STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055367	A. Building B. Wing	12/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monrovia Gardens Healthcare Center	615 W. Duarte Rd. Monrovia, CA 91016

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 44027 Based on interview and record review, the facility failed to protect one of three sampled residents' (Resident 1) right to be treated with dignity and respect when Registered Nurse (RN) 1 instructed Resident 1, in the presence of Resident 1's visitor, that Resident 1 needed to provide a urine sample (a collection of urine that can be used for a variety of tests). This failure resulted in Resident 1 feeling embarrassed and disrespected. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident 1 on 7/12/2019, with diagnoses including congestive heart failure (condition in which the heart cannot pump enough blood to all parts of the body), acquired absence of right and left leg below knee (amputation, a surgical procedure to remove a limb), and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 10/16/2024, the MDS indicated Resident 2 had no impairment in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 required supervision or touch assistance from staff for bathing, toileting and personal hygiene, and dressing. During an interview on 12/24/2024 at 10:02 a.m. with Resident 1, Resident 1 stated that on 12/12/2024 at around 10 a.m., her friend (FR 1) was visiting Resident 1 at the facility. Resident 1 stated RN 1 came into her room and said RN 1 needed a urine sample from Resident 1. Resident 1 stated RN 1 held up the urine cup like it was a prize from The Price is Right (a game show). Resident 1 stated Resident 1 felt embarrassed and mortified because RN 1 behaved that way in front of FR 1. Resident 1 stated RN 1 should have privately talked to Resident 1 about the urine sample and not in front of FR 1. Resident 1 stated she felt disrespected. Resident 1 stated Licensed Vocational Nurse (LVN) 1 was also present when RN 1 was asking Resident 1 for a urine sample. During an interview on 12/24/2024 at 10:07 a.m. with FR 1, FR 1 stated FR 1 was present inside Resident 1's room when RN 1 informed Resident 1 that Resident 1 needed to provide a urine sample before leaving the facility and again when Resident 1 returned to the facility. (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: 055367	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/24/2024
NAME OF PROVIDER OR SUPPLIER Monrovia Gardens Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 615 W. Duarte Rd. Monrovia, CA 91016	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/24/2024 at 10:20 a.m. with LVN 1, LVN 1 stated LVN 1 witnessed RN 1 asking Resident 1 for a urine sample in the presence of FR 1. LVN 1 stated Resident 1 later informed LVN 1 that Resident 1 did not like how RN 1 asked for a urine sample in front of FR 1. During an interview on 12/24/2024 at 10:40 a.m. with the Director of Nursing (DON), The DON stated facility should discuss the need to collect a urine sample with a resident (in general) in private or get permission first to talk in front of the resident's visitor. The DON stated that was important to protect the resident's dignity. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, revised February 2021, the P&P indicated, Employees shall treat all residents with kindness, respect, and dignity. The P&P indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity; .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027 Based on interview and record review, the facility failed to monitor blood sugar levels for one of three sampled residents (Resident 4) who was diabetic (diabetes, also known as diabetes mellitus, is a chronic condition that affects how the body uses glucose [sugar] for energy). This failure had the potential for Resident 4's blood sugar levels to be too high or too low which could lead to illness and/or death. Findings: During a review of Resident 4's Admission Record (AR), the AR indicated the facility admitted Resident 4 on 12/21/2024. During a review of Resident 4's LTC Skilled Admission History & Physical (H&P), dated 12/22/2024, the H&P indicated Resident 4 had diagnoses including type 1 diabetes (a type of diabetes also called juvenile diabetes), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). The H&P indicated Resident 4 had a history of using an insulin pump (a small, portable device that delivers insulin [hormone that regulates blood sugar levels] continuously throughout the day to people with type 1 diabetes) to control her blood sugar levels. During a concurrent interview and record review on 12/24/2024, at 11:57 a.m. with the Director of Nursing (DON), Resident 4's Discharge to SNF (Skilled Nursing Facility) Summary and Transfer Orders (Transfer Orders), dated 12/21/2024 was reviewed. The Transfer Orders indicated Resident 4 was a type 1 diabetic who had a history of using an insulin pump. The DON stated Resident 4 did not have an insulin pump while she was residing at the facility. The Transfer Orders indicated to continue OneTouch Delica Plus Lancet (lancing device which pricks the finger and causes a drop of blood for diabetes testing) . Use 4 times a day as directed to test blood sugar . The DON stated the facility staff did not continue the order to check Resident 4's blood sugar as indicated on the Transfer Orders. The DON stated facility staff were not monitoring Resident 4's blood sugar. During a telephone interview on 12/24/2024 at 12:55 p.m. with Resident 4's daughter (FM 1), FM 1 stated Resident 4 had been a type 1 diabetic for [AGE] years. FM 1 stated Resident 4 was currently at the G Acute Care Hospital. FM 1 stated Resident 4's blood sugar level was in the 700s when Resident 4 was transferred from the facility to GACH on 12/23/2024. FM 1 stated the facility was not managing Resident 4's blood sugar. FM 1 stated before Resident was admitted to the facility, the GACH staff were checking Resident 4's blood sugar and giving Resident 4 insulin. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/24/2024, at 2:00 p.m. with the DON, Resident 4's Transfer Orders, dated 12/21/2024 was reviewed. The Transfer Orders indicated Resident 4 was a type 1 diabetic. The DON stated the [NAME] had processed the Transfer Orders on 12/21/2024 when Resident 4 was admitted to the facility. The DON stated the DON noticed Resident 4 was a type 1 diabetic. The DON stated all residents with type 1 diabetes should have their blood sugar levels monitored. The DON stated the blood sugar levels should be checked at least twice a day. The DON stated the DON did not have a discussion with Resident 4's physician to ask the physician for an order to monitor Resident 4's blood sugar levels. The DON stated not monitoring type 1 diabetic residents' blood sugar levels was dangerous to the health of the residents (in general). During a review of the facility's policy and procedure (P&P) titled, Diabetes - Clinical Protocol, revised November 2020, the P&P indicated, For residents with confirmed diabetes, the nurse shall assess and document/report .Resident's blood sugar history over 48 hours . The P&P indicated, For the resident receiving insulin who is well controlled: monitor blood glucose levels twice a day if on insulin (for example, before breakfast and lunch and as necessary); monitor 3 to 4 times a day if on intensive insulin therapy or sliding-scale insulin .