10/20/2025 POC accepted.

California State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 950000007	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madera Post Acute Center	**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
C0000	Initial Comments The following reflects the findings of the California Department of Public Health during a relicensing survey conducted from 9/24/2025 to 9/26/2025. The resident census at the time of survey was 129.	C0000	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).	
C0900	Nursing Service--Administration of Medication CFR(s): T22 DIV5 CH3 ART3-72313(a)(2) (a) Medications and treatments shall be administered as follows: (2) Medications and treatments shall be administered as prescribed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of nine sampled patients (Patient 6) who was on continuous oxygen (colorless, odorless and tasteless gas) therapy received oxygen as ordered in accordance with the physician's order and the facility's Policy and Procedure (P&P) on oxygen administration. This deficient practice had the potential to result in respiratory complications associated with oxygen therapy and result in harm for Patient 6. Findings: During a review of Patient 6's Admission Record (AR), the AR indicated Patient 6 was initially admitted to the facility on 9/18/2025 with diagnoses including respiratory failure (a medical condition where the lungs are unable to adequately exchange oxygen), chronic obstructive pulmonary disease (COPD- lung disease causing restricted airflow and breathing problems), pleural effusion (the accumulation of excess fluid in the area between the lungs and the chest wall) and encounter for palliative care (patient receives care related to a serious or life-limiting illness).	C0900	Nursing Service--Administration of Medication 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: - On 9/24/25, Patient 6's oxygen setting was corrected and adjusted to 2 L/min as ordered by the physician. - On 9/24/25, the Assistant Director of Nursing (ADON) provided a one-on-one in-service to LVN #2 regarding accurate oxygen administration in accordance with physician orders. - On 9/24/25, the ADON and Director of Staff Development (DSD) conducted an in-service for Licensed Nurses, CNAs, and staff on proper oxygen administration practices per physician orders and the facility's Oxygen Policy and Procedure. 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. - On 09/24/25, the Assistant Director of Nursing (ADON) conducted rounds on all residents receiving oxygen therapy to verify that oxygen settings were consistent with current physician orders. - No other residents were found to be affected by this deficient practice. What measures will be put into place or what systemic changes will the facility make to ensure that the identified practice does not recur. - From 10/15/25-10/16/25, the ADON and DSD conducted in-service training for all Licensed Nurses, Certified Nursing Assistants (CNAs) and staff on accurate oxygen administration in accordance with physician orders and the facility's Policy and Procedure on Oxygen Use. - Starting 10/13/2025, the ADON and/or DSD will conduct random rounds 3x/week for 3 months to monitor compliance with proper oxygen administration per physician orders. Any findings identified during the rounds will be addressed promptly, and reeducation will be provided as necessary.	10/17/25

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	10/17/25

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C0900	Continued from page 1 During a review of Patient 6's History and Physical (H&P) dated 9/23/2025, the H&P indicated Patient 6's neurological function (ability to send, receive, and process information to control the body's activities) was intact (had the capacity to understand and make own decisions). During a review of Patient 6's Minimum Data Set (MDS – a patient assessment tool) dated 9/25/2025, the MDS indicated Patient 6 was dependent (helper does all the effort) for showering/bathing self. The MDS indicated Patient 6 required substantial/maximal assistance (helper does more than half the effort to complete activity) for toileting and partial/moderate assistance (helper does less than half the effort) for oral and personal hygiene and upper/lower body dressing. During a review of Patient 6's Order Summary Report (OSR) dated 9/18/2025, the OSR indicated continuous oxygen at 2 liters of oxygen per minute (2l/min) via (through) nasal cannula (NC - a thin, flexible tube with two prongs inserted into the nostrils to deliver supplemental oxygen)/mask to keep oxygen saturation (the amount of oxygen circulating in the blood) above 90% every shift for Patient 6. During a review of Patient 6's untitled Care Plan (CP) dated 9/24/2025, the CP indicated Patient 6 was on oxygen therapy. The CP intervention indicated continuous oxygen at 2L/min via nasal cannula/mask to keep oxygen saturation above 90%. The CP interventions also included administering oxygen as ordered by the physician. During a review of Patient 6's Weights and Vitals Summary (WVS), the WVS indicated Patient 6 was on Room Air (RA) on 9/19/2025 at 12:15 am, 9/20/2025 at 1:59 pm, 9/202025 at 7:26 pm, 9/20/2025 at 9:50 pm, 9/21/2025 at 4:10 am, 9/21/2025 at 9:10 am, 9/21/2025 9:02 pm, 9/22/2025 at 12:08 am, 9/22/2025 at 9:51am, 9/22/2025 at 4:29 pm, 9/23/2025 at 12:44 pm, and on 9/24/2025 at 1:22 pm. During an observation of Patient 6 on 9/24/2025 at 10:27 am in Patient 6's room, Patient 6 was resting in bed with ongoing oxygen (O2) via NC set at 1 L/min.	C0900	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 integrated into the quality assurance system. - The ADON and/or DSD will be reporting the results of the monitoring to the QA committee monthly x 3 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.	

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C0900	Continued from page 2 During an observation of Patient 6 and interview and record review (RR) with Assistant Director of Nursing (ADON) on 9/24/2025 at 11:52am, the ADON confirmed Patient 6's O2 was set at 1.5L/min. The ADON stated Patient 6's O2 should be set according to the doctors' orders which is continuous O2 at 2L/min. The ADON stated, if the O2 was not set according to the doctors' orders, it could compromise Patient 6's oxygen saturation causing shortness of breath and confusion, potentially progressing to organ damage and even death in severe cases. During an observation of Patient 6 and interview and RR with License Vocational Nurse 2 (LVN 2) on 9/24/2025 at 12:03 pm, LVN 2 confirmed Patient 6's O2 was set at 1.5 L/min and the physician's order of continuous O2 at 2L/min via nasal cannula for Patient 6 was not followed. LVN 2 stated not following the physician's order had the potential to result in breathing problems for Patient 6. During an interview with the Infection Prevention Nurse (IPN) on 9/25/2025 at 2:30 pm, the IPN stated it was not acceptable to keep Patient 6 on RA when the physician's order indicated continuous O2. The IPN stated Patient 6 needed to have O2 at all times and not on RA. The IPN stated Patient 6 could be harmed if not provided with continuous O2 because Patient 6 had respiratory failure and COPD. During an interview with the facility's Director of Nursing (DON) on 9/25/2025 at 3:00pm, the DON stated all staff (in general) needed to follow the physician's orders. The DON stated it was important to keep Patient 6 on continuous O2 as ordered because Patient 6 had respiratory failure and could easily desaturate (low oxygen saturation level). The DON stated if Patient 6 was on RA, the O2 saturation was not maintained with continuous oxygen. The DON stated if Patient 6 was not on O2, it could potentially harm the patient. During a review of the facility's P&P titled "Oxygen Administration", revised 7/2013, the P&P indicated, "The purpose of the oxygen therapy is to provide sufficient oxygen to the blood stream and tissues."	C0900		
C1115	Nursing Service--Patient Care CFR(s): T22 DIV5 CH3 ART3-72315(m)	C1115	C1115 Nursing Service--Patient Care	

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C1115	Continued from page 3 (m) Patient call signals shall be answered promptly. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the call light (a device used by patients to call for assistance from hospital staff) was within reach (an arm's length) for one of nine sampled patients (Patient 6). This deficient practice had the potential to result in delayed provision of care and services and risk for falls/injury for Patient 6. Findings: During a review of Patient 6's Admission Record (AR), the AR indicated Patient 6 was initially admitted to the facility on 9/18/2025 with diagnoses including respiratory failure (a medical condition where the lungs are unable to adequately exchange oxygen), chronic obstructive pulmonary disease (COPD- lung disease causing restricted airflow and breathing problems), pleural effusion (the accumulation of excess fluid in the area between the lungs and the chest wall) and encounter for palliative care (patient receives care related to a serious or life-limiting illness). During a review of Patient 6's History and Physical (H&P) dated 9/23/2025, the H&P indicated Patient 6's neurological function (ability to send, receive, and process information to control the body's activities) was intact (had the capacity to understand and make own decisions). During a review of Patient 6's Minimum Data Set (MDS – a patient assessment tool) dated 9/25/2025, the MDS indicated Patient 6 was dependent (helper does all the effort) for showering/bathing self. The MDS indicated Patient 6 required substantial/maximal assistance (helper does more than half the effort to complete activity) for toileting and partial/moderate assistance (helper does less than half the effort) for oral and personal hygiene and upper/lower body dressing. During a review of Patient 6's Order Summary Report (OSR) dated 9/18/2025, the OSR indicated "Safety/fall precautions every shift" for Patient 6.	C1115	**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:** - On 9/24/25, patients 6's call light was immediately placed within reach. **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.** - On 9/24/25, the Director of Staff Development (DSD) conducted facility-wide rounds to verify proper placement of call lights. - No other residents were affected by this deficient practice. **What measures will be put into place or what systemic changes will the facility make to ensure that the identified practice does not recur.** - On 9/24/25, and 10/14/25, the DSD conducted in-service training for all staff on the proper use and placement of call lights, emphasizing the importance of ensuring that call lights are always within the resident's reach. - Starting 10/10/25, the DSD will conduct random checks of call light placement 5x/week reviewing 5 residents each day, for a duration of three months. **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 integrated into the quality assurance system.** - The DSD will be reporting the results of the monitoring to the QA committee monthly x 3 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.	

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C1115	Continued from page 4 During a review of Patient 6's Fall Risk Assessment (FRA-method of assessing a patient's likelihood of falling) dated 9/18/2025, the FRA indicated Patient 6 was assessed as high risk for fall due to history of fall, predisposing disease and intermittent confusion. During a review of Patient 6's Care Plan (CP) dated 9/18/2025, the CP indicated Patient 6 was as risk for falls related to progressive dementia (gradual and irreversible decline in cognitive abilities, such as memory, thinking, reasoning, and problem-solving) and history of falls. The CP interventions indicated for nursing staff to ensure the call light was within reach and to encourage the patient to use it to call for assistance as needed. During an observation on 9/24/2025 at 10:27 am, in Patient 6's room, Patient 6 was awake, lying in bed. Patient 6's call light was under Patient 6's pillow. Patient 6 stated, Patient 6 wanted to call the nurse. Patient 6 stated "I could not reach my call light, I don't know where it is". During an interview on 9/25/2025 at 2:30 pm, with the facility's Director of Nursing (DON), the DON stated, patient's call light needed to be within reach and accessible for patients to use if they need help and assistance from the staff and also for the patient's safety. The DON stated patients should be able to use the call light at any time to call for assistance or help with care, to prevent an accident/injury. The DON stated, if the call light was not accessible, the patient could suffer injury from a fall. During an interview on 9/26/2025 at 9:55 am with License Vocational Nurse 2 (LVN 2), LVN 2 stated, the patient's call light needed to be within patient's reach at all times. LVN 2 stated it was not acceptable to have the call light under Patient 6's pillow because the patient won't be able to reach it to call for assistance. LVN 2 stated not having the call light within reach can potentially cause a patient to fall and delay patient care. During a review of the facility's Policies and Procedures (P&Ps) titled "Call Lights", revised 1/2025, the P&P indicated, "It is the policy of the facility to	C1115		

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C1115	Continued from page 5 provide the resident a means of communication with nursing staff. Place the call light device within patient's reach before leaving room." During a review of the facility's P&P titled "Accommodation of Needs", revised 1/2025, the P&P indicated, "It is the policy of the facility to provide accommodation of reasonable needs to the residents while in the facility." Examples of accommodation of need would be to provide a call light.	C1115		
C1280	Nursing Service--Patients with Infectious Dis CFR(s): T22 DIV5 CH3 ART3-72321(c)(1) (c) The following shall be available in each nurse's station: (1) The facility's infection control policies and procedures. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation and interview the facility failed to ensure the facility's infection control (IC) Policies and Procedures (P&P) was available in four of four Nurse's Station (Nursing Stations 1, 2, 3 and 4). This violation had the potential to deprive nursing staff accessibility to important information regarding infection control and the facility's policies and procedures on infection control. Findings: During a concurrent observation in Nursing Station 3 and interview on 9/24/2025 at 11:40 pm with the Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated LVN 1 was unable to find the IC policy and procedure binder in Nursing Station 3. LVN 1 stated, if LVN 1 needed guidance regarding infection control LVN 1 would consult the Director of Nursing (DON). During a concurrent observation in Nursing Station 3 and interview on 9/24/2025 at 11:44 am with the Infection Preventionist Nurse (IPN), IPN stated there was no IC P&P binder in Nursing Station 3. The IPN stated the IC P&P was inside the IPN's office. The IPN stated every nursing station needed to have the IC P&P	C1280	C1280 Nursing Service--Patients with Infectious Dis 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: - On 9/24/25, copies of the current Facility Infection Control Policies and Procedures Manual were printed and placed at all four nursing stations by the Infection Preventionist. 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. - On 9/24/25, the Infection Preventionist (IP) verified that all four nursing stations contained the Infection Control Policies and Procedures Manual. - No other residents were affected by this deficient practice. What measures will be put into place or what systemic changes will the facility make to ensure that the identified practice does not recur. - On 9/24/25 and 10/10/25, the Infection Preventionist (IP) conducted an in-service training to educate staff on the location and accessibility of the facility's Infection Control Policies and Procedures Manual. - Starting 10/14/25, the Infection Preventionist will monitor the availability of the Infection Control Policies and Procedures manual at each nursing station 2x/week for three months to ensure accessibility for all staff. 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 integrated into the quality assurance system. - The Infection Preventionist will be reporting the results of the monitoring to the QA committee monthly x 3 months for review and recommendations and ensure substantial compliance is sustained.	

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C1280	Continued from page 6 for staff to access in case they needed the guidelines to provide proper care and treatment to patients with regards to infection control. During a concurrent observation in Nursing Station 1 and interview on 9/24/2025 at 11:49 am with Registered Nurse 1 (RN 1), RN 1 stated RN 1 could not find the IC P&P in Nursing Station 1. During a concurrent observation in Nursing Station 4 and interview on 9/24/2025 at 11:59 am with the IPN, the IPN stated the IPN was unable to find the IC P&P in Nursing Station 4. During a concurrent observation in Nursing Station 2 and interview on 9/24/2025 at 12:05 pm with the Assistant Director of Nursing (ADON), the ADON stated the ADON was unable to find the IC P&P in Nursing Station 2. During an interview on 9/24/2025 at 3:39 pm with the facility's DON, the DON stated the facility's IC P&P needed to be in all four (4) nursing stations for staff to readily access the guideline on how to provide proper care and treatment to the patients in the course of an outbreak (an occurrence of cases of diseases above the expected number of cases) or any infection control issues.	C1280	- 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.	
C1285	Nursing Service--Patients with Infectious Dis CFR(s): T22 DIV5 CH3 ART3-72321(c)(2) (c) The following shall be available in each nurse's station: (2) Name, address and telephone numbers of local health officers. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation and interview the facility failed to ensure the name, address and telephone number of local health officers were available in four of four Nursing Stations (Nursing Stations 1, 2, 3 and 4). This violation had the potential to deprive nursing staff of accessibility to contact the local health	C1285	C1285 Nursing Service--Patients with Infectious Dis 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: - On 9/24/25, the Administrator Assistant posted updated information for the current Local Health Officers at all four nursing stations. 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. - On 9/24/25, the Administrator Assistant verified that all four nursing stations had the current Local Health Officers information posted. - No other residents were affected by this deficient practice.	

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C1285	Continued from page 7 officers. Findings: During a concurrent observation in Nursing Station 1 and interview on 9/24/2025 at 11:52 am with Registered Nurse 1 (RN 1), RN 1 stated Nursing Station 1 did not have the name, address and telephone number of the local health officers. During a concurrent observation in Nursing Station 4 and interview on 9/24/2025 at 11:59 am with the Infection Prevention Nurse (IPN), the IPN was unable to find the name, address and telephone number of the local health officers in Nursing Station 4. During a concurrent observation in Nursing Station 2 and interview on 9/24/2025 at 12:05 pm with the Assistant Director of Nursing (ADON), the ADON was unable to find the name, address and telephone number of the local health officers in Nursing Station 2. During a concurrent observation in Nursing Station 3 and interview on 9/24/2025 at 12:08 pm with the IPN, the IPN was unable to find the name, address and telephone number of the local health officers in Nursing Station 3. During an interview on 9/24/2025 at 3:39 pm with the facility's DON, the DON stated the name, address and telephone number of the local health officers needed to be in all four (4) Nursing Stations for staff to easily access the contact information of local public health nurse or local health officers for guidance.	C1285	What measures will be put into place or what systemic changes will the facility make to ensure that the identified practice does not recur. - On 9/24/25 and 10/10/25, the Administrator Assistant conducted an in-service training to educate staff on the location and accessibility of the Local Health Officers' information. - Starting 10/14/25, the Administrator Assistant will monitor the posting of the Local Health Officers' information at each nursing station 2x/week for three months to ensure accessibility for all staff. 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 integrated into the quality assurance system. - The Administrator Assistant will be reporting the results of the monitoring to the QA committee monthly x 3 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.	
C1890	Pharmaceutical Service--General CFR(s): T22 DIV5 CH3 ART3-72353(b) (b) Dispensing, labeling, storage and administration of drugs and biologicals shall be in conformance with state and federal laws. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure accurate storage instructions on the medication label for one Novolog 100 U/ml and two Lantus Solostar 100 injection pens located in	C1890	C1890 Pharmaceutical Service--General 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: - On 9/25/25, the Novolog 100 U/ml and two Lantus Solostar 100 injection pens for patients 10, 11 and 12 were immediately discarded.	

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C1890	Continued from page 8 Nursing Station 3 medication cart for three of three sampled patients (Patients 10,11, and 12). This failure had the potential to result in improper storage, affecting the efficacy of medications. Findings: During a review of Patient 10's Admission Record (AR), the AR indicated the facility admitted Patient 10 on 8/26/2025 with diagnoses including type 2 diabetes mellitus (elevated blood sugar levels) and lack of coordination. During a review of Patient 10's Minimum Data Set (MDS-patient assessment tool) dated 7/3/2025, the MDS indicated Patient 10 was dependent on staff to assist with toileting, showering, and removing/placing on footwear. During a review of Patient 11's AR, the AR indicated the facility admitted Patient 11 on 9/11/2025 with diagnoses including type 2 diabetes mellitus and psychosis (severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality). During a review of Patient 11's MDS dated 9/17/2025, the MDS indicated Patient 11 required maximal assistance with oral and personal hygiene and getting dressed. The MDS indicated Patient 11 was dependent on others for toileting and shower/bathing. During a review of Patient 12's AR, the AR indicated the facility admitted Patient 12 on 9/16/2020 with diagnoses including type 2 diabetes mellitus and abnormalities of gait (way a person walks) and mobility (how easily a person can move). During a review of Patient 12's MDS dated 8/13/2025, the MDS indicated Patient 12 required setup or clean up assistance for eating and oral hygiene. During a concurrent observation and interview on 9/24/2025 at 3:05 p.m. with LVN 1 of the medication cart in Nursing Station 3, three insulin injection pens had storage instructions labeled to, "Keep refrigerated	C1890	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. - All residents with insulin orders are considered at risk of being affected. - On 10/10/25, the Director of Nursing (DON) conducted an audit of all residents with insulin orders to identify any instances of improper insulin storage. - Following the audit, it was determined that no other residents were affected by this deficient practice. What measures will be put into place or what systemic changes will the facility make to ensure that the identified practice does not recur. - On 9/26/25, the Director of Nursing (DON) conducted an in-service with LVN#1 regarding accurate medication storage practices. - The education included a detailed review of the medication labeling instructions, with an emphasis on the proper storage requirements for insulin to maintain potency and efficacy. - On 10/10/25 and 10/16/25, the Director of Nursing (DON) conducted in-service training for all licensed nurses on the facility's policy and procedure for accurate medication storage practices. - The education included a detailed review of the medication labeling instructions, with particular emphasis on the proper storage requirements for insulin to maintain potency and efficacy - Starting 10/16/25, the DON and/or ADON, will conduct random audits 2–3x/week for 3 months to ensure proper insulin storage. 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 integrated into the quality assurance system. - The DON and/or ADON will be reporting the results of the monitoring to the QA committee monthly x 3 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 950000007	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/26/2025

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C1890	Continued from page 9 after opening". LVN 1 stated insulin does not require refrigeration after opening. One Lantus Solostar 100U/ml belonged to Patient 11. One Lantus Solostar 100U/ml and one Novolog 100U/ml belonged to Patient 10. One Lantus Solostar 100U/ml belonged to Patient 12. During an interview on 9/24/2025 at 3:16 p.m., with Registered Nurse 1 (RN1), RN 1 stated the instructions on the insulin injection pens should be worded/labeled correctly and should not indicate refrigeration was needed. RN 1 stated the insulin medication could be ineffective if left in the refrigerator and that licensed staff should have clarified with the pharmacist that the medication label instructions on the insulin injection pens were accurate. During a review of the facility's policy and procedure (P&P) titled, Drug Storage, dated 1/2025, the P&P indicated, "It is the policy of the facility to ensure the proper and safe storage of drugs and biological. "Additional drug storage requirements including proper labeling".	C1890		
C5105	Content of Health Records CFR(s): T22 DIV5 CH3 ART5-72547(a)(4) (a) A facility shall maintain for each patient a health record which shall include: (4) Physician orders, including drugs, treatment and diet orders, progress notes, signed and dated on each visit. Physician's orders shall be correctly recapitulated. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure the patient's monthly physician's order recapitulation report (summarized report) was signed and dated for two of nine sampled patients (Patients 7 and 8). These violations had the potential for Patients 7 and 8 not to receive accurate medication and treatment as ordered and had the potential for medication errors. Findings:	C5105	C5105 Content of Health Records 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: - On 09/24/25, the monthly Physician's Order Recapitulation Reports for Patients #7 and #8 were reviewed, signed, and dated by the physician. 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. - On 9/26/25, the Medical Records Director conducted a facility wide audit to verify all Physician's Order Recapitulation Reports were named, signed and dated - No other residents were affected by this finding.	

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C5105	Continued from page 10 a. During a review of Patient 7's Admission Record (AR), the AR indicated the facility admitted Patient 7 on 5/10/2025 with diagnoses that included diabetes mellitus type 2 (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine) and chronic pain syndrome (a condition characterized by persistent, severe pain that lasts for at least three months). During a review of Patient 7's Minimum Data Set (MDS – a patient assessment tool) dated 6/24/2025, the MDS indicated Patient 7 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Patient 7 required maximum assistance (helper does less than half the effort) with toileting hygiene, shower, lower body dressing and putting on/taking off footwear. During a review of Patient 7's Order Summary Report (OSR) dated 8/1/2025, the OSR did not indicate the name of the physician who approved the orders and the date the physician approved the orders. During a review of Patient 7's OSR dated 9/11/2025, the OSR did not indicate the name of the physician, the signature of the physician who approved the orders and the date the physician approved the orders. During a concurrent interview and record review of Patient 7's OSR on 9/24/2025 at 2:58 pm, with the facility's Director of Nursing (DON), the DON stated, the monthly physician's recapitulated orders on 9/11/2025 was not signed by the approving physician acknowledging the accuracy and completeness of the orders. The DON stated the monthly physician's recapitulated orders on 8/1/2025 was signed but the approving physician's name was not indicated and the OSR was undated. The DON stated the OSR needed to be signed and dated by the approving physician every month to clarify/validate the physician's orders. b. During a review of Patient 8's AR, the AR indicated the facility admitted Patient 8 on 11/23/2024 with diagnoses that included diabetes mellitus type 2 and other symptoms and signs involving cognitive functions and awareness.	C5105	What measures will be put into place or what systemic changes will the facility make to ensure that the identified practice does not recur. - On 10/10/2025, the Director of Nursing (DON) provided an in-service to the Medical Records staff regarding proper completion of the Physician's Order Recapitulation Reports, with emphasis on ensuring all reports are accurately identified, signed, and dated by the physician. - Starting 10/10/25, the Medical Records Director will audit all Physician's Order Recapitulation Reports once a week for 3 months to ensure all reports are accurately identified, signed, and dated by the physician 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 integrated into the quality assurance system. - The Medical Records Director will be reporting the results of the monitoring to the QA committee monthly x 3 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.	

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C5105	Continued from page 11 During a review of Patient 8's MDS dated 8/28/2025, the MDS indicated Patient 8 had severely impaired cognition. The MDS indicated Patient 8 was dependent (helper does all of the effort) with staff for eating, oral hygiene, toileting hygiene, shower, upper body dressing, lower body dressing, putting on and/or taking off footwear and personal hygiene. During a review of Patient 8's OSR dated 8/1/2025 and 9/11/2025, the OSR did not indicate the name of the physician who approved the orders and the date the physician approved the orders. During a concurrent interview and record review of Patient 8's OSR on 9/24/2025 at 2:57 pm, with the DON, the DON stated the monthly physician's recapitulated orders on 8/1/2025 and 9/11/2025 did not indicate the approving physician's name who acknowledged the accuracy and completeness of the orders and the date the physician approved the orders. During a review of the facility's Policy and Procedure (P&P) titled, "Physician Services," revised 1/2025, the P&P indicated, monthly recaps shall be noted by a licensed nursed when the physician signs the recapitulation of orders.	C5105		
C5155	Content of Health Records CFR(s): T22 DIV5 CH3 ART5-72547(a)(5)(F) (a) A facility shall maintain for each patient a health record which shall include: (5) Nurses' notes which shall be signed and dated. Nurses' notes shall include: (F) Medications and treatments administered and recorded as prescribed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure complete and accurate documentation for two of nine sampled patients (Patients 7 and 9) by failing to: a. Ensure Patient 7's target behavior was documented	C5155	C5155 Content of Health Records 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: - On 9/25/25, Patient 7 was reassessed following a reported episode of inconsolable crying possibly related to the current antidepressant medication. - Upon assessment by the RN Supervisor, no further episodes of inconsolable crying were observed.The physician was notified and reviewed the resident's current medications and behavioral patterns for a 3-month look-back period.Gradual Dose Reduction (GDR) was initiated. - On 09/29/2025, a 1:1 in-service training was conducted with the RN responsible for Patient 9's IV therapy regarding accurate documentation practices, including: - Type of IV fluid, rate of infusion per hour, additives, if and signature and title of the person recording the data.	

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C5155	Continued from page 12 for the use of Zoloft (Sertraline, a medication used to treat depression [a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily functioning]) as ordered. b. Ensure Patient 9's Dextrose Sodium Chloride (D5NaCl) Solution 5-0.45 percent (%) was administered and documented as ordered. These failures resulted in incomplete medical records for Patients 7 and 9 and had the potential to negatively affect the patient's care and wellbeing. Based on interview and record review, the facility failed to ensure complete and accurate documentation for two of nine sampled patients (Patients 7 and 9) by failing to: a. Ensure Patient 7's target behavior was documented for the use of Zoloft (Sertraline, a medication used to treat depression [a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily functioning]) as ordered. b. Ensure Patient 9's Dextrose Sodium Chloride (D5NaCl) Solution 5-0.45 percent (%) was administered and documented as ordered. These failures resulted in incomplete medical records for Patients 7 and 9 and had the potential to negatively affect the patient's care and wellbeing. Findings: a. During a review of Patient 7's Admission Record (AR), the AR indicated the facility admitted Patient 7 on 5/10/2025 with diagnoses that included diabetes mellitus type 2 (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine) and chronic pain syndrome (a condition characterized by persistent, severe pain that lasts for at least three months). During a review of Patient 7's Minimum Data Set (MDS – a patient assessment tool) dated 6/24/2025, the MDS indicated Patient 7 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS	C5155	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. - All residents with antidepressant medication are potentially at risk of being affected. - All residents with IV Hydration, IV medication, and Peripheral Lines are potentially at risk of being affected. - On 10/10/25, the Director of Nursing (DON) conducted a comprehensive audit of all residents with an order for antidepressant medication to ensure accuracy and completeness of behavior monitoring documentation. - No other residents were affected by this deficient practice. - On 10/10/25, the Director of Nursing (DON) conducted an audit of all residents with an order for IV Hydration, IV medication, and peripheral lines. The audit emphasized accurate documentation practices, including identification of IV fluid type, infusion rate (mL/hour), additives if applicable, and the signature name and title of recording nurse. - No other residents were affected by this deficient practice. What measures will be put into place or what systemic changes will the facility make to ensure that the identified practice does not recur. - From 10/10/25 to 10/16/25, the Director of nursing (DON) conducted in-service training for licensed nurses on the facility's medication administration policy and procedure, emphasizing the importance accuracy and completeness of behavior monitoring documentation. - From 10/10/2025 to 10/16/2025, the director of nursing (DON) and assistant director of nursing (ADON) conducted in-service training for licensed nurses regarding facility's medication administration policy and procedure, emphasizing accurate documentation practices, including identification of IV fluid type, infusion rate (mL/hour), additives if applicable, and the signature name and title of recording nurse. - Starting 10/16/25, the DON and/or ADON will conduct a random audits 2-3x/week for 3 months audit of residents with an order for antidepressant medication to ensure accuracy and completeness of behavior monitoring documentation.	

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C5155	Continued from page 13 indicated Patient 7 required maximum assistance (helper does less than half the effort) with toileting hygiene, shower, lower body dressing and putting on/taking off footwear. During a review of Patient 7's Order Summary Report (OSR) dated 5/10/2025, the OSR indicated to monitor episodes of depression as evidenced by unconsolable crying while on Zoloft, every shift. During a review of Patient 7's Medication Administration Record (MAR) for the month of September 2025, the MAR indicated monitoring for episodes of depression as evidenced by unconsolable crying while on Zoloft was not documented/checked/signed off as performed on the following dates and shifts: 1. 9/7/2025 to 9/9/2025 for 7 am to 3 pm shift. 2. 9/7/2025 to 9/8/2025 for 3 pm to 11 pm shift. 3. 9/6/2025 to 9/8/2025 for 11 pm to 7 am shift. During a concurrent interview and record review of Patient 7's medical record (chart) on 9/24/2025 at 3:29 pm with facility's Director of Nursing (DON), the DON stated, Patient 7's target behavior was not documented/checked/signed off as performed on the following dates and shifts: 1. 9/7/2025 to 9/9/2025 for 7 am to 3 pm shift. 2. 9/7/2025 to 9/8/2025 for 3 pm to 11 pm shift. 3. 9/6/2025 to 9/8/2025 for 11 pm to 7 am shift. The DON stated target behavior needed to be monitored and documented by the licensed nurses every shift as ordered to determine if the medication (Zoloft) was effective or not. During a review of the facility's policy and procedure (P&P) titled, "Unnecessary Drugs," dated 1/2025, the P&P indicated each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: without adequate monitoring. During a review of the facility's P&P titled, "Unnecessary Drugs," dated 1/2025, the P&P indicated	C5155	- Starting 10/16/25, the DON and/or ADON will conduct a random audits 2-3x/week for 3 months to audit residents with an order for IV Hydration, IV medication and residents with peripheral lines. The audit will emphasize accurate documentation practices, including identification of IV fluid type, infusion rate (mL/hour), additives if applicable, and the signature name and title of recording nurse. - 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. 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 integrated into the quality assurance system. - The DON and/or ADON will be reporting the results of the monitoring to the QA committee monthly x 3 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.	

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C5155	Continued from page 14 for behavior/orientation: documentation of a resident's behavior/orientation should include: F. Signature and title of person recording the data. b. During a review of Patient 9's AR, the AR indicated the facility admitted Patient 9 on 5/22/2025 with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning) and unspecified protein – calorie malnutrition (occurs when a person doesn't eat enough proteins and calories to meet nutritional needs). During a review of Patient 9's MDS dated 9/2/2025, the MDS indicated Patient 9 had severely impaired cognition for daily decision making. The MDS indicated Patient 9 was dependent (helper does all the effort) from staff with toileting hygiene, shower, lower body dressing and putting on/taking off footwear. During a review of Patient 9's OSR dated 9/16/2025, the OSR indicated to administer D5NaCl Solution 5-0.45 % use 500 milliliter (ml, unit of measurement) one time a day for poor PO (by mouth) intake at 50 ml per hour (ml/hr) to continue until resident consumes more than 50 % intake of food. During a review of Patient 9's Intravenous (within a vein) Medication Administration Record (MAR) for the month of September 2025, the IV MAR indicated Dextrose NaCl Solution 5- 0.45% use 500 ml one time a day for poor PO intake at 50 ml/hr. to continue until resident consumes more than 50 % intake of food was not documented/checked/signed off as performed on 9/18/2025, 9/19/2025, and 9/232025. During a concurrent interview and record review of Patient 9's medical record (chart) on 9/24/2025 at 3:50 pm with facility's DON, the DON stated, Patient 9's Dextrose NaCl Solution 5- 0.45% 500 ml one time a day for poor PO intake was not documented/checked/signed off as performed on 9/18/2025, 9/19/2025, and 9/232025. The DON stated, if fluids were not administered as ordered, Patient 9 could develop dehydration (abnormal loss of water from the body), hypoglycemia (a condition where the blood glucose [sugar] levels drop too low) and lethargy (lacking energy and interest or being sluggish and mentally slow).	C5155		

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C5155	Continued from page 15 During a review of the facility's P&P titled, "Unnecessary Drugs," dated 1/2025, the P&P indicated documenting I.V. Therapy should include: specifying the type of fluid, rate of infusion/hour, and additives, if any and signature and title of person recording the data.	C5155		
C5430	Patient Identification CFR(s): T22 DIV5 CH3 ART5-72555 Each patient shall be provided with a wristband identification tag or other means of identification which shall be worn at all times unless the attending physician notes in the health record that the patient's condition would not permit such identification. Minimum information shall include the name of the patient and the name of the facility. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to provide a wristband identification tag or other means of identification which shall be worn at all times for two of three sampled patients (Patients 7 and 8). These violations had the potential for Patients 7 and 8 not to be accurately identified and could negatively affect the care provided to Patients 7 and 8. Findings: a. During a review of Patient 7's Admission Record (AR), the AR indicated the facility admitted Patient 7 on 5/10/2025 with diagnoses that included diabetes mellitus type 2 (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine) and chronic pain syndrome (a condition characterized by persistent, severe pain that lasts for at least three months). During a review of Patient 7's Minimum Data Set (MDS – a patient assessment tool) dated 6/24/2025, the MDS indicated Patient 7 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Patient 7 required maximum assistance (helper does less than half the effort) with toileting hygiene,	C5430	C5430 Patient Identification 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: - On 9/24/25 patients 7 and 8 were immediately provided with wristbands after it was identified that they were without one. 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. - All residents are at risk of being affected. - On 9/26/25, a facility-wide resident identification wristband audit was conducted by the Administrator Assistant. - No other residents were affected by this deficient practice. What measures will be put into place or what systemic changes will the facility make to ensure that the identified practice does not recur. - On 9/24/25, the Admissions Department received in-service training on the proper placement of identification wristbands for all admitted residents, conducted by the Administrator Assistant. - From 10/13/25–10/1525, all staff received in-service training on resident identification wristbands, conducted by the Administrator Assistant. - Starting 10/13/25 the Administrator Assistant will perform random weekly checks of five residents for 3 months using an audit form to ensure proper use of identification wristbands. 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 integrated into the quality assurance system. - The Administrator Assistant will be reporting the results of the monitoring to the QA committee monthly x 3 months for review and recommendations and ensure substantial compliance is sustained.	

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C5430	Continued from page 16 shower, lower body dressing and putting on/taking off footwear. During a concurrent observation and interview on 9/24/2025 at 9:54 am inside Patient 7's room, Patient 7 was awake, lying in bed with no wristband identification tag or any other means of identification. Patient 7 stated "I don't have a name band. It's OK with me to have the identification wristband." During a concurrent observation and interview on 9/24/2025 at 9:58 am inside Patient 7's room, the Director of Staff and Development (DSD) stated, Patient 7 did not have the identification wristband or any other means of identification. The DSD stated Patient 7 needed to wear a wristband to identify the patient especially during medication administration, and in case of an emergency situation. The DSD stated identification wristband should be provided to patients upon admission. b. During a review of Patient 8's AR, the AR indicated the facility admitted Patient 8 on 11/23/2024 with diagnoses that included diabetes mellitus type 2 and other symptoms and signs involving cognitive functions and awareness. During a review of Patient 8's MDS dated 8/28/2025, the MDS indicated Patient 8 had severely impaired cognition. The MDS indicated Patient 8 was dependent (helper does all of the effort) with staff for eating, oral hygiene, toileting hygiene, shower, upper body dressing, lower body dressing, putting on and/or taking off footwear and personal hygiene. During a concurrent observation and interview on 9/24/2025 at 10:03 am inside Patient 8's room together with the DSD, Patient 8 was awake, lying in bed with no wristband identification tag or any other means of identification. The DSD stated Patient 8 did not have any identification wristband or any other means of identification. During an interview on 9/24/2025 at 3:45 pm, with the facility's Director of Nursing (DON), the DON stated all patients needed to have a wristband identification at all times for staff to identify the patient before	C5430	- 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 950000007	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madera Post Acute Center	**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
C5430	Continued from page 17 providing care and treatment. The DON stated, patients needed to have a wristband, especially for patients who were nonverbal or confused that could not identify themselves. The DON stated the identification wristband should include the patient's name and the facility's name. During a review of the facility's Policy and Procedure (P&P) titled, "Admission, Discharge and Transfer," dated 1/2025, the P&P indicated to ensure that a resident is properly identified prior to receiving any medication, treatment, or special service. The P&P indicated the wristband was a means of identification. The P&P indicated wristband or ankle band identification must be worn by the residents at all times.	C5430		