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	10/27/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each 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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accommodate the needs four of four sampled residents (Residents 1, 2, 3, and 4) in accordance with the facility's Policy and Procedure (P&P) by failing to ensure the call light (a device used by residents to signal his or her needs for assistance) was functioning during the power outage for 11 hours from 10/16/2025 at 9:30 PM to 10/17/2025 at 8:30 AM.These deficient practices had the potential for Residents 1, 2, 3, and 4 who were assessed as high risk of falls to not be able to call the facility staff for help or assistance and placed the residents at risk for harm/injury.Findings: 1. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to facility on 8/19/2024 with diagnoses including morbid obesity (severe obesity- a serious health condition that results from an abnormally high body mass) and history of falling. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 8/23/2025, the MDS indicated Resident 1's cognitive skills (ability to make daily decisions) was intact. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with lower body dressing, toileting hygiene and shower/bathing self. The MDS indicated Resident 1 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating, oral hygiene, and personal hygiene. During a review of Resident 1's Care Plan (CP) related to risk for falls revised 9/5/2025, the CP indicated facility staff should ensure Resident 1's call light was within reach and encourage the resident to use it for assistance as needed. During an interview on 10/22/2025 at 3:26 PM with Resident 1, Resident 1 stated the call light system was not working from 10/16/2025 after 9:30 PM to 10/17/2025 at 8:30 AM during the power outage in the facility. Resident 1 stated Resident 1 did not get any call bell to ring for help and had to yell for help when Resident 1 needed assistance. 2. During a review of Resident 2's AR, the AR indicated Resident 2 was admitted to facility on 10/25/2024 with diagnoses including hemiplegia (partial or total paralysis on one side of body) and hemiparesis (weakness on one side of the body), left hip and knee osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and epilepsy (a long-term disease that causes repeated seizures). During a review of Resident 2's History and Physical (HP) dated 10/28/2024, the HP indicated Resident 2 was alert and oriented. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 was dependent on (helper does all the effort) with toileting hygiene and shower/bathing self, upper and lower body dressing, and personal hygiene. The MDS indicated Resident 2 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral hygiene. During a review of Resident 2's CP related to risk for falls, revised 8/14/2025, the CP indicated facility staff should ensure the call light was within reach and for Resident 2 to get prompt response to all requests for assistance. During an interview on 10/22/2025 at 3:15 PM with Resident 2, Resident 2 stated the call light system was not working during the night the power in the facility was off, Resident 2 stated Resident 2 did not receive any call bell or device to request assistance if needed. 3. During a review of Resident 3's AR, the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including cerebral palsy (a group of conditions that affect movement and posture), hypertension (high blood pressure), and epilepsy. During a review of Resident 3's CP related to risk for falls, revised 5/21/2025, the CP indicated facility staff should ensure Resident 3's call light was within reach and for Resident 3 to get prompt response to all requests for assistance. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3's cognitive skills were intact. The MDS indicated Resident 3 was dependent on toileting hygiene and shower/bathe self and putting on/taking off footwear. The MDS indicated that Resident 3 required substantial/maximal assistance with personal hygiene and lower body dressing. During an interview on 10/22/2025 at 3:02 PM with Resident 3, Resident 3 stated the call light system was not working during the night the power was off for more than ten hours in the facility. Resident 3 stated Resident 3 did not receive any call bell or device to request assistance. 4. During a review of Resident 4's AR, the AR indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including acute respiratory failure with hypoxia (a medical emergency where the lungs cannot supply enough oxygen to the blood), end stage renal disease (ESRD -irreversible kidney failure) and cerebral infarction (disrupted blood flow to the brain). During a review of Resident 4's HP dated 6/18/2025, the HP indicated Resident 4 had intact cognition including orientation, attention, and memory, and had normal insight and judgment. During a review of Resident 4's MDS dated [DATE], the MDS indicated

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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 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. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the facility's Policy and Procedure (P&P) titled Medication Orders and Receipt Record to ensure three of three sampled residents (Residents 1, 6 and 7)'s medication delivered by the pharmacy were checked, signed, dated and timed by licensed staff upon receiving. This failure had the potential for missing medication or residents receiving wrong medication. Findings: 1. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to facility on 8/19/2024 with diagnoses including morbid obesity (severe obesity- a serious health condition that results from an abnormally high body mass) and history of falling. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 8/23/2025, the MDS indicated Resident 1's cognitive skills (ability to make daily decisions) was intact. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with lower body dressing, toileting hygiene and shower/bathing self. The MDS indicated Resident 1 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating, oral hygiene, and personal hygiene. During a review of Resident 1's Treatment Administration Record (TAR), dated 8/2025, 9/2025 and 10/2025, the TAR indicated Resident 1 had an order for Ketoconazole (is a drug used in the management and treatment of fungal infections) External Shampoo 2% Topical, apply to scalp topically every day shift every Monday, Thursday, Saturday for Seborrheic Dermatitis (skin disease that cause scaly, oily, and flaky patches, on the scalp, face, ears, and chest), leave in for 5 minutes then wash out. The medication order date was 7/25/2025. 2. During a review of Resident 6's AR, the AR indicated Resident 6 was admitted to facility on 2/14/2025 with diagnoses including acute respiratory failure with hypoxia (a medical emergency where the lungs cannot supply enough oxygen to the blood), end stage renal disease (ESRD -irreversible kidney failure), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 6's History and Physical (HP), dated 2/17/2025, the HP indicated Resident 6 had full mental capacity to make own decisions. During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6 had intact cognition. The MDS indicated Resident 6 required substantial/maximal assistance with lower body dressing, putting on/taking off footwear and shower/bathing self. The MDS indicated Resident 6 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, upper body dressing, and personal hygiene. During a review of Resident 6's Order Listing Report (OLR) dated 7/2024, the OLR indicated Resident 6 had a medication order for Ipratropium-Albuterol (medication used to prevent difficulty breathing, chest tightness, and coughing in people with COPD) Inhalation Solution 0.5-2.5 milligram (MG, a unit of measurement)/3 milliliter (ML, a unit of measurement), one inhalation by mouth via nebulizer (a medical device that turns liquid medication into a fine mist for inhalation, making it easier to deliver medicine deep into the lungs) two times a day for COPD for 12 weeks. 3. During a review of Resident 7's AR, the AR indicated Resident 7 was originally admitted to facility on 5/8/2023 and readmitted on [DATE] with diagnoses including ESRD), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and major depressive disorder (a persistent feeling of sadness and loss of interest). During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7's cognitive skill was intact. The MDS indicated Resident 7 required partial/moderate assistance with shower/bathe self, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 7 required supervision or touching assistance with upper body dressing and personal hygiene. During a review of Resident 7's OLR dated 7/2024, the OLR indicated Resident 7 had an order for Doxycycline Hyclate Oral Tablet 100 MG, one tablet by mouth two times a day for facial redness for 60 Days. The last medication ordered date was 7/17/2025. During a review of Resident 7's H&P dated 8/22/2025, the HP indicated Resident 7 had the capacity to understand and make own decisions. During an interview on 10/23/2025 at 10:59 AM with Treatment Nurse 2 (TN 2), TN2 stated every medication received from the pharmacy should have a receipt with signature, date, and time of pharmacy delivery. During a concurrent interview on 10/27/2025 at 3:32pm with Registered Nurse 3 (RN 3) and record review of the facility's Prescription Delivery Receipt (PDR) as of 7/14/25, RN 3 stated there was no date, time or signature of the licensed nurse who received the medications for Residents 1, 6 and 7. RN 3 stated the licensed nurse should sign, date and indicate the time on the receipt upon receiving the medications, and make a copy of the signed receipt as part of the residents' record. During a review of the facility's undated P&P titled