STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055259	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monrovia Post Acute	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51745 Based on interview and record review, the facility failed to ensure the assessment entries on the Minimum Data Set (MDS- a resident assessment tool) related to active diagnoses was accurately documented to reflect the resident's medical condition for one of nine resident (Resident 2). This failure had the potential to negatively affect Resident 2's plan of care and delivery of necessary care and services. During a review of Resident 2 ' s Admission Record (AR), the AR indicated the facility admitted Resident 2 on 8/19/2024 with diagnoses that included squamous cell carcinoma of skin (a type of cancer that starts as a growth on the skin), acute embolism (an obstacle or blockage in a blood vessel) and thrombosis (the formation of a blood clot inside a blood vessel) of unspecified deep veins of lower extremity (refers to the part of the body that includes the legs and feet) and edema (swelling caused by too much fluid trapped in the body ' s tissues). During a review of Resident 2 ' s MDS dated [DATE] the MDS indicated this was the first assessment since the most recent admission. The MDS indicated Resident 2 had an active diagnosis of cancer. The MDS indicated Resident 2 was cognitively (ability to think, remember, and reason) intact. During a review of Resident 2 ' s History and Physical (H&P) dated 8/20/24, the H&P indicated Resident 2 had a past medical history of squamous cell carcinoma. During a review of Resident 2 ' s General Acute Care Hospital (GACH) H&P Report dated 8/14/2024, the GACH H&P indicated Resident 2 had a past medical history of squamous cell carcinoma of the skin. During an interview on 3/5/2025 at 1:12 pm, with Resident 2, Resident 2 stated she was concerned because medical records from the facility indicated Resident 2 had an active diagnosis of cancer. Resident 2 stated she did not have active cancer but a history of skin cancer. During an interview on 3/6/2025 at 3:02 pm, with Resident 2, Resident 2 stated she was last treated for skin cancer around seven to eight years ago. She stated she asked the Nurse Practitioner (NP-a nurse with advanced clinical training who provides direct patient care) about the active diagnosis of cancer on her MDS and the NP told her she did not have skin cancer. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/6/2025 at 2:35 pm, with the Minimum Data Set Nurse (MDSN) 1, Resident 2 ' s initial MDS dated [DATE], current MDS dated [DATE], and Resident 2 ' s GACH H&P dated 8/14/2024 were reviewed. The initial MDS indicated Resident 2 had active cancer at the time of admission. The current MDS indicated Resident 2 had an active diagnoses of squamous cell carcinoma. The GACH H&P indicated Resident 2 had a past medical history of squamous cell carcinoma. The MDSN 1 stated the facility gets the active diagnoses from the hospital records of the patient upon admission. The MDSN 1 stated when the patient is admitted the supervisor Registered Nurse calls the Doctor to clarify the orders for the patient. The MDSN 1 stated she does not know if Resident 2 has active cancer. The MDSN 1 stated it is important to have the correct information on the MDS so the patient can be treated properly. During an interview on 3/6/2025 at 7:20 pm, with the Director of Nursing (DON), the DON stated when a resident is admitted the diagnoses list from the hospital is used to input the active diagnoses in the MDS. The DON stated Resident 2 had a history of squamous cell carcinoma. The DON stated Resident 2 does not have active cancer. The DON stated the MDS should be accurate so the resident can receive proper care based on the care plan. The DON stated the accuracy of the MDS is important because it is used for monitoring and billing the resident. During a review of the facility ' s Policy and Procedure (P&P) titled, Resident Assessments, (undated), the P&P indicated comprehensive assessments, including the MDS, are completed per federal regulations. The P&P indicated All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information.

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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 0697

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide safe, appropriate pain management for a resident who requires such services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46687

Based on observation, interview, and record review, the facility failed to recognize, assess, and provide effective pain management to two of nine sampled residents (Resident 2 and Resident 3), according to the facility's policies and procedures (P&P) titled, Pain- Clinical Protocol, and Changes in Resident Condition, by failing to:

1. Ensure Resident 2's request to Licensed Vocational Nurse (LVN) 5 to have pain medications of ibuprofen (medication used to treat mild pain rated one to three out of 10) and Tylenol (acetaminophen- pain medication used to treat mild pain rated one to three out of 10) changed from as needed (medication taken when symptoms occur) to scheduled (medication taken at regular intervals) was reported to Resident 2's physician.

2. Ensure LVN 4 accurately documented Resident 3's pain score (pain score indicating level of pain with zero being no pain and 10 being the worst pain) on 3/6/2025 at 1:50 pm when LVN 4 gave Resident 3 Tylenol.

3. Ensure LVN 4 gave the appropriate pain medication to treat Resident 3's pain level of nine out of 10 (severe pain- rated as seven to 10 out of 10 pain) on 3/6/2025 at 1:50 pm, instead of Tylenol.

As a result of these failures, Resident 2's pain was not being treated effectively. Resident 3 was in severe pain from 1:50 pm until 5:45 pm when Resident 3 was given Norco (hydrocodone-acetaminophen- pain medication used to treat moderate to severe pain [five to 10 out of 10 pain]). Resident 3 hid under Resident 3's blankets, was shaking, crying, and stated, I want to die I'm in so much pain. These failures had the potential to cause Resident 2 and Resident 3 psychosocial (mental, emotional, social, and spiritual effects) harm, and cause a decline in health.

Cross Reference: F842

Findings:

a. During a review of Resident 2's Admission Record (AR), the AR indicated the facility admitted Resident 2 on 8/19/2024 with diagnoses that included acute embolism (an obstacle or blockage in a blood vessel) and thrombosis (the formation of a blood clot inside a blood vessel) of unspecified deep veins of lower extremity and edema (swelling caused by too much fluid trapped in the body's tissues).

During a review of Resident 2's untitled Care Plan (CP), initiated 8/20/2024, the CP indicated Resident 2 was at risk for pain related to limited mobility. The CP goals indicated Resident 2 would verbalize adequate relief of pain or ability to cope with incompletely relieved pain. The CP interventions included to administer Tylenol (a drug used to treat pain), lidocaine (provides numbing relief for pain), and ibuprofen (a drug used to treat pain) as ordered, to evaluate the effectiveness of pain intervention including resident satisfaction with results and the impact on functional ability, and to notify physician if interventions are unsuccessful.

(continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 1/13/2025 dated 2/23/2025, the MDS indicated Resident 2 had intact cognition (ability to think, remember, and function). The MDS indicated Resident 2 was receiving as needed pain medications. During a review of Resident 2's Order Summary Report (OSR), active as of 3/6/2025, the OSR indicated Resident 2 had an order for ibuprofen oral tablet 400 mg, give one tablet by mouth every eight hours as needed for breakthrough pain and Tylenol extra strength oral tablet 500 mg, give two tablets by mouth every eight hours as needed for mild pain. During an interview on 3/5/2025 timed at 1:12 pm, with Resident 2, the resident stated prior to being admitted to the facility the resident was receiving Tylenol and ibuprofen on a scheduled basis instead of as needed. Resident 2 stated during that time the resident's pain was better managed. During an interview on 3/6/2025 timed at 3:02 pm, with Resident 2, Resident 2 stated she had asked the staff multiple times to change the pain medication orders from as needed to routinely scheduled but nothing had been done about it. During an interview on 3/6/2025 timed at 4:27 pm, with LVN 5, LVN 5 stated Resident 2 regularly complained of pain and received Tylenol or ibuprofen as needed. LVN 5 stated Resident 2 asked to have the Tylenol and ibuprofen changed from an as needed medication to scheduled and LVN 5 sent a text to the physician with the resident's request. LVN 5 stated this happened at the end of a shift a few months ago (could not remember the date) and did not hear back from the physician before clocking out. LVN 5 stated this communication was not documented in Resident 2's medical record. LVN 5 stated the request was not followed up because LVN 5 had forgotten about it after being off for the weekend. LVN 5 stated it is important to follow up with the resident's request to ensure the resident's needs are being met and pain management is addressed. b. During a review of Resident 3's AR, the AR indicated the facility initially admitted Resident 3 on 4/16/2024, and was readmitted on [DATE] with diagnoses that included type II diabetes mellitus (DM2- A condition that happens because of a problem in the way the body regulates and uses sugar as fuel) with chronic kidney disease (damage to the kidneys so they cannot filter blood the way they should), and hydronephrosis (a condition where urine backs up into the kidneys, causing them to swell, generally caused by infection or obstruction) During a review of Resident 3's untitled CP, initiated 4/17/2024, the CP indicated Resident 3 was at risk for pain related to disease process. The CP goals indicated Resident 3 would verbalize adequate relief of pain or ability to cope with incompletely relieved pain. The CP interventions included to administer analgesia (pain medication) as ordered and to give a half hour before treatment or care, and to monitor/record pain characteristics and as needed: quality, severity, anatomical location, onset, duration, aggravating factors, and relieving factors. During a review of Resident 3's MDS, the MDS indicated Resident 3 had severely impaired cognition (ability to think, remember, and reason). The MDS indicated Resident 3 frequently experienced pain or hurting over the last five days. The MDS indicated Resident 3 experienced seven out of 10 pain over the last five days of the MDS assessment. During a review of Resident 3's OSR, active as of 3/6/2025, the OSR indicated Resident 3 had the following orders: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Norco Oral Tablet 10-325 milligrams (mg- unit of measurement) (hydrocodone-acetaminophen), give one tablet via gastrostomy tube (GT- tube inserted through the belly that brings nutrition directly to the stomach) every eight hours as needed for breakthrough pain (sudden increase in pain that may occur in patients who already have chronic pain from infection, disease, or other conditions) 2. Tylenol oral (mouth) tablet 325 mg (acetaminophen), give 2 tablets via GT every six hours as needed for mild pain (one to three out of 10), not to exceed three grams (g- unit of measurement) per day. During a review of Resident 3's medication administration record (MAR- a report that serves as a legal record of the medications administered to a resident) dated 3/6/2025, the MAR indicated Resident 3 received Norco oral table 10-325 mg, one tablet via GT on 3/6/2025 at 10:07 am for seven out of 10 pain. The MAR indicated LVN 4 administered the Norco. MAR indicated Resident 3 received Tylenol oral tablet 325 mg, two tablets via GT at 1:50 pm for three out of 10 pain. The MAR indicated LVN 4 administered the Tylenol. During a concurrent observation and interview on 3/6/2025, timed at 2:12 pm, with Resident 3, inside Resident 3's room, Resident 3's pain was observed. Resident 3 had blankets covering Resident 3's head. Resident 3 stated Resident 3 was cold, dizzy, and In so much pain. Resident 3 was observed shaking. Resident 3 stated Resident 3's feet hurt, so bad, and was in nine out of 10 pain. Resident 3 stated Resident 3 received pain medication not long before the interview but could not remember what Resident 3 received. Resident 3 stated Resident 3's nurse (LVN 4) did not ask how much pain Resident 3 was in before giving Resident 3 pain medication not long ago. Resident 3 stated, I want to die I'm in so much pain. During a concurrent observation and interview on 3/6/2025, timed at 2:20 pm, with LVN 4, inside of Resident 3's room, Resident 3 was observed. Resident 3 told LVN 4 Resident 3 was in nine out of 10 pain. LVN 4 informed Resident 3 that Resident 3 received Tylenol at 1:50 pm. LVN 4 stated LVN 4 could not give Resident 3 Norco until 6 pm because it was last given at 10 am and could only be given every eight hours. Resident 3 began crying again. During a concurrent interview and record review on 3/6/2025, timed at 4:37 pm, with LVN 4, Resident 3's MAR for 3/2025 was reviewed. LVN 4 stated LVN 4 gave Resident 3 Tylenol at 1:50 pm, without asking Resident 3 how much pain Resident 3 had because Resident 3 could not receive more Norco until 6 pm. LVN 4 stated, Giving something was better than giving nothing. LVN 4 stated LVN 4 should have asked Resident 3's pain score so it could be treated appropriately instead of documenting Resident 3's pain score 3 out 10. LVN 4 stated Resident 3's pain score was nine out of 10. LVN 4 stated LVN 4 should have asked what Resident 3's pain score was and notified Resident 3's primary care provider (PCP). LVN 4 stated Tylenol is not used to treat severe pain, but mild pain. LVN 4 stated not asking Resident 3 what Resident 3's pain score was and documenting a pain score of 3 out 10 incorrect and inaccurate documentation put Resident 3 in more pain than Resident 3 needed to be, resulting in Resident 3's not being managed properly. LVN 4 stated 9 out 10 pain could be considered uncontrolled pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/6/2025, timed at 7:13 pm, with the Director of Nursing (DON), the DON stated (in general) when a resident requests a medication change, the assigned licensed nurse (LN) should notify the physician and document in the progress notes (PN), and was important for continuity of care and ensuring the residents' needs were addressed in a timely manner. The DON stated (in general) LNs were supposed to assess residents' pain score before giving pain medication because staff had to give appropriate medication based on the pain score. The DON stated Tylenol generally treated mild pain rated one to three out of 10. The DON stated it was not appropriate to give Tylenol to treat a pain score of nine out of 10. The DON stated LNs are to document the resident's pain was not controlled and call the physician to get an appropriate order, if there was nothing appropriate to give already. The DON stated it was not okay to document a pain score if a resident's pain level was not assessed. The DON stated residents could be given inappropriate medication to treat their pain and could end up with more or uncontrolled pain. During a review of the facility's P&P titled, Pain- Clinical Protocol, revised 10/2022, the P&P indicated the physician, and staff would identify individuals who have pain or are risk for having pain. The P&P indicated nursing staff would assess each individual for pain upon admission to the facility, at the quarterly review, and whenever there was a significant change of condition, and when there was new onset of new pain or worsening of existing pain. The P&P indicated nursing staff would identify any situations or interventions where an increase in the resident's pain would be anticipated, for example with wound care, ambulation (walking), or repositioning. The P&P indicated pain medications should be selected based on pertinent treatment guidelines. The P&P indicated generally, and to the extent possible, an analgesic regiment should utilize the simplest regimen and lowest risk medications before using more problematic or higher risk approaches. The P&P indicated if the resident's pain was complex or not responding to standard interventions, the attending physician may consider additional consultative support. During a review of the facility's P&P titled, Changes in Resident Condition, dated 11/3/2023, the P&P indicated the resident, attending physician, and legal representative were notified when changes in condition or certain events occur. Communication with the interdisciplinary team (IDT- group of health care professionals with various areas of expertise who work together toward goals of their residents) and caregivers was also important to ensure that consistency and continuity were maintained for the resident's benefit. The P&P indicated changes of condition were communicated from shift to shift through the 24-hour report management system and examples of clinical condition changes included onset of new concern/incident. The P&P indicated to document in the resident's medical record the date and time of the change of condition, who was notified regarding the condition change, information communicated, and response and/or orders received.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 46687 Based on observation, interview, and record review, the facility failed to ensure one of nine sampled Residents (Resident 5) received prescribed (ordered by a physician) medications in accordance with the facility's policy and procedure (P&P) titled, Administering Medications, by failing to: 1. Ensure Licensed Vocational Nurse (LVN) 6 administered Resident 5's medications as ordered for the following medications: a. calcium (medication or mineral in nutritional supplements and multivitamins used to treat or prevent conditions associated with low calcium levels) 600+D3 (fat-soluble vitamin essential for bone health). b. Freshkote (medication used to relieve dry, irritated eyes) ophthalmic (eye) solution. c. glipizide (medication that stimulates the release of insulin from the pancreas [organ that produces insulin- natural substance that is needed to break down sugar in the body] directing your body to store blood sugar helping to lower blood sugar [BS- also known as blood glucose, is the main sugar found in the blood] and restore the way food is used to make energy). d. metoprolol (medication used to treat hypertension [HTN- condition where the force of blood against artery walls is consistently too high and blood pressure [BP- the pressure circulating blood against the walls of blood vessels; abnormal BP was less than 120/80 millimeters of mercury [mmHg- unit of measurement] and above 140/90 mmHg considered high blood pressure] is consistently high]], chest pain and heart failure). e. muro 128 (solution that lowers swelling in eyes by removing extra fluid from the cornea [transparent part of the eye that covers the iris [part of eye that has color] and the pupil [black point of eye] and allows light to enter the inside) ophthalmic solution . As result of this failure, Resident 5 did not received calcium, Freshkate ophthalmic solution, glipizide, metoprolol, and muro 128 ophthalmic solution on time and had the potential for Resident 5 to suffer from high blood sugar, upset stomach, and discomfort to Resident 5's eyes. Findings: During a review of Resident 5's Admission Record (AR), the AR indicated the facility admitted Resident 5 on 10/22/2024 with diagnoses that included type II diabetes mellitus (DM2- A condition that happens because of a problem in the way the body regulates and uses sugar as fuel), hypertensive heart disease without heart failure (chronic changes in the left ventricle and atrium, and coronary arteries as a result of chronic raised blood pressure), and ischemic cardiomyopathy (ICM- condition where the heart muscle is damaged due to reduced blood flow leading to heart failure). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 5's minimum data set (MDS- a resident assessment tool), dated 12/30/2024, the MDS indicated Resident 5 had intact cognition (ability to think, remember, and reason). The MDS indicated Resident 5 had active diagnoses of DM2 and HTN. The MDS indicated Resident 2 was on hypoglycemic medication (drugs used to lower blood sugar levels in individuals with diabetes) and antiplatelet medication (prevent platelets [small, colorless cell fragments in the blood that form clots and stop or prevent bleeding] from clumping together and forming blood clots [clumps of blood that have changed from a liquid to a gel that happens to stop damaged blood vessels from leaking blood, either at the skin or inside the body]). During a review of Resident 5's Order Summary Report (OSR), active as of 3/2025, the OSR indicated the following physician orders: a. calcium oral tablet 600-10 milligram (mg- unit of measurement)-micrograms (mcg- unit of measurement), give one tablet by mouth two times a day for supplement. b. Freshkote Ophthalmic Solution 2.7 percent (%) to 2% (Polyvinyl Alcohol-Povidone), instill one drop in both eyes four times a day for dryness. c. glipizide five mg oral (by mouth), give one tablet by mouth two times a day for DM2 before meals. d. metoprolol tartrate oral tablet, 25 mg, give 0.5 tablet by mouth two times a day for HTN, hold if systolic (top number) is less than 110 or heartrate (HR- heart beat) is less than 60 beats per minute (bpm), give with food/snacks. e. muro 128 ophthalmic solution 2% (sodium chloride [salt water] hypertonic [higher concentration of dissolved substances [solutes] compared to a solution or body fluid, causing water to move out of cells and potentially shrink them]), instill one drop in right eye four times a day for swelling reduction after surgery. During a review of Resident 5's MAR for 3/2025, the The MAR indicated Resident 5's glipizide was due at 4:30 pm. The MAR indicated Resident 5's calcium, Freshkote, metoprolol, and muro 128 were due at 5 pm. During an observation on 3/6/2025, timed at 4:57 pm, LVN 6 was preparing medications for residents other than Resident 5. During a concurrent observation and interview on 3/6/2025, timed at 6:13 pm, at the medication cart outside of Resident 5's room, LVN 6 was preparing Resident 5's medications. LVN 6 stated Resident 5 was going to receive calcium, Freshkote, glipizide, metoprolol, and muro 128. LVN 6 stated glipizide was supposed to given before meals. LVN 6 stated metoprolol was supposed to given with a snack or meal. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/6/2025, timed at 6:20 pm, at the medication cart outside of Resident 5's room, LVN 6 was administering Resident 5's calcium, Freshkote, glipizide, metoprolol, and muro 128 to Resident 5. LVN 6 stated Resident 5 was supposed to receive glipizide at 4:30 pm before meals to help with BS increases. LVN 6 stated Resident 5 had dinner at 5:30 pm. LVN 6 stated taking glipizide one hour after Resident 5's meal could cause Resident 5 to have high BS. LVN 6 stated Resident 5 was supposed to received metoprolol with food or a snack, otherwise the medication absorption could be affected or cause Resident 5 to have a stomachache. LVN 6 stated Freshkote helped with Resident 5's dry eyes and muro 128 helped reduce swelling in the eyes. LVN 6 stated Resident 5 could develop eye dryness or swelling that could cause pain and discomfort because the eye drops were not given on time. LVN 6 stated Resident 5's calcium, Freshkote, glipizide, metoprolol, and muro 128 were due at 5 pm. LVN 6 stated (in general) a resident's medication could be administered one hour before or one hour after the medication due time. During an interview on 3/6/2025, timed at 7:13 pm, with the Director of Nursing (DON), the DON stated licensed nurses (LN) could not give medication on time, there were supposed to ask for help. The DON stated medication should be given to residents in the order they are due, not by room number. The DON stated LNs had one hour before and one hour after the medication due time to administer medications. The DON stated if a medication order indicated to give before meals or with food or snack, the order should be followed. The DON stated glipizide was important to give before meals because it helped regulate BS in residents with DM2. The DON stated if glipizide was given after a meal, a resident's BS may not be controlled, they could become hyperglycemic, which could lead to complications such as headache, dizziness, or even coma (prolonged state of unconsciousness characterized by a lack of responsiveness to the environment). The DON stated if a medication like metoprolol indicated to give with food or a snack, it should be administered as ordered, or it could affect absorption or cause gastrointestinal (stomach) upset. The DON stated not receiving Freshkote or muro 128 on time could lead to eye dryness and swelling, making it very uncomfortable or painful for the resident (Resident 5). During a review of the facility's P&P titled, Administering Medications, revised 4/2019, the P&P indicated medications were administered in a safe and timely manner, and as prescribed. The P&P indicated staffing schedules were arranged to ensure medications were administered without unnecessary interruptions. The P&P indicated medications were administered in accordance with the prescriber orders, including any required time frame. The P&P indicated administration times were determined by need and benefit, not staff convenience with factors considered such as enhancing optimal therapeutic effect of the medication and preventing potential medication or food interactions. The P&P indicated medications were administered with one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monrovia Post Acute	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)

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 46687

Based on interview and record review, the facility failed to ensure accurate documentation on the medication administration record (MAR- a report that serves as a legal record of the medications administered to a resident) for one of nine sampled residents (Resident 3), according to the facility's policy and procedure (P&P) titled, Charting and Documentation, by failing to:

1. Ensure Licensed Vocational Nurse (LVN) 4 accurately documented Resident 3's pain score (pain score indicating level of pain with zero being no pain and 10 being the worst pain) when LVN 4 gave Resident 3 Tylenol (acetaminophen- pain medication used to treat mild pain rated one to three out of 10).

This failure had the potential to negatively affect Resident 3's plan of care and delivery of necessary care and services for uncontrolled pain management.

Cross Reference: F697

Findings:

During a review of Resident 3's Admission Record (AR), the AR indicated the facility admitted Resident 3 on 4/16/2024 and was readmitted on [DATE] with diagnoses that included type II diabetes mellitus (DM2- A condition that happens because of a problem in the way the body regulates and uses sugar as fuel) with chronic kidney disease (damage to the kidneys so they cannot filter blood the way they should), and hydronephrosis (a condition where urine backs up into the kidneys, causing them to swell, generally caused by infection or obstruction)

During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool), dated 1/13/2025, the MDS indicated Resident 3 had severely impaired cognition (ability to think, remember, and reason). The MDS indicated Resident 3 frequently experienced pain or hurting over the last five days. The MDS indicated Resident 3 experienced seven out of 10 pain over the last five days of the MDS assessment.

During a review of Resident 3's medication administration record (MAR- a report that serves as a legal record of the medications administered to a resident) dated 3/6/2025, the MAR indicated Resident 3 received Norco oral table 10-325 mg, one tablet via GT on 3/6/2025 at 10:07 am for seven out of 10 pain. The MAR indicated LVN 4 administered the Norco.

During a review of the same MAR, the MAR indicated Resident 3 received Tylenol oral tablet 325 mg, two tablets via GT at 1:50 pm for three out of 10 pain. The MAR indicated LVN 4 administered the Tylenol.

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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 03/06/2025
NAME OF PROVIDER OR SUPPLIER Monrovia Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1220 E. Huntington Drive Duarte, CA 91010	

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/6/2025, timed at 2:12 pm, with Resident 3, inside Resident 3's room, Resident 3's pain was observed. Resident 3 had blankets covering Resident 3's head. Resident 3 stated Resident 3 was cold, dizzy, and In so much pain. Resident 3 was shaking and stated Resident 3's Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow imprecise movement) symptoms flared when Resident 3 was stressed. Resident 3 stated Resident 3's feet hurt, so bad, and was in nine out of 10 pain. Resident 3 stated Resident 3 received pain medication not long before the interview but could not remember what Resident 3 received. Resident 3 stated Resident 3's nurse (LVN 4) did not ask how much pain Resident 3 was in before giving Resident 3 pain medication not long ago. Resident 3 stated, I want to die I'm in so much pain. During a concurrent observation and interview on 3/6/2025, timed at 2:20 pm, with LVN 4, inside of Resident 3's room, Resident 3 was observed. Resident 3 told LVN 4 Resident 3 was nine out of 10 pain. LVN 4 informed Resident 3 that Resident 3 received Tylenol at 1:50 pm. LVN 4 stated LVN 4 could not give Resident 3 Norco until 6 pm because it was last given at 10 am and could only be given every eight hours. Resident 3 began crying again. During a concurrent interview and record review on 3/6/2025, timed at 4:37 pm, with LVN 4, Resident 3's MAR for 3/2025 was reviewed. LVN 4 stated LVN 4 gave Resident 3 Tylenol at 1:50 pm, without asking Resident 3 how much pain Resident 3 had because Resident 3 could not receive more Norco until 6 pm. LVN 4 stated, Giving something was better than giving nothing. LVN 4 stated LVN 4 should have asked Resident 3 was Resident 3's pain score was so it could be treated appropriately instead of documenting Resident 3's pain score was 3 out 10. LVN 4 stated Resident 3's pain score was nine out of 10. LVN 4 stated LVN 4 should have asked what Resident 3's pain score was and notified Resident 3's primary care provider (PCP). LVN 4 stated Tylenol is not used to treat severe pain, but mild pain. LVN 4 stated not asking Resident 3 what Resident 3's pain score was and documenting a pain score of 3 out 10 incorrect and inaccurate documentation and put Resident 3 in more pain than Resident 3 need to be and could make Resident 3's pain out of control. LVN 4 stated 9 out 10 pain could be considered uncontrolled pain. During an interview on 3/6/2025, timed at 7:13 pm, with the Director of Nursing (DON), the DON stated (in general) licensed nurses (LN) were supposed to assess residents' pain score before giving pain medication because staff had to give appropriate medication based on the pain score. The DON stated Tylenol generally treated mild pain rated one to three out of 10. The DON stated it was not appropriate to give Tylenol to treat nine out of 10 pain. The DON stated LNs should document resident's pain was not controlled and call the physician to get an appropriate order, if there was nothing appropriate to give already. The DON stated it was not okay to document a pain score if a resident's pain level was not assessed. The DON stated residents could be given inappropriate medication to treat their pain and could end up with more or uncontrolled pain. During a review of the facility's P&P titled, Charting and Documentation, revised 7/2017, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes to the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The P&P indicated the medical should facilitate communication between the interdisciplinary team (IDT- group of health care professionals with various areas of expertise who work together toward goals of their residents) regarding the resident's condition and response to care. The P&P indicated documentation in the medical record would be objective (not opinionated or speculative), complete, and accurate.

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 03/06/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687 Based on observation, interview, and record review, the facility failed to follow its policies and procedures titled, Handwashing/Hand Hygiene (procedures that included the use of alcohol-based hand rubs (containing 60%-95% alcohol) and hand washing with soap and water), and Enhanced Barrier Precautions (EBP- set of infection control measures that use personal protective equipment [PPE- equipment worn to minimize exposure to hazards] to reduce the spread of multidrug-resistant organisms [MDRO- organism that is resistant to most antibiotics] by wearing a gown and gloves) by failing to: 1. Ensure Certified Nurse Assistant (CNA) 2 performed hand hygiene before and after providing care to Resident 8. 2. Ensure CNA 3 performed hand hygiene before and after providing care to Resident 10. These failures had the potential to transmit and spread infection from residents to staff that could result in widespread infection in the facility. Findings: a. During a review of Resident 8 ' s Admission Record (AR), the AR indicated the facility admitted initially Resident 8 on 10/12/2021 and was readmitted on [DATE], with diagnoses including chronic kidney disease (damage to the kidneys so they cannot filter blood the way they should) and type II diabetes mellitus (DM2- A condition that happens because of a problem in the way the body regulates and uses sugar as fuel). During a review of Resident 8 ' s Minimum Data Set (MDS- a resident assessment tool) dated 1/21/2025, the MDS indicated Resident 8 had intact cognition (ability to think, remember, and function). The MDS indicated Resident 8 had an infection of the foot and a diabetic foot ulcer (an open sore or wound that develops on the feet of people with diabetes). During an observation on 3/6/2025, timed at 3:23 pm, outside of Resident 8 ' s room, CNA 2 was observed. A sign outside of Resident 8 ' s room to the right of the door indicated EBP, and to perform hand hygiene before entering the room, and upon exiting the room. CNA 2 then walked into Resident 8 ' s room without performing hand hygiene, then checked Resident 8 ' s blood pressure (BP- the pressure circulating blood against the walls of blood vessels; abnormal BP was less than 120/80 mmHg and above140/90 mmHg was considered high blood pressure). CNA 2 exited Resident 8 ' s room without performing hand hygiene. During a concurrent observation and interview on 3/6/2025, timed at 3:28 pm, outside of Resident 8 ' s room, with CNA 2, the EBP sign was observed. CNA 2 stated the sign next to the door indicated everyone entering Resident 8 ' s room and when exiting Resident 8 ' s room had to perform hand hygiene. CNA 2 stated CNA 2 did not have to perform hand hygiene before entering the room or checking Resident 8 ' s BP because Resident 8 was not on EBP. CNA 2 stated hand hygiene was important, so infection was not spread. 44114 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055259	A. Building B. Wing	03/06/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 10 ' s AR, the AR indicated the facility admitted initially 7/26/2022 and was readmitted on [DATE], with the diagnoses including cervical disc degeneration (where the discs in the cervical spine (neck) degenerate and lose their cushioning properties), hypertensive heart disease (a condition where prolonged high blood pressure damages the heart muscle and blood vessels), and hyperlipidemia (a condition characterized by high levels of fats in the blood, including cholesterol and triglycerides). During a review of Resident 10 ' s MDS, dated [DATE], the MDS indicated Resident 10 had intact cognition (ability to think, remember, and function). During an observation on 3/6/2025, timed at 3:30 pm, outside of Resident 10 ' s room, CNA 3 was observed. A sign outside of Resident 10 ' s room to the left of the door indicated EBP, and to perform hand hygiene before entering the room, and upon exiting the room. CNA 3 then entered Resident 10 ' s room without performing hand hygiene. CNA 3 repositioned Resident 10 ' s bedside table closer to the resident and pulled the curtain, CNA 3 exited Resident 10 ' s room without performing hand hygiene. During a concurrent observation and interview on 3/6/2025, timed at 3:31 pm, outside of Resident 10 ' s room, with CNA 3, the EBP sign was observed. CNA 3 stated I should have sanitized my hands for EBP before and after entering Resident 10 ' s room. CNA 3 stated I was in-serviced and did not follow the policy of sanitizing hands to stop the spread of infection. During an interview on 3/6/2025, timed at 7:13 pm, with the Director of Nursing (DON), the DON stated staff were supposed to perform hand hygiene before and after entering a resident ' s room to avoid transmission of organisms. The DON stated if staff were not performing hand hygiene, then they could spread infections and residents would get sick. During a review of the facility ' s policy and Procedure (P&P) titled, Hand Washing/Hand Hygiene, revised October 2023, the P&P indicated, this facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. During a review of the P&P Enhanced Barrier Precautions - F880 Infection Control, undated, the P&P indicated, Enhanced barrier precautions (EBPs) are used to reduce the transmission of multi-drug-resistant organisms (MDROs) to residents. Standard precautions apply to the care of all residents regardless of suspected or confirmed infection or colonization status.