

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 06/10/2025
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on interview and record review, the facility failed to ensure 1 of 3 sampled resident (Resident 1) was notified of a diagnostic test result that indicated Resident 1 had a mass (a lump) that measured 3.4-centimeter (cm, unit of measurement) on Resident 1's right kidney on 01/29/2025. Additionally, the facility failed to ensure appropriate follow-up was completed by Resident 1's physician (unidentified) to determine whether further interventions were necessary for Resident 1.</p> <p>This failure resulted in a delay in medical treatment and had the potential to result in a physical decline to Resident 1 due to the delayed treatment of a potentially serious medical condition.</p> <p>Findings:</p> <p>During a review of Resident 1's admission Record (AR), the facility initially admitted Resident 1 on 5/8/2023, and readmitted the resident on 10/6/2024 with diagnoses including diabetes mellitus (DM, long-term disease that results in elevated levels of glucose in the blood), and end stage renal disease (ESRD- a medical condition in which a person's kidneys cease functioning on a permanent basis).</p> <p>During a review of Resident 1's History and Physical (H&P), dated 10/7/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Radiology (medical specialty that uses medical imaging to diagnose diseases and guides treatment within the body) Results Report, the report indicated Resident 1 had a retroperitoneal (having to do with the area outside or behind the peritoneum [the tissue that lines the abdominal wall and covers most of the organs in the abdomen]) ultrasound (an imaging test that uses sound waves to create real-time pictures or video of soft tissues inside the body) report dated 1/29/2025, the report's findings indicated a 3.4 cm hypoechoic (not many echoes) oval mass on the upper inner pole of the right kidney. The report indicated a recommendation for a further evaluation by magnetic resonance imaging (MRI, medical imaging technique used in radiology to generate pictures of inside the body) with and without contrast (agents used to highlight specific parts of the soft tissues) or a contrast-enhanced computed tomography scan (CT, a medical imaging technique used to obtain detailed internal images of the body) to differentiate the mass.</p> <p>During a review of the Progress Notes (PN) dated 01/30/2025, the notes indicated Resident 1 was made aware of the ultrasound results and a nephrology (branch of medicine that deals with the study of the kidneys) referral was made.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/3/2025, the MDS indicated Resident 1's cognitive (the ability to think and process information) skills for daily decisions making were intact. The MDS indicated Resident 1 was independent (resident completes the activity by self with no assistance from staff) with activities of daily living (ADL, term used in healthcare that refers to self-care activities).</p> <p>During an interview on 6/10/2025 at 11AM, Resident 1 stated Resident 1 did not know anything was wrong with his kidney until Resident 1 saw the nephrologist (unidentified) in May 2025. Resident 1 stated, the nephrologist told Resident 1 about the mass, and Resident 1 was shocked. Resident 1 stated the delay in communication made Resident 1 experience anxiety and worry about the potential for cancer due to a family history of the disease.</p> <p>During an interview on 6/10/2025 at 3:40 PM, the Nephrology Nurse Practitioner (NNP) stated she was not aware of Resident 1's ultrasound results until Resident 1's appointment on 5/20/2025. The NNP stated the facility faxed Resident 1's results to the NNP the day of the appointment and the facility told the NNP they forgot to fax the results. The NNP stated if the results were sent timely to the NNP, further diagnostic studies could have been initiated sooner.</p> <p>During an interview on 06/10/2025 at 4PM with the Director of Nursing (DON), the DON stated, Licensed Vocational Nurse (LVN) 2 documented LVN 2 informed Resident 1 of the results, but LVN 2 did not indicate in the PNs whether LVN 2 gave Resident 1 a copy of the [test] results. The DON stated there was no follow-up to show whether Resident 1's physician (unidentified) wanted further testing like an MRI. The DON stated there was no documented evidence that indicated Resident 1 understood the significance of the result findings, or whether Resident 1's physician was informed of the recommendation to follow-up with imaging [studies].</p> <p>During a review of the facility's undated policy and procedure (P&P) titled, Lab and Diagnostic Test Results - Clinical, the P&P's protocol indicated:</p> <ol style="list-style-type: none"> 1. When test results are reported to the facility, a nurse will first review the results. 2. A nurse will identify the urgency of communicating with the Attending Physician based on physician request, the seriousness of any abnormality, and the individual's current condition. 3. Staff should document information about when, how, and to whom the information was provided and the response. This should be done in the Progress Notes section of the medical record. 4. If the results include new orders from the physician, the nurse verifies the orders with the resident or family and ensures they are carried out accordingly. 		