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	08/20/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify Resident 1's doctor of Resident 1's refusals of accuchecks (sampling a drop of blood from the finger to determine the blood glucose [sugar] level) and insulin (a hormone that lowers the level of glucose [a type of sugar] or sugar in the blood) injection on 8/3/2025 and 8/4/2025.These failures had the potential to result in Resident 1 to not receive treatment to address Resident 1's risks for hypoglycemia (a condition where the level of glucose in the blood drops below a healthy range) or hyperglycemia (having too much glucose in the blood) which could negatively affect Resident 1's health and wellbeing.(Cross Reference F686 andF755) Findings:During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to facility on 4/16/2024 and readmitted to the facility on [DATE] with diagnoses including Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), dementia (a group of thinking and social symptoms that interferes with daily functioning), and type 2 diabetes mellitus (DM, a chronic condition that affects the way the body processes blood sugar). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 7/15/2025, the MDS indicated Resident 1 was moderately impaired in cognitive skills (ability to make daily decisions). Resident 1 was dependent (helper does all the effort) on staff for bathing, dressing, and toileting, oral, and personal hygiene.During a review of Resident 1's Order Summary Report (OSR), dated 8/18/2025, the OSR indicated a physician order for Resident 1 to receive Insulin Aspart Injection Solution (Insulin as a medication, insulin is any pharmaceutical preparation of the protein hormone insulin that is used to treat high blood glucose) as per a sliding scale (the amount of insulin given is based on Resident 1's blood glucose [sugar] level). The OSR indicated the facility should check Resident 1's blood glucose level, and administer Insulin Aspart if needed, before meals and at bedtime. The OSR also indicated a physician order for Resident 1 to receive Insulin Glargine-yfgn Subcutaneous (injection under the skin) Solution (a long-acting insulin used to treat high blood glucose) 25 units subcutaneously two times a day for DM.During a concurrent interview and record review on 8/14/2025 at 1:56 PM with Registered Nurse (RN) 1, Resident 1's Medication Administration Record (MAR), for August 2025, was reviewed. The MAR indicated Licensed Vocational Nurse (LVN) 1 documented that Resident 1 refused to let LVN 1 check Resident 1's blood sugar with an accucheck on 8/3/2025 at the scheduled times of 4:30 PM and 9 PM. The MAR also indicated Resident 1 refused accuchecks on 8/4/2025 at the scheduled times of 6:30 AM and 11:30 AM. The MAR also indicated Resident 1 refused to receive Resident 1's Insulin Glargine-yfgn Subcutaneous Solution on 8/3/2025 at the scheduled time of 4:30 PM. RN 1 stated if a resident (in general) refused accuchecks, facility staff should attempt two more times and then notify the resident's (in general) doctor of the refusal of treatment. During a phone interview on 8/18/2025 at 9:05 AM with LVN 1, LVN 1 confirmed Resident 1 refused accuchecks on 8/3/2025 at 4:30 PM and 9 PM, and refused Insulin Glargine-yfgn 25 units inject on 8/3/2025 at 4:30 PM. LVN 1 stated LVN 1 did not report Resident 1's refusals of accuchecks and insulin to Resident 1's doctor. During a phone interview on 8/19/2025 at 10:51 AM with Resident 1's Medical Doctor (MD) 1, MD 1 stated MD 1 was not notified about Resident 1's refusal of accucheck on 8/3/2025 at 4:30 PM and 9 PM, and insulin injection on 8/3/2025 at 4:30 PM. During a phone interview on 8/19/2025 at 1:11 PM with Resident 1's Patient Care Coordinator (PCC) 2 from Resident 1's primary medical doctor's (MD 2) office, PCC 2 stated MD 2 was not notified about Resident 1's refusal of accucheck and refusals of Resident 1's scheduled insulin injection on 8/3/2025 and 8/4/2025. During a review of the facility's Policy and Procedure (P&P) titled, Change in a Resident's Condition or Status revised 2/2021, the P&P indicated, .The nurse will notify the resident's attending physician or physician on call when there has been a(an).refusal of treatment or medications two (2) or more consecutive times.

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	08/20/2025

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report an allegation of abuse for one of two sampled residents (Resident 8) to the California Department of Public Health (the Department), the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities), and to the local law enforcement, within two hours, in accordance with the facility's policy and procedure (P&P), titled Abuse Investigation and Reporting, dated 7/2017.This failure resulted in the delay of notification to the Department and had the potential to result in Resident 8 to be subjected to abuse while at the facilityFindings:During a review of Resident 8's admission Record, the admission Record indicated the facility originally admitted Resident 8 on 7/5/2025, and readmitted the resident on 8/15/2025 with diagnosis that included type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic pulmonary edema (a long-term condition where fluid accumulates in the lungs), and toxic encephalopathy (a brain disorder caused by exposure to poisonous substances, leading to symptoms such as confusion, memory loss, and changes in personality).During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated 7/12/2025, the MDS indicated Resident 8 was mild impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 8 required substantial/maximal assistance (helper does more than half the effort to lift or hold trunk or limbs and provides more than half the effort) for toileting hygiene, shower/bathe self, upper and lower body dressing, and putting on/taking off footwear. Resident 8 required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for personal hygiene.During a review of Resident 8's Progress Notes (PN), dated 8/17/2025, the PN indicated the Social Service Director (SSD) interviewed Resident 8, and Resident 8 stated a CNA wearing green scrubs (CNA 2) told Resident 8 to shut up and hit Resident 8 on the mouth during 8/15/2025 night shift (from 8/15/2025 at 11 p.m. to 8/16/2025 at 7 a.m.). During a phone interview on 8/18/2025 at 1:55 PM with CNA 2, CNA 2 stated CNA 2 did not report when Resident 8 told CNA 2 You are hitting me during 8/15/2025 night shift when CNA 2 was providing care to Resident 8. CNA 2 stated CNA 2 should report to charge nurse, administrator, local law enforcement immediately when an allegation of abuse was made by residents.During an interview on 8/18/2025 at 3:52 PM with the DON, the DON stated the staff should report to California Department of Public Health (CDPH), local law enforcement, and ombudsman within two hours when a resident say's, You tried to hit me.During an interview on 8/19/2025 at 3:35 PM with the Administrator, the Administrator stated, the Administrator, did not receive an allegation of abuse report from CNA 2 during 8/15/2025 night shift (11pm to 7am).During a review of the facility's policy and procedure (P&P) titled, Abuse Investigation and Reporting, dated 7/2017, the P&P indicated, An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than:a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; ort. Twenty-four (24) hours, if the alleged violation does not involve abuse AND has not resulted in serious bodily injury.

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	08/20/2025

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. (continued on next page)

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	055259	A. Building B. Wing	08/20/2025

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide treatment and services to improve one of three (3) resident's (Resident 10) ability to carry out activities of daily living (ADL, basic activities such as eating, dressing, toileting) by failing to offer and assist Resident 10 out of bed into a chair for meals as ordered by the physician. This deficient practice placed Resident 10 at risk for a functional decline in physical functioning and mobility, decreased quality of life, pressure sore (injuries to the skin and underlying tissue resulting from prolonged pressure on the skin) development, and feelings of low self-esteem and self-worth. Findings: During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was admitted to the facility on [DATE] with diagnoses including right-sided hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following a cerebral infarction (blockage of the flow of blood brain, causing or resulting in brain tissue death), aphasia (loss of ability to understand or express speech, caused by brain damage), osteoarthritis (loss of protective cartilage that cushions the ends of your bones) of the left hip and knee, and dysphagia (difficulty swallowing). During a review of Resident 10's History & Physical (H&P), dated 10/28/2024, the H&P indicated the plan for Resident 10's care included assistance with ADLs as needed with the goal of keeping Resident 10 as independent as possible. During a review of Resident 10's Order Summary Report, the Order Summary Report indicated a physician's order, dated 7/30/2025, to assist Resident 10 out of bed to a chair with meals, 3 times a day. During a review of Resident 10's Minimum Data Set (MDS, a resident assessment tool), dated 8/1/2025, the MDS indicated Resident 10 had moderate cognitive (mental action or process of acquiring knowledge and understanding) impairment for daily decision making and had unclear speech. The MDS indicated Resident 10 required set up/clean up assistance (helper sets up or cleans up) for eating, supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity) for oral hygiene, and was dependent (helper does all the effort) for toileting hygiene, bathing, dressing, personal hygiene, rolling to both sides, and standing. The MDS indicated Resident 10 had functional limitations in range of motion (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one leg (hip, knee, ankle, foot). During an interview and observation on 8/19/2025 at 12:39 pm, while in Resident 10's room, Resident 10 was lying in bed with the head of the bed elevated eating lunch. Resident 10 was non-verbal and communicated by nodding (yes) and shaking head (no) when asked questions. Resident 10 nodded firmly when asked if he wanted to get out of bed into a chair for lunch. Resident 10 shook his head when asked if staff offered to assist him out of bed into a chair for lunch. During an interview on 8/19/2025 at 12:45 pm, Certified Nursing Assistant 3 (CNA 1) stated she set up Resident 10's food tray in bed and did not offer to assist Resident 1 into a chair for lunch. CNA 3 stated she was aware she was supposed to offer and assist Resident 10 into a chair for all meals but did not offer Resident 10 assistance today because Resident 10 usually refused due to pain in the left hip and left knee. CNA 1 stated it was important to offer and assist residents out of bed and into a chair for meals to prevent the residents from becoming weaker. During an interview and record review on 8/19/2025 at 1 pm, Registered Nurse 3 (RN 3) reviewed Resident 10's physician's orders and confirmed Resident 10 had a physician's order for staff to assist Resident 10 into a chair for meals, three times a day. RN 3 stated Resident 10 rarely got out of bed and confirmed he had not seen Resident 10 get out of bed for meals for a long time. RN 3 stated staff was to offer assistance and help Resident 10 out of bed to chair for all meals, three times a day, as ordered by the physician. RN 3 stated it was important for staff to assist Resident 10 out of bed into a chair for meals because it helped prevent deconditioning and improved Resident 10's abilities to socialize, participate in ADLs, and helped prevent pressure sores (injuries to the skin and underlying tissue resulting from prolonged pressure on the skin). During an interview on 8/20/2025 at 3:51 pm, the Director of Nursing (DON) stated staff should always offer to assist and help residents out of bed into a chair for meals as ordered by the physician. The DON stated staff must always offer to assist a resident out of bed to chair for meals if ordered by the physician and if appropriate for out of bed activities despite history of refusals. The DON stated it was important staff assisted residents to a chair for meals because it was an optimal positioning for eating, improved mobility, and improved a resident's level of independence. During a review of the facility's undated Policy and Procedure (P/P) titled Activities of Daily Living (ADLs), Supporting, the P/P indicated residents were provided with care

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	08/20/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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	08/20/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 10) received treatment and care in accordance with professional standards of practice by failing to ensure Resident 10's Orthopedic (specialty area in medicine referring to the management of the muscles, bones, and their connective structures) consultation recommendations were implemented. This deficient practice resulted in a delay of care and had the potential for worsening pain and swelling in Resident 10's left hip and left knee and a decline in Resident 10's mobility, range of motion (ROM, full movement potential of a joint), physical comfort and psychosocial well-being. Findings: During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was admitted to the facility on [DATE] with diagnoses including right-sided hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following a cerebral infarction (blockage of the flow of blood brain, causing or resulting in brain tissue death), aphasia (loss of ability to understand or express speech, caused by brain damage), and osteoarthritis (loss of protective cartilage that cushions the ends of your bones) of the left hip and knee. During a review of Resident 10's Order Summary Report, the Order Summary Report indicated a physician's order, dated 12/10/2024, to consult Orthopedics for Resident 10's left hip and left knee pain. During a review of Resident 10's Orthopedic Consultation Office Visit Note (Ortho note), dated 3/20/2025, the Ortho note indicated Resident 10 was diagnosed with severe hip and knee osteoarthritis. The Ortho note indicated physician recommendations for Resident 10 to receive cortisone injections (medication used to reduce pain and inflammation in a certain area of the body) to the left hip and left knee with interventional radiology (IR, medical specialty using imaging techniques to guide minimally invasive procedures for the diagnosis and treatment of various medical conditions), continued pain management and Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) at the facility. During a review of Resident 10's Progress Notes, dated 3/20/2025, the Progress Notes indicated Resident 10 went to an Orthopedic follow appointment and received a recommendation for a cortisone injections to Resident 10's left hip and left knee with IR and required insurance authorization. During a review of Resident 10's Order Summary Report, the Order Summary Report indicated a physician's order, dated 3/20/2025, for a cortisone injection and lidocaine (medication used to relieve pain) to Resident 10's left hip and left knee with IR. During a review of Resident 10's Minimum Data Set (MDS, a resident assessment tool), dated 8/1/2025, the MDS indicated Resident 10 had moderate cognitive (mental action or process of acquiring knowledge and understanding) impairment for daily decision making and had unclear speech. The MDS indicated Resident 10 required set up/clean up assistance (helper sets up or cleans up) for eating, supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity) for oral hygiene, and was dependent (helper does all the effort) for toileting hygiene, bathing, dressing, personal hygiene, rolling to both sides, and standing. The MDS indicated Resident 10 had functional limitations in range of motion (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one leg (hip, knee, ankle, foot). During a concurrent telephone interview and record review on 8/19/2025 at 3:03 pm, Medical Assistant 1 (MA 1) at Resident 10's Orthopedic office reviewed Resident 10's clinical record. MA 1 confirmed the Orthopedic physician recommended Resident 10 receive cortisone injections to the left hip and left knee, continued pain management, and PT while in the facility. MA 1 confirmed Resident 10 had not yet received the left hip and left knee cortisone injections and no appointment had been scheduled. MA 1 stated it was the facility's responsibility to follow up with the recommendation and schedule an appointment for Resident 10 to receive the left hip and left hip cortisone injections when ready. During a concurrent interview and record review on 8/20/2025 at 9:31 am, Physical Therapist 1 (PT 1) reviewed Resident 10's clinical record. PT 1 confirmed Resident 10 was discharged from PT services on 11/7/2024 and had not received any PT evaluation orders since then. PT 1 stated Resident 10 would benefit from PT services if recommended by the physician and if Resident 10 was agreeable to participate in PT. During a concurrent interview and record review on 8/20/2025 at 11:53 am, Registered Nurse 3 (RN 3) stated the charge nurse or RN supervisor was responsible for accepting a resident's paperwork, implementing new physician orders and recommendations received, and scheduling any follow up appointments when a resident returned to the facility from a consultation appointment. RN 3 reviewed Resident 10's Ortho note, dated 3/20/2025, and

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	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document a weekly skin check for one of two sampled residents (Resident 1) from 7/5 - 7/18/2025.This failure had the potential for Resident 1's skin wounds to get worse and to not receive timely treatment for the worsening skin wounds.(Cross Reference F580 and F755) Findings:During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), dementia (a group of thinking and social symptoms that interferes with daily functioning), and type 2 diabetes mellitus (DM, a chronic condition that affects the way the body processes blood sugar). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 7/15/2025, the MDS indicated Resident 1 was moderately impaired in cognitive skills (ability to make daily decisions). Resident 1 was dependent (helper does all the effort) on staff for bathing, dressing, and toileting, oral, and personal hygiene. During a review of Resident 1's Progress Notes (PN), dated 8/19/2025, the PN indicated facility staff failed to document an assessment of Resident 1's skin wounds from 7/5/2025 to 7/18/2025. During a concurrent interview and record review on 8/14/2025, at 2:29 PM with the Treatment Nurse (TN), Resident 1's medical record was reviewed Resident 1's medical record failed to indicate a Weekly Wound Note was documented from 7/5/2025 - 7/18/2025. The TN confirmed Resident 1 was readmitted to the facility on [DATE] with multiple pressure injuries and Moisture-Associated Skin Damage (MASD, a condition where prolonged exposure to moisture, such as urine, sweat, or wound exudate, leads to skin breakdown and irritation) to Resident 1's buttock. The TN stated the TN was responsible for completing a weekly wound note for Resident 1. The TN stated the TN missed documenting Resident 1's weekly wound note. The TN stated the purpose of the weekly wound note was to track the progress or decline of Resident 1's skin conditions. During a review of the facility's undated, policy and procedure (P&P) titled, Wound Prevention, the P&P indicated, .Weekly skin checks will be conducted by the licensed nurse. This will be documented in the resident's Electronic Medical Record (EMR).

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	08/20/2025

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Monrovia Post Acute	1220 E. Huntington Drive Duarte, CA 91010

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of two sampled resident's (Resident 1) supply of Morphine Sulfate (a medication used to treat pain) was restocked and readily available when the resident needed it. This failure had the potential to result in Resident 1 to experience unrelieved pain.(Cross Reference F580 and F685)Findings:During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to facility on 4/16/2024 and readmitted to the facility on [DATE] with diagnoses including Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), dementia (a group of thinking and social symptoms that interferes with daily functioning), and type 2 diabetes mellitus (DM, a chronic condition that affects the way the body processes blood sugar). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 7/15/2025, the MDS indicated Resident 1 was moderately impaired in cognitive skills (ability to make daily decisions). Resident 1 was dependent (helper does all the effort) on staff for bathing, dressing, and toileting, oral, and personal hygiene. During a review of Resident 1's Order Summary Report (OSR) dated 8/18/2024, the OSR indicated Resident 1 had a medication order for Morphine Sulfate (a medication used to treat pain) Oral Tablet 15 milligram (MG, a unit of measurement) Give 1 tablet by mouth every 12 hours for pain management. The medication order started on 7/4/2025.During a concurrent interview and record review on 8/18/2025 at 11 AM with The Director of Nursing (DON), Resident 1's Medication Administration Record (MAR), for August 2025, was reviewed. The MAR indicated Resident 1 did not receive Resident 1's ordered Morphine Sulfate 15 MG on 8/3/2025 at 6 AM and 6 PM and on 8/4/2025 at 6 AM. The DON confirmed Resident 1 was on Morphine Sulfate for pain management. The DON confirmed Resident 1's Morphine Sulfate supply ran out on 8/2/2025 and that Resident 1 missed her 2 doses on 8/3/2025 and one dose on 8/4/2025. The DON stated the medication ran out because Resident 1's ordering physician had not signed for the morphine.During a telephone interview on 8/18/2025 at 11:20 AM with the facility's contracted Pharmacist (Pharm), the Pharm stated the refill request for Resident 1's Morphine Sulfate 15 mg was not refilled until 8/4/2025. The Pharm stated the pharmacy did not start the process to refill the request for refill until 8/3/2025. The Pharm stated the refill request for Resident 1's Morphine Sulfate should have been refilled two days prior to the supply running out at the facility. During a review of the facility's Policy and Procedure (P&P) titled, Medication Orders and Receipt Record, revised April 2007, the P&P indicated, .Medications should be ordered in advance, based on the dispensing pharmacy's required lead time. During a review of the facility's undated P&P titled, Transmitting Medication Orders the P&P indicated, .Reorder these medications when a three to five-day supply remains in the medication storage.Federal Schedule II controlled substances:a. Inform the pharmacy when a five-day supply remains in the medication storage. There is no authorized automatic refill available for scheduled II controlled substancesb. Upon nurses reorder request, the Pharmacy then is required by law to communicate and obtain a prescription from the physician before any new or reordered Schedule II medication may be dispensed.c. Therefore it is imperative that the facility reorder these medications at least 5 days ahead of running out of medication.d. Nurse must call and speak to a pharmacist if a reorder is urgently needed to expedite the process.

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	08/20/2025

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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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. (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	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monrovia Post Acute	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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a Speech Therapy (ST, profession aimed in the prevention, assessment, and treatment of speech, language, communicative, and swallowing disorders) evaluation in accordance with the physician's orders for one of three sampled residents (Resident 10) who had swallowing, communication, and cognitive (mental action or process of acquiring knowledge and understanding) concerns.This deficient practice prevented Resident 10 from receiving ST services to potentially improve swallowing, cognitive, and communication abilities and maintain or achieve the highest practicable level of function. Findings: During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was admitted to the facility on [DATE] with diagnoses including right-sided hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following a cerebral infarction (blockage of the flow of blood brain, causing or resulting in brain tissue death), aphasia (loss of ability to understand or express speech, caused by brain damage), and dysphagia (difficulty swallowing). During a review of Resident 10's physician's orders, dated 5/1/2025, the physician's orders indicated two ST evaluation orders: 1) ST to evaluate Resident 10 and 2) ST to evaluate Resident 10 due to Resident 10 refusing chopped food. During a review of Resident 10's physician's orders, dated 7/29/2025, the physician's order indicated Resident 10's diet was for soft and bite sized food. During a review of Resident 10's Minimum Data Set (MDS, a resident assessment tool), dated 8/1/2025, the MDS indicated Resident 10 had moderate cognitive (mental action or process of acquiring knowledge and understanding) impairment for daily decision making. The MDS indicated Resident 10 had unclear speech and was usually able to express ideas and wants and was usually able to understand others. The MDS indicated Resident 10 required set up/clean up assistance (helper sets up or cleans up) for eating, supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity) for oral hygiene, and was dependent (helper does all the effort) for toileting hygiene, bathing, dressing, personal hygiene, rolling to both sides, and standing. During a concurrent observation and interview on 8/19/2025 at 10:47 am, Resident 10 was lying in bed. Resident 10 was non-verbal and responded yes by nodding head and no by shaking head side to side. Resident 10 appeared to be frustrated when trying to communicate, picked up his personal mobile phone, and gestured to speak with his family member because he was having difficulty answering questions. During a concurrent observation and interview on 8/20/2025 at 10:17 am, Resident 10 was lying in bed. Resident 10 tried texting and typing on his personal mobile phone to communicate but could not. Resident 10 nodded when asked if he was having a difficult time communicating. During an interview and record review on 8/20/2025 at 10:50 am, the interim Director of Rehabilitation (IDOR) reviewed Resident 10's clinical record and confirmed ST did not evaluate Resident 10 as ordered by the physician on or around 5/1/2025. During a telephone interview on 8/20/2025 at 1:10 pm, Speech Therapist 1 (ST 1) stated ST evaluated and treated residents per physician's orders with swallowing, communication, and cognitive disorders. ST 1 stated ST did not always provide ST evaluations when ordered by the physician. ST 1 stated she typically completed an initial therapy screen of the resident, which was a limited, hands off (therapist does not physically touch or formally assess a resident) screen that consisted primarily of a comprehensive (inclusive, including everything necessary) review of the resident's clinical records and interviews with the resident and staff to determine if a formal, skilled rehab evaluation was warranted. ST 1 stated ST only completed a ST evaluation if the resident had a history of a stroke, was on a modified diet (meal plan that is altered in either texture or nutritional content to meet specific needs or health conditions), and/or findings from the screen indicated a need for a formal evaluation despite physician's orders for a formal ST evaluation. ST 1 stated the ST evaluation was a comprehensive assessment of the resident's ST needs which included a physical, hands-on assessment of eating and trialing different food textures, speech, language, and cognition. ST 1 stated a therapy screen and an ST evaluation were different. ST 1 stated it was important residents received ST evaluations per physician's orders to ensure the resident's needs and concerns were met and properly addressed. During an interview and record review on 8/20/2025 at 3:51 pm, the Director of Nursing (DON) stated the facility provided rehabilitation services which included PT, OT, and ST per physician's orders. The DON stated she reviewed Resident 10's clinical record with the Medical Records Department and confirmed they were unable to locate any ST evaluations as ordered by the physician on or around 5/1/2025. The DON stated ST

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	055259	A. Building B. Wing	08/20/2025

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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 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. (continued on next page)

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medical records for one of three sampled residents (Resident 10) were readily accessible by failing to ensure Resident 10's Orthopedic (specialty area in medicine referring to the management of the muscles, bones, and their connective structures) consultation note, dated 3/20/2025, was readily accessible. This deficient practice had the potential to delay and negatively affect the delivery of necessary care and services. Findings: During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was admitted to the facility on [DATE] with diagnoses including right-sided hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following a cerebral infarction (blockage of the flow of blood brain, causing or resulting in brain tissue death), aphasia (loss of ability to understand or express speech, caused by brain damage), and osteoarthritis (loss of protective cartilage that cushions the ends of your bones) of the left hip and knee. During a review of Resident 10's Order Summary Report, the Order Summary Report indicated a physician's order, dated 12/10/2024, to consult Orthopedics for Resident 10's left hip and left knee pain. During a review of Resident 10's Progress Notes, dated 3/20/2025, the Progress Notes indicated Resident 10 went to an Orthopedic follow up appointment and received a recommendation for a cortisone injection to Resident 10's left hip and left knee and required insurance authorization. During a review of Resident 10's electronic medical records, there were no Orthopedic Consultation Notes from 3/20/2025. During a review of Resident 10's Minimum Data Set (MDS, a resident assessment tool), dated 8/1/2025, the MDS indicated Resident 10 had moderate cognitive (mental action or process of acquiring knowledge and understanding) impairment for daily decision making and had unclear speech. The MDS indicated Resident 10 required set up/clean up assistance (helper sets up or cleans up) for eating, supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity) for oral hygiene, and was dependent (helper does all the effort) for toileting hygiene, bathing, dressing, personal hygiene, rolling to both sides, and standing. The MDS indicated Resident 10 had functional limitations in range of motion (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one leg (hip, knee, ankle, foot). During a concurrent interview and record review on 8/19/2025 at 1 pm, Registered Nurse 3 (RN 3) stated the facility was transitioning to paperless charting and all medical records were stored electronically. RN 3 stated all consultation notes should be in the electronic medical record under the miscellaneous tab. RN 3 reviewed Resident 10's electronic medical records and confirmed he was unable to find Resident 10's Orthopedic note, dated 3/20/2025. RN 3 stated he did not know what the Orthopedic follow up recommendation for Resident 10's left hip and left knee because he was unable to find the most current Orthopedic note, dated 3/20/2025. RN 3 stated medical records should be readily accessible to ensure staff was aware of a resident's plan of care. During an interview on 8/19/2025 at 2:06 pm, the Director of Nursing (DON) stated the facility was transitioning to paperless medical charting and all medical records were stored electronically. The DON stated she was unable to find Resident 10's Orthopedic note, dated 3/20/2025. The DON stated the Medical Records Department was unable to locate Resident 10's Orthopedic notes and called the Orthopedic clinic to fax Resident 10's office visit notes to the facility since they were unable to find them. During a follow up interview on 8/20/2025 at 3:51 pm, the DON stated all medical records should be readily accessible to all staff to ensure all recommendations were implemented and staff was aware of a resident's plan of care. The DON stated inaccessible medical records could result in a delay in a resident's care and missed interventions. During a review of the facility's P/P titled Location and Storage of Medical Records, revised 12/2006, the P/P indicated the facility must protect and safeguard all medical records. The P/P indicated all current medical records were filed in the Medical Records Department and maintained by the Medical Records Clerk.