <ul style="list-style-type: none"> ● On 8/9/25, Resident 1 was transferred to the hospital for further evaluation. ● On 09/08/2025 1:1 Inservice with LVN 1 regarding obtaining physicians order prior to holding medication. ● On 09/08/2025 1:1 Inservice with LVN 2 regarding accurate medication administration documentation. How the facility will identify other residents having the potential to be affected by the same identified practice and what corrective action will be taken. <ul style="list-style-type: none"> ● All residents in the facility with long acting insulin are potentially at risk of being affected. ● On 09/08/2025, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) conducted an audit of all residents with orders for long-acting insulin to identify any instances of medication being withheld without a physician's order. ● No other residents are affected by this deficient practice. 	9/12/25

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 reverse for further 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 Administrator	(X6) DATE 9/12/25
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F0684 SS = E	<p>Continued from page 1</p> <p>These deficient practices had the potential to result in serious health complications for Resident 1.</p> <p>Findings:</p> <p>A. During a review of Resident 1's Admission Record (AR), the AR indicated the facility originally admitted Resident 1 on 11/4/2018 and readmitted the resident on 8/12/2025 with a diagnosis including type 2 diabetes mellitus (a chronic [persistent or long-lasting] disease characterized by high blood sugar levels due to insufficient insulin [a hormone which regulates the amount of sugar in the blood] production) and unspecified hypoglycemia (body's blood sugar level goes below the standard range).</p> <p>During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 6/25/2025, the MDS indicated Resident 1's cognitive (the ability to think and process information) skills for daily decision making were intact.</p> <p>During a review of Resident 1's Order Summary Report (OSR) dated 7/1/2025, the OSR indicated Resident 1 had an order for Tresiba 55 units (a unit of measurement) subcutaneous injection (a method of delivering medication into the fatty tissue layer located just beneath the skin) in the morning related to type 2 diabetes mellitus with a start date of 4/23/2025.</p> <p>During review of Resident 1's Medication Administration Record (MAR) dated 7/1/2025 -7/31/2025 and 8/1/2025 - 8/31/2025, the MAR indicated the 6:30 AM dose for Tresiba 55-unit[s] subcutaneous injection was held on 7/11/2025, 7/12/2025, 7/18/2025, 7/23/2025, 7/29/2025, 7/30/2025, 8/2/2025, and 8/6/2025 by LVN 1.</p> <p>During a review of Resident 1's Care Plan (CP) titled "(Resident 1) has diabetes mellitus," initiated 4/29/2025, revised 8/13/2025, cancelled 8/13/2025, the CP's goal indicated Resident 1 will have no complications related to diabetes. The CP's interventions indicated for licensed nursing staff to administer diabetes medication as ordered by the doctor and monitor/document for side effects and effectiveness.</p> <p>During a telephone interview on 8/20/2025 at 3:44 PM with LVN 1, LVN 1 stated LVN 1 would hold Resident 1's 6:30 AM dose of Tresiba 55 units if Resident 1's blood sugar level was below 170 milligrams per deciliter (mg/dL-a unit of measurement). LVN 1 stated Resident 1's Tresiba order did not indicate the Tresiba should be held if Resident 1's blood sugar was below 170</p>	F0684	<ul style="list-style-type: none"> ● On 09/08/2025, the Director of Nursing (DON), and Assistant Director of Nursing (ADON) audited all medication administration records to ensure accurate documentation for residents with long-acting insulin orders. ● No other residents are affected by this deficient practice. <p>What measures will be put into place or what systemic changes will the facility make to ensure that the identified practice does not recur.</p> <ul style="list-style-type: none"> ● From 09/09/2025 to 09/12/2025, the Director of Nursing (DON) conducted in-service training for licensed nurses on the facility's medication administration policy and procedure, emphasizing the importance of obtaining a physician's order before withholding any medication. ● From 09/09/2025-09/12/25 the Director of Nursing (DON) conducted in-service training on accurate documentation practices for medication administration to ensure compliance with facility standards. ● Starting on 9/10/25, the DON and ADON will conduct random 3-5x a week audit for any long-acting insulin withheld without physician's order. ● Starting 09/10/2025 DON and ADON will conduct random 3-5x a week audit for accurate documentation of all medication administration for all resident's with long-acting insulin orders. ● Any findings identified during the audits will be addressed promptly, and reeducation will be provided as necessary. A summary of each audit will be submitted to the DON and ED for review and follow up. 	

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F0684 SS = E	<p>Continued from page 2 mg/dL. LVN 1 stated LVN 1 notified the Registered Nurse Supervisor (RN1) that LVN 1 held the Tresiba medication.</p> <p>During a telephone interview on 8/20/2025 at 4:30 PM with RN 1, RN 1 stated LVN 1 informed RN 1 that LVN 1 held the Tresiba Medication for Resident 1. RN 1 stated the doctor was not notified when Resident 1's Tresiba was held.</p> <p>During an interview on 8/21/2025 at 12:25 PM with the Director of Nursing (DON), the DON stated if a physician's order does not indicate a medication was to be held, it was the facility's policy to get a doctor's order prior to holding the medication.</p> <p>B. During an interview on 8/20/2025 at 12:53 PM with Resident 1, Resident 1 stated on the morning of 8/9/2025 LVN 2 administered Tresiba 55 units to Resident 1.</p> <p>During a telephone interview on 8/20/2025 at 3:37 PM with LVN 2, LVN 2 stated on 8/9/2025 at 5:40 AM, LVN 2 administered Tresiba 55 units to Resident 1.</p> <p>During a concurrent interview and record review on 8/21/2025 at 12:25 PM with the DON, Resident 1's MAR dated 8/1/2025-8/31/2025 was reviewed. The MAR indicated the 8/9/2025 6:30 AM dose for Tresiba 55-unit[s] subcutaneous injection was not administered. The DON stated LVN 2 should have documented the 6:30 AM dose of Tresiba administered by LVN 2 on 8/9/2025 in Resident 1's MAR.</p> <p>During a review of the facility's undated Policy and Procedure (P&P) titled, "Medication Administration," the P&P indicated, medications will be administered as prescribed by the physician. The P&P's administration process indicated that the person administering the medication is to initial the resident's medication sheet in the provided space under the appropriate date and time for that particular dose administered. The P&P's administration process indicated, documentation on the medication sheet is done immediately following administration.</p>	F0684	<p>How the facility plans to monitor its performance to make sure that solutions are sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is in-tegrated into the quality assurance system.</p> <ul style="list-style-type: none"> ● The DON and ADON will be reporting the results of the monitoring to the QA committee monthly x3 months for review and recommendations and ensure substantial compliance is sustained. ● Any deficient practices will be corrected immediately and discussed during QA committee meetings to identify root cause and action plan to prevent any further deficient practices. 	