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	06/10/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a Hoyer lift sling (a supportive fabric device that cradles an individual used with a Hoyer lift [a patient lift, a mechanical device with lifting mechanism] to safely transfer individuals with limited mobility between a bed, wheelchair, or toilet) was maintained in a safe and functional condition prior to a transfer for one of two sampled residents (Resident 2). As a result, on 6/4/2026, the Hoyer lift sling ripped while Resident 2 was lifted off the bed, suspending Resident 2 in the air. Resident 2 fell from the Hoyer lift to the floor. Resident 2 sustained a Lumbar 2 (L2, lower back) wedge compression fracture (a break or collapse in the front portion of the second lower back vertebra [spine bone] causing a wedge shape), and moderate sharp pain (typically sudden, intense, and acts as a warning signal from the body. It is most commonly caused by a recent injury) to Resident 2's lower back. The facility transferred Resident 2 to a General Acute Care Hospital (GACH 1) for further evaluation and treatment.Findings: During a review of Resident 2's admission Record (AR), the AR indicated Resident 2 was originally admitted to the facility 8/28/2025 with multiple diagnoses including hemiplegia (a form of paralysis [complete or partial loss of muscle function in a part of the body] that affects one entire side of the body) and hemiparesis (muscle weakness or partial paralysis affecting only one side of the body) following cerebral infarction (commonly known as a stroke), affecting the left non-dominant side (the left half of the body for a right-handed person).During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 3/4/2026, the MDS indicated Resident 2 had intact cognition (ability to understand and process information) and was dependent (helper does all of the effort, the resident does none of the effort to complete the activity) on bed to chair transfers and lying to sitting on the side of the bed.During a review of Resident 2's Change in Condition Evaluation (COC, an alteration in a resident's physical health that differs from his/her previous baseline), dated 6/4/2026, timed at 10 AM, the COC indicated Resident 2 had an assisted fall (an unintentional descent to the floor where a caregiver is present to physically guide the resident to the floor) to the floor with two staff members (Certified Nursing Assistant [CNA] 5 and CNA 6] present during a transfer due to a malfunction of the Hoyer lift sling. The COC indicated the Medical Doctor (MD, Resident 2's physician) was notified of the fall and the MD ordered a stat (immediately or without delay) X-ray (medical imaging that uses radiation to take pictures of bones and organs inside the body) of the left lower extremity (leg) and an X-ray of bilateral (two sides) hips. During a review of Resident 2's X-ray report on the lumbar spine dated 6/4/2026, the X-ray report indicated mild L2 anterior (situated toward or at the front of the body) wedge compression fracture.During a review of the Order Summary Report (OSR), dated 6/4/2026, the OSR indicated an order to transfer Resident 2 to GACH 1 due to L2 anterior wedge compression fracture.During a review of Resident 2's Progress Notes (PN), dated 6/4/2026, timed at 7:20 PM, the PN indicated Resident 2 complained of generalized body pain and had 5 out of 10 pain (on a pain scale from 0 to 10, 0 represents no pain, 4 to 5 represents moderate pain, and 10 represents worst pain imaginable) to the lower back (on 6/4/2026) at 5:17 PM. The PN indicated Resident 2 was given pain medication (pain reliever, Acetaminophen/Tylenol). The PN indicated Resident 2's lumbar spine X-ray indicated a mild L2 (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
	055259	A. Building B. Wing	06/10/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	compression fracture. The PN indicated the MD ordered to transfer Resident 2 to GACH 1 for further evaluation and treatment. The PN indicated Resident 2 was taken to GACH 1 via ambulance [on 6/4/2026] at 7:20 PM. During a review of Resident 2's GACH 1 Patient Results (PR), dated 6/4/2026, the PR indicated Resident 2's computed tomography (CT -advanced X-ray that takes multiple pictures of bones, organs, and soft tissues from different angles) scan of the lumbar spine without contrast (a specialized substance used during imaging tests to highlight specific organs, blood vessels, or tissues) indicated acute transverse comminuted fracture of L2 superior vertebral endplate (a sudden horizontal break located at the top flat surface of the second lumbar spine bone) with less than 10% reduction in height (a vertebral bone in the spine has collapsed slightly and lost up to 10% of its original vertical size). During a review of Resident 2's GACH 1 Discharge Instructions (DI), signed 6/5/2026, the DI indicated Resident 2 was seen in the emergency room (ER) after sustaining a fall at the facility. The DI indicated the CT imaging demonstrated a fracture in the lumbar spine at L2. The DI indicated Resident 2 would benefit from a Thoracolumbosacral Orthosis (TLSO, rigid medical-grade back brace designed to immobilize and support the middle, lower, and sacral regions of the spine, used to relieve pain, promote healing, and stabilize fractures) brace to resume normal activity. During a review of Resident 2's PN, dated 6/5/2026, timed at 11:34 AM, the PN indicated Resident 2 returned (readmitted) to the facility from GACH 1. The PN indicated Resident 2 reported 4/10 lower back pain (moderate pain) during transfers from the bed to the wheelchair and when staff repositioning Resident 2.During a concurrent observation of Resident 2 in Resident 2's bed and interview on 6/9/2026 at 11:05 AM with Resident 2, Resident 2 was lying in bed on Resident 2's back. Resident 2 held the left side of Resident 2's bed rail with Resident 2's right hand and grimaced as Resident 2 showed the pain felt while Resident 2 moved. Resident 2 stated facility nurses (in general) used the Hoyer lift [with a Hoyer lift sling] every day to assist Resident 2's transfer from the bed to a wheelchair due to weakness on Resident 2's left side from a prior stroke. Resident 2 stated [on 6/4/2026] two CNAs (CNA 5 and CNA 6) attempted to transfer Resident 2 from Resident 2's bed to a wheelchair as part of Resident 2's normal routine to go to activities. Resident 2 stated, I saw the Hoyer lift sling before it snapped. Resident 2 stated the Hoyer lift sling looked old and worn and had threads coming out. Resident 2 stated Resident 2 was placed on the Hoyer lift sling and was lifted off the bed to the level of the doorknob. Resident 2 stated during the lateral move from the bed to the wheelchair, the Hoyer lift sling strap supporting Resident 2's legs tore and Resident 2 remained suspended on the Hoyer lift sling for a brief moment before falling onto the ground and landing on Resident 2's buttocks and lower back. Resident 2 stated Resident 2 started to feel moderate sharp pain on Resident 2's lower back when Resident 2 was lifted from the floor by facility employees (CNA 5, CNA 6, Licensed Vocational Nurse [LVN] 2, and Registered Nurse [RN] 3) with a bedsheet. Resident 2 stated Resident 2 also experienced (moderate) sharp pain on Resident 2's lower back when Resident 2 was turned side to side by staff during pericare (process of gently washing a person's private parts, performed daily).During a concurrent interview and a review on 6/9/2026 at 2:25 PM, the facility's In-service (staff training) Meeting Minutes (ISMM), titled Safety, dated 12/29/2025, were reviewed with the Director of Staff Development (DSD), the ISMM's brief summary of lecture indicated Before the transfer of a resident, inspect the Hoyer lift and Hoyer lift sling for damage. The DSD stated the facility's latest in-service, dated 12/29/2025, on the use of Hoyer lifts indicated to check the Hoyer lift slings for any indication that the Hoyer lift sling was not safe to use such as having signs of wear and tear.During an interview on 6/9/2026 at 2:47 PM with LVN 2, LVN 2 stated [on 6/4/2026] two CNAs [CNA 5 and CNA 6] were transferring Resident 2 from Resident 2's bed to the wheelchair when the Hoyer lift Hoyer lift sling's black strap located near Resident 2's legs ripped. LVN 2 stated CNA 5 attempted to hold Resident 2 up, but Resident 2 slid off the Hoyer lift sling onto the ground. LVN 2 stated, prior to Resident 2's assisted fall, no staff had reported signs of wear and tear on the Hoyer lift slings. LVN 2 stated the Hoyer lift slings were not assigned to specific residents and staff (in general) were supposed to inspect the Hoyer lift slings for damage prior to their use. LVN 2 stated (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	06/10/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	after staff assisted Resident 2 back to bed, LVN 2 showed the ripped black Hoyer lift sling strap to the Director of Maintenance (DM), the Administrator (ADM), and the DON.During a concurrent interview and a review of the facility's Resident Lifts Inspect Mobile Lifts and an interview on 6/9/2026 at 3:33 PM with the DM, the facility's Resident Lifts Inspect Mobile Lifts checklist completed by the DM, dated 5/26/2026, indicated to remind nursing staff to inspect all Hoyer lift slings and lifting straps for wear. The checklist indicated items identified as poor condition should be removed from service. The DM stated the DM replaced a damaged Hoyer lift sling in March 2026 but had not seen any more Hoyer lift slings with signs of wear and tear until Resident 2 fell on 6/4/2026. The DM stated, when completing the checklist, the DM did not know which Hoyer lift sling was inspected and could not differentiate between Hoyer lift slings.During an interview on 6/10/2026 at 12 PM with CNA 5, CNA 5 stated every day, CNA 5 assisted Resident 2 out of bed to participate in activities. CNA 5 stated in the morning of 6/4/2026, CNA 5 called CNA 6 to Resident 2's room to assist with Resident 2's transfer. CNA 5 stated Resident 2 always required the use of a Hoyer lift to transfer Resident 2 from the bed to the wheelchair. CNA 5 stated CNA 5 was familiar with how to use the Hoyer lift and Hoyer lift sling. CNA 5 stated the selected Hoyer lift sling used on Resident 2 looked worn in some areas, but CNA 5 did not think the Hoyer lift sling was so worn that the Hoyer lift sling would break or tear. CNA 5 stated the Hoyer lift sling ripped and CNA 5 tried to hold Resident 2, but Resident 2 was too heavy (233 pounds, unit of weight) and fell. CNA 5 stated CNA 5 had received in-services in the past (12/29/2025) and was instructed not to use Hoyer lift slings that looked worn. During an interview on 6/10/2026 at 1:11 PM with the Director of Rehabilitation (DOR), the DOR stated Resident 2 stayed in bed from 6/4/2026 to 6/10/2026 while waiting to receive a lumbar brace (TLSO) and Resident 2 had not been assisted out of bed. The DOR stated, after Resident 2's fall, Resident 2 experienced moderate pain in the lower part of the back. During an interview on 6/10/2026 at 4:50 PM with the ADM and the DON, the ADM stated the Hoyer lift slings were replaced on an as-needed basis and the facility did not have a system in place other than visual inspections [to ensure the Hoyer lift slings were not worn and torn]. The DON stated ultimately the final inspection needed to be done by the person using the sling to determine if the sling was in a [good] working condition. The DON stated the DON did not know the condition of the sling [used on Resident 2 on 6/4/2026] prior to being used. During a review of the facility's undated Instruction Manual for Full Body Sling (IMFBS), the IMFBS's warning indicated to carefully inspect the sling before each use and after each laundering for wear and damage to seams, fabric, straps, and strap loops. The IMFBS indicated torn, cut, frayed or broken slings could fail, resulting in serious personal injury to the user or caregiver. The IMFBS indicated use only slings that are in good condition. The IMFBS indicated to discard and destroy old, unusable slings. During a review of the facility's policy and procedure (P&P) titled, Lifting Machine, Using a Mechanical, dated 7/2017, the P&P's steps in the procedure indicated to make sure that all necessary equipment (slings, hooks, chains, straps, and supports) is on hand and in good condition. The P&P indicated before resident is lifted, double check the security of the sling attachment. The P&P indicated check the stability of the straps, lift the resident two (2) inches from the surface to check the stability of the attachments, and the fit of the sling and weight distribution.