

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 03/20/2025
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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>44027</p> <p>Based on interview and record review, the facility failed for one of four sampled residents (Resident 1) to assist Resident 1 in finding her missing personal belongings.</p> <p>This failure had the potential for Resident 1 to feel unheard and/or disrespected.</p> <p>(Cross Reference F842)</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident 1 on 8/19/2024 with diagnoses including acute embolism (a medical condition where a foreign substance, such as a blood clot, air bubble, or tumor, travels through the bloodstream and blocks a blood vessel) and thrombosis (blood clot) of unspecified deep veins of lower extremities, morbid obesity (excessive amount of body weight), and fall.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 2/23/2025, the MDS indicated Resident 1 had no impairments in cognitive skills (ability to make daily decisions). The MDS indicated Resident 9 required substantial/maximal assistance (helper does more than half the effort) from staff for bathing, lower body dressing, and toileting hygiene.</p> <p>During an interview on 3/20/2025 at 10:08 a.m. with Resident 1, Resident 1 stated Resident 1 was missing two cord holders (device used to strap power cords together). Resident 1 stated Resident 1 reported the missing items to Certified Nursing Assistant (CNA) 1.</p> <p>During an interview on 3/20/2025 at 11:50 a.m. with CNA 1, CNA 1 stated Resident 1 informed CNA 1 that Resident 1 was missing two cord holders. CNA 1 stated CNA 1 did not report Resident 1 ' s missing items to CNA 1 ' s supervisors.</p> <p>During a concurrent interview and record review on 3/20/2025 at 1:45 p.m. with the Director of Nursing (DON), the facility ' s Theft and Loss Report Log, dated January 2025 and February 2025, were reviewed. The Theft and Loss Report Log indicated no theft or loss were reported. The DON stated the log should list any reports of missing items.</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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/20/2025 at 2:55 p.m. with the DON, the DON stated if residents (in general) report missing personal belongings to CNA 's (in general), the CNA should report the missing items to their immediate supervisor who should in turn report to the facility 's social services.</p> <p>During a review of the facility ' s Policy and Procedure (P&P) titled, Personal Property, revised August 2022, the P&P indicated, .Resident belongings are treated with respect by facility staff, regardless of perceived value.</p> <p>Based on interview and record review, the facility failed for one of four sampled residents (Resident 1) to assist Resident 1in finding her missing personal belongings.</p> <p>This failure had the potential for Resident 1 to feel unheard and/or disrespected.</p> <p>(Cross Reference F842)</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident 1 on 8/19/2024 with diagnoses including acute embolism (a medical condition where a foreign substance, such as a blood clot, air bubble, or tumor, travels through the bloodstream and blocks a blood vessel) and thrombosis (blood clot) of unspecified deep veins of lower extremities, morbid obesity (excessive amount of body weight), and fall.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 2/23/2025, the MDS indicated Resident 1 had no impairments in cognitive skills (ability to make daily decisions). The MDS indicated Resident 9 required substantial/maximal assistance (helper does more than half the effort) from staff for bathing, lower body dressing, and toileting hygiene.</p> <p>During an interview on 3/20/2025 at 10:08 a.m. with Resident 1, Resident 1 stated Resident 1 was missing two cord holders (device used to strap power cords together). Resident 1 stated Resident 1 reported the missing items to Certified Nursing Assistant (CNA) 1.</p> <p>During an interview on 3/20/2025 at 11:50 a.m. with CNA 1, CNA 1 stated Resident 1 informed CNA 1 that Resident 1 was missing two cord holders. CNA 1 stated CNA 1 did not report Resident 1's missing items to CNA 1's supervisors.</p> <p>During a concurrent interview and record review on 3/20/2025 at 1:45 p.m. with the Director of Nursing (DON), the facility's Theft and Loss Report Log, dated January 2025 and February 2025, were reviewed. The Theft and Loss Report Log indicated no theft or loss were reported. The DON stated the log should list any reports of missing items.</p> <p>During an interview on 3/20/2025 at 2:55 p.m. with the DON, the DON stated if residents (in general) report missing personal belongings to CNA's (in general), the CNA should report the missing items to their immediate supervisor who should in turn report to the facility's social services.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Personal Property, revised August 2022, the P&P indicated, .Resident belongings are treated with respect by facility staff, regardless of perceived value.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>44027</p> <p>Based on interview and record review, the facility failed to accurately document in one of four sampled residents (Resident 1) medical record the facility staff members who were present at Resident 1 ' s quarterly care conference (also known as a care plan meeting, is a scheduled meeting where staff, residents, and family members discuss the resident's care plan, progress, and any concerns) on 2/27/2025.</p> <p>This failure resulted in Resident 1 ' s medical records to contain inaccurate information.</p> <p>(Cross Reference F557)</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident 1 on 8/19/2024 with diagnoses including acute embolism (a medical condition where a foreign substance, such as a blood clot, air bubble, or tumor, travels through the bloodstream and blocks a blood vessel) and thrombosis (blood clot) of unspecified deep veins of lower extremities, morbid obesity (excessive amount of body weight), and fall.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 2/23/2025, the MDS indicated Resident 1 had no impairments in cognitive skills (ability to make daily decisions). The MDS indicated Resident 9 required substantial/maximal assistance (helper does more than half the effort) from staff for bathing, lower body dressing, and toileting hygiene.</p> <p>During an interview on 3/20/2025 at 10:08 a.m. with Resident 1, Resident 1 stated the facility conducted a care plan meeting with Resident 1 on 2/27/2025 at Resident 1 ' s bedside. Resident 1 stated the facility staff inaccuratly documented on Resident 1 ' s medical record that the activities assistant was present at the care plan meeting.</p> <p>During a concurrent interview and record review on 3/20/2025 at 12:49 p.m. with the Activities Assistant (AA), Resident 1 ' s Multidisciplinary Care Conference, dated 2/27/2025, was reviewed. Resident 1 ' s Multidisciplinary Care Conference indicated the AA attended the quarterly care conference on 2/27/2025. The AA stated the AA did not attend the care conference.</p> <p>During a concurrent interview and record review on 3/20/2025 at 2:00 p.m. with the Director of Nursing (DON), Resident 1 ' s Multidisciplinary Care Conference, dated 2/27/2025, was reviewed. Resident 1 ' s Multidisciplinary Care Conference indicated AA attended the quarterly care conference on 2/27/2025 along with Dietary, the MDS nurse, the Social Worker, and Resident 1. The DON stated it was the DON ' s expectation that the different disciplines meet at the same time to be on the same page.</p> <p>During a review of the facility ' s Policy and Procedure (P&P) titled, Charting and Documentation, revised July 2017, the P&P indicated, Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.</p> <p>(continued on next page)</p>		

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