

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/05/2024
NAME OF PROVIDER OR SUPPLIER  Monrovia Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  1220 E. Huntington Drive Duarte, CA 91010	

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)
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>37662</p> <p>Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 5) was free from physical restraints (any manual method, physical or mechanical device, equipment, or material that is attached or adjacent to a resident's body, cannot be easily removed by a resident, and restricts the resident's freedom of movement or access to their body) for use of convenience (the result of any action that has the effect of altering a resident's behavior and requires a lesser amount of care or effort, and is not in a resident's best interest) by failing to ensure Certified Nurse Assistant (CNA) 1 did not tie the bedsheet/fitted sheet to the grab bar and keep Resident 5's arms under the fitted sheet to prevent Resident 5 from moving the resident's arms.</p> <p>This failure violated Resident 5's right and had the potential for Resident 5 to suffer psychosocial (mental, emotional, social, and spiritual effects) harm, and/or physical injury.</p> <p>Findings:</p> <p>During a review of Resident 5's Admission Record (AR), the AR indicated the facility admitted Resident 5 on 2/27/24, with diagnoses of Parkinsonism (brain conditions that cause slowed movements, stiffness, and tremors), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and history of falling.</p> <p>During a review of Resident 5's Admission Minimum Data Set ([MDS] a standardized assessment and care planning tool), dated 3/2/24, the MDS indicated Resident 5 had severely impaired cognition (ability to think and process information). The MDS indicated Resident 5 required substantial/maximal assistance (helper does more than half the effort or helper lifts or holds trunk or limbs and provided more than half the effort) for eating, oral hygiene, and toileting hygiene. The MDS indicated Resident 5 required substantial/maximal assistance for sitting to standing (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed).</p> <p>During a review of Resident 5's Physician's Orders (PO), dated 3/19/24, the PO indicated to monitor Resident 5's episodes of anxiety (a feeling of fear, dread, and uneasiness) m/b (manifested by) periods of restlessness and attempting to pull out foley catheter (a device that drains urine from the urinary bladder into a collection bag outside of the body) and to tally with hashmarks on the MAR (Medication Administration Record) every shift.</p> <p>(continued on next page)</p>

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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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 5's MAR, dated 3/1/24 to 3/31/24, the MAR indicated to monitor Resident 5's episodes of anxiety m/b periods of restlessness and attempting to pull out foley catheter and to tally with hashmarks on the MAR every shift. The MAR indicated Resident 5 did not have any episodes of anxiety m/b periods of restlessness and attempting to pull out foley catheter on 3/30/24 during 7 am to 3 pm, 3 pm to 11 pm, and 11 pm to 7 am shifts.</p> <p>During a review of Resident 5's Progress Notes (PN), dated on 3/30/24 at 12 pm, written by Licensed Vocational Nurse 5 (LVN 5), the PN indicated CNAs and Charge Nurse reported that a fitted sheet was wrapped into the grab bar causing Resident 5 to have limited movement. The PN indicated CNAs removed the fitted sheet from the grab bar immediately.</p> <p>During a review of Resident 5's PN, dated on 3/30/24 at 2:30 pm, written by Registered Nurse 2 (RN 2), the PN indicated RN 2 received report (shift change report when responsibility and accountability for the care of a patient is transferred from one nurse to another) from the charge nurse and assigned CNA that patient (Resident 5) was noted with limited mobility due to a fitted sheet observed to be wrapped around the grab bars.</p> <p>During a review of Resident 5's Care Plan (CP), titled, Alleged abuse (fitted sheet wrapped on the resident's grab bar causing limited movement) dated 3/30/24, the CP indicated the facility staff would anticipate and meet Resident 5's needs and to keep the call light in reach for assistance at all times.</p> <p>During a review of Resident 5's PN, dated on 3/31/24 at 11:49 am, written by RN 2, the PN indicated RN 2 re-assessed (re-evaluates client functioning, health and psychosocial status; identifies changes since the initial or most recent assessment; and determines new or ongoing needs) Resident 5 due to the being found with a fitted sheet wrapped over him and wrapped around the grab bars suspected to limit Resident 5's mobility due to Resident 5's tendency to become restless.</p> <p>During an interview on 4/5/24 at 11:15 am, CNA 2 stated CNA 2 was walking down the hall towards Station 2 to get coffee for her resident. CNA 2 stated CNA 3 called CNA 2 to come into Resident 5's room. CNA 2 stated Resident 5 was awake and sitting upright with Resident 5's legs elevated. CNA 2 stated Resident 5's arms were by Resident 5's side under the fitted sheet. CNA 2 stated the fitted sheet was tied in a knot on Resident 5's right side grab bar. CNA 2 stated the fitted sheet was wrapped up and over Resident 5's left side grab bar. CNA 2 stated the fitted sheet was fitted over the mattress at the foot of Resident 5's bed. CNA 2 stated there were two blankets on top of Resident 5 over the fitted sheet. CNA 2 stated that the blue blanket was a regular blanket and the white one was a lighter blanket. CNA 2 stated CNA 2 told CNA 3 that it should not be like this and to report the situation. CNA 2 stated CNA 3 reported it to RN 1. CNA 2 called for LVN 6 to come into Resident 5's room. CNA 2 stated while LVN 6 was talking to CNA 2, CNA 2 removed the fitted sheet on Resident 5.</p> <p>During a phone interview on 4/5/25 at 12:13 pm, CNA 3 stated CNA 3 found a fitted sheet on top of Resident 5's grab bar with a blue blanket on top. CNA 3 stated the fitted sheet was tied on Resident 5's right grab bar and wrapped in Resident 5's left grab bar. CNA 3 stated the bottom of the fitted sheet was on Resident 5's bed and covered with a blanket. CNA 3 stated CNA 2 released the fitted sheet on Resident 5's right side and went to call LVN 6. CNA 3 stated LVN 6 and RN 2 came into Resident 5's room and checked Resident 5.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/5/24 at 12:30 pm, LVN 6 stated LVN 6 was alerted by CNA 2 to come into Resident 5's room. LVN 6 stated Resident 5 was sitting up in bed. LVN 6 stated Resident 5's arms were underneath a blanket. LVN 6 stated the top of the fitted sheet was tied onto Resident 5's right railing and wrapped around the left railing. LVN 6 stated the sides of the fitted sheet were tucked in and fitted around the bed on all sides. LVN 6 stated it was a fitted sheet and Resident 5 was inside it. LVN 6 stated as LVN 6 was coming into Resident 5's room, CNA 2 was undoing the knot. LVN 6 stated LVN 6 unwrapped the sheet and uncovered Resident 5 so that he had free movement. LVN 6 stated there were two blankets on top of the fitted sheet. LVN 6 stated Resident 5 was covered by the two blankets exposing the tied blankets to the railing. LVN 6 stated once LVN 6 untied the sheet, Resident 5 was able to move Resident 5's arms about. LVN 6 stated Resident 5 could move Resident 5's arms minimally while Resident 5 was wrapped under the fitted sheet. LVN 6 stated Resident 5 was moving under the sheet but there was resistance when Resident 5 moved Resident 5's arms.</p> <p>During a phone interview with CNA 1 on 4/5/24 at 3 pm, CNA 1 stated at around 1:30 am, Resident 5 was awake and trying to pull Resident 5's catheter out. CNA 1 stated CNA 1 informed Resident 5 not to pull the catheter because Resident 5 was going to hurt himself. CNA 1 stated Resident 5 stopped and CNA 1 covered Resident 5 with a blue blanket and Resident 5 calmed down. CNA 1 stated CNA 1 put the blankets around Resident 5's rails around 4 am. CNA 1 stated CNA 1 did it so that Resident 5 would not hurt himself. CNA 1 stated Resident 5 was trying to get up and CNA 1 put the fitted sheet on the mattress as if Resident 5 was being hugged and that Resident 5 stayed calm. CNA 1 stated CNA 1 was not going to tie the fitted sheet but because Resident 5 was trying to get up, CNA 1 tied it. CNA 1 stated it was a busy period between 4 to 6 am because CNA 1 goes to answer call lights. CNA 1 stated CNA 1 went back to Resident 5's room and Resident 5 was asleep and calm and so CNA 1 went to attend to other residents. CNA 1 stated the facility made CNA 1 aware of the allegations and that CNA 1 was suspended immediately. CNA 1 stated when CNA 1 came in-person to speak to the director of staff development (DSD) and the administrator (ADM), DSD, and ADM asked if CNA 1 knew what CNA 1 did was abuse. CNA 1 stated that CNA 1 regretted doing what CNA 1 did and that was not how CNA 1 worked. CNA 1 stated CNA 1 learned to communicate with the charge nurses and to determine if it was safe to do certain interventions for a resident.</p> <p>During a review of the facility's policy and procedure (PP) titled, Abuse Prevention Program, revised on 12/16, the PP indicated the facility's residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The PP indicated this includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The PP indicated the administration would protect their residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual.</p> <p>During a review of the facility's PP titled, Use of Restraints, revised on 12/07, the PP indicated physical restraints were defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>37662</p> <p>Based on observation, interview, and record review, the facility failed to provide a low air loss mattress (LAL mattress, a type of medical mattress designed to reduce pressure on the skin, which helps prevent pressure ulcers ([PU] localized damage to the skin and underlying soft tissue, usually over a bony prominence (areas where bones are close to the surface) or related to a medical or other device, resulting from sustained pressure) as per Physician's Order for one of three sampled residents (Resident 1</p> <p>This deficient practice had the potential for Resident 1's PU to worsen.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), the AR indicated the facility readmitted Resident 1 on 4/2/24, with diagnoses of acute kidney failure (when kidneys suddenly become unable to filter waste products from your blood), pressure ulcer of sacral ([sacrum] a triangular bone at the base of the spine), region, and muscle wasting and atrophy (a weakening, shrinking, and loss of muscle caused by disease or lack of use).</p> <p>During a review of Resident 1's Admission Minimum Data Set ([MDS] a standardized assessment and care planning tool), dated 2/25/24, the MDS indicated Resident 1 had severely impaired cognition (ability to think and process information). The MDS indicated Resident 1 was dependent (helper provided all the effort or the assistance of two or more helpers was required for the resident to complete the activity) for toileting hygiene, showering/bathing, and personal hygiene. The MDS indicated Resident 1 required substantial/maximal assistance for rolling left and right (the ability to roll from lying on back to left and right side and return to lying on back on the bed).</p> <p>During a review of Resident 1's Treatment Administration Record (TAR), dated, 4/1/24-4/30/24, the TAR indicated Resident 1's PU included:</p> <ol style="list-style-type: none"> <li>1. Left buttock (UTD [Unstageable full thickness skin or tissue loss - depth unknown]) PI ([pressure injury] localized damage to the skin and underlying soft tissue, usually over a bony prominence (areas where bones are close to the surface)).</li> <li>2. Sacroccoccyx (A bone formed by fusion of the sacrum and coccyx [tailbone]) DTI ([Deep Tissue Injury] persistent non-blanchable (discoloration of the skin that does not turn white when pressed) deep red, purple or maroon areas of intact skin, non-intact skin or blood-filled blisters caused by damage to the underlying soft tissues).</li> </ol> <p>During a review of Resident 1's Physician Order's, dated 4/4/24, the Physicaion Order's indicated Resident 1 may have LAL mattress for skin maintenance and pressure injury prevention. The Physician's Order indicated to monitor placement and function every shift.</p> <p>During a review of Resident 1's Care Plan titled, readmitted with UTD PI (4/2/2024), dated 4/4/24, the Care Plan indicated the interventions included to provide a LAL mattress for Resident 1.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 4/4/24 at 8:54 am, Resident 1 was laying on Resident 1's left side on a regular mattress.</p> <p>During a concurrent observation and interview on 4/4/24 at 11:05 am, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 1 had a LAL mattress before Resident 1 was discharged . LVN 1 stated Resident 1 had a physician's order for the LAL mattress, but they were waiting for an available LAL mattress.</p> <p>During an interview on 4/4/24 at 1:38 pm with LVN 2, LVN 2 stated Resident 1 was on a regular mattress, but should be on a LAL mattress.</p> <p>During an interview on 4/4/24 at 1:58 pm, LVN 1 stated they did not get the mattress the day before because they were waiting for it to be available. LVN 1 stated they have a storage in the facility for in-house mattresses, but there were all being used. LVN 1 stated they would be getting a LAL mattress later that day. LVN 1 stated she did not communicate Resident 1's physician's order for LAL mattress with the Maintenance Supervisor (MS) because she knew the facility did not have any LAL mattresses. LVN 1 stated the importance of a proper mattress was to ensure skin maintenance and used for wound management. LVN 1 stated LAL mattresses help to offload (minimizing or removing any weight or force that could be applied to the tissue) and alleviate pressure. LVN 1 stated a LAL mattress was a helpful tool for wound management.</p> <p>During an interview on 4/4/24 at 3:10 pm with Registered Nurse 1 (RN 1), RN 1 stated the facility would be getting Resident 1's LAL mattress from an outsource. RN 1 stated the importance of the LAL mattress was for wound healing and so that Resident 1 would not have any further complications.</p> <p>During an observation on 4/4/24 at 3:32 pm, a LAL mattress was being inflated in the adjacent (very near or next to) hallway.</p> <p>During a concurrent observation and interview on 4/5/24 at 8:28 am, Resident 1's LAL mattress was still in the hallway. LVN 3 stated she was not sure why Resident 1 did not have the LAL mattress.</p> <p>During a concurrent observation 4/5/24 at 8:29 am, Resident 1 was laying on Resident 1's right side on a regular mattress. LVN 4 stated Resident 1 was laying on a regular bed. LVN 4 stated if Resident had unstageable or Stage 3 (injury extends through the skin into deeper tissue and fat but does not reach muscle, tendon, or bone) PU, Resident 1 should be on a LAL mattress. LVN 4 stated the importance of Resident 1 being on the correct mattress type was to prevent skin breakdown or any further skin breakdown and for pressure relief for Resident 1. LVN 4 stated Resident 1 should be on a LAL mattress and the facility staff was going to change it right away.</p> <p>During a review of the facility's, Treatment Nurse- LVN Job Description, with a revision date of 09/20, indicated the LVN Treatment Nurse should provide treatment and therapeutic services per physician orders. The LVN Treatment Nurse Job Description indicated the LVN Treatment Nurse should ensure that residents with decubitus ulcers (damage to an area of the skin caused by constant pressure on the area for a long time) received appropriate prophylaxis (prevention) and treatment, such as daily inspection, turning and activity, a well-planned diet, and maintenance of clean, dry bed.</p>		