

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  01/24/2025
NAME OF PROVIDER OR SUPPLIER  Monrovia Gardens Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34273</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure a communication device was provided to 1 of 18 sampled residents (Resident 17) when Resident 17, who was not able to speak, went out to a medical appointment on 1/21/2025.</p> <p>This failure had the potential for Resident 17 to not be able to communicate during a medical appointment.</p> <p>Findings:</p> <p>During a review of Resident 17's Admission Record (AR), the AR indicated Resident 17 was admitted to the facility on [DATE], with diagnoses which included conversion disorder (condition where a mental health issue causes physical symptoms), anarthria (loss of speech due to inability to control the muscles used for speaking), and aphonia (loss of voice).</p> <p>During a review of Resident 17's Minimum Data Set (MDS - a resident assessment tool), dated 1/9/2025, the MDS indicated Resident 17 had no speech but was able to express ideas and wants. The MDS indicated Resident 17 was dependent (helper does all the effort) on staff for toileting hygiene, lower body dressing, and putting on/taking off footwear. The MDS Resident 17 required substantial/maximal assistance (helper does more than half the effort) with showering/bathing and with personal hygiene.</p> <p>During a review of Resident 17's care plan (CP), dated 10/14/2023, the CP indicated Resident 17 had a communication problem related to aphonia and anarthria, was non-verbal, and used the telephone to make needs known and type responses. The CP indicated Resident 17 used a [brand name tablet computer] to communicate, and for staff to ensure availability and functioning of adaptive communication equipment.</p> <p>During a review of the Social Services Director (SSD) Progress Note (SSD PN), dated 12/23/2024 and timed 11:34 a.m., the SSD PN indicated Resident 17 had an outside appointment on 1/21/2025 at 8 a.m. with an occupational therapist (OT- a healthcare professional who helps individuals improve their ability to perform everyday activities).</p> <p>During a review of a nursing progress note (NPN), dated 1/21/2025 and timed 2:52 p.m., the NPN indicated Resident 17 arrived from an outside appointment at 10 a.m. via gurney and accompanied by two attendants.</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 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/22/2025 at 2:44 p.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated Resident 17 did not speak and used a tablet and or mobile telephone to communicate.</p> <p>During an observation on 1/22/2025 at 3:30 p.m. in Resident 17's room, Resident 17 was seen communicating with CNA 10 using a tablet computer. Resident 17 typed on the tablet and CNA 10 read Resident 17's words on the tablet. Resident 17 was non-verbal, pointed at things, and tapped on the tablet with Resident 17's fingers.</p> <p>During an interview on 1/23/2025 at 7:27 a.m. with CNA 12, CNA 12 stated CNA 12 accompanied Resident 17 to an outside appointment on 1/21/2025. CNA 12 stated Resident 17 did not have a communication device at the appointment on 1/21/2025 and had to use CNA 12's mobile telephone to communicate during the appointment.</p> <p>During an interview on 1/23/2025 at 12:26 p.m. with the SSD, the SSD stated Resident 17 must go out to all outside appointments with a communication device.</p> <p>During a telephone interview on 1/23/2025 at 1:35 p.m. with Licensed Vocational Nurse (LVN) 8, LVN 8 stated LVN 8 took care of Resident 17 on 1/20/2025 from 11 p.m. to 7 a.m. on 1/21/2025. LVN 8 stated Resident 17 left for an outside appointment on 1/21/2025 but could not remember if Resident 17 had a tablet computer when Resident 17 left for Resident 17's appointment. LVN 8 stated Resident 17 must have a tablet because that was Resident 17's form of communication.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Resident Rights, dated 2/2021, the P&amp;P indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to . communication with and access to people and services, both inside and outside the facility .</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44114</p> <p>Based on observation, interview, and record review, the facility failed to implement the care plan for 2 of 18 sampled residents (Residents 12 and 17) by failing to:</p> <ol style="list-style-type: none"> <li>1. Ensure Certified Nursing Assistant (CNA) 4, Licensed Vocational Nurse (LVN) 6, and all nurses (any CNAs, LVNs, and Registered Nurses [RNs]) in the nursing station provided frequent visual checks and kept Resident 12 at the nursing station for monitoring.</li> <li>2. Ensure LVN 9 administered medications to Resident 17 accompanied by another staff.</li> </ol> <p>These failures had the potential for Resident 12 and Resident 17 to not receive the care and services needed to address Resident 12's fall risk and Resident 17's psychosocial well-being.</p> <p>Cross Reference F689</p> <p>Findings:</p> <p>1. During a review of Resident 12's Admission Record (AR), the AR indicated the facility admitted Resident 12 to the facility on [DATE], with diagnoses that included congested heart failure (CHF - a heart condition that develops when the heart does not pump enough blood for the body's needs), type 2 diabetes (DM2 - a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and end stage renal disease (ESRD - a condition where the kidneys have permanently lost most of their function and can no longer adequately filter waste products from the blood) with hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed).</p> <p>During a review of Resident 12's first untitled care plan (CP), initiated on 7/14/2023, and revised on 8/2/2024, the CP indicated Resident 12 was at risk for falls related to limited mobility, balance problems, confusion, poor safety awareness, history of multiple falls, and use of psychotropics (medications that affect the mind, emotions, and behavior) and diuretic (medication that causes the kidneys to make more urine). The CP interventions included to anticipate and meet Resident 12's needs, follow facility's fall protocol, and provide a safe environment.</p> <p>During a review of Resident 12's Fall Risk Assessment (FRA), dated 4/15/2024, the FRA indicated Resident 12 was at high risk for falls due to history of falls, use of psychotropics, antihypertensive (medication to treat high blood pressure), and hypoglycemic agents (medications to treat high blood sugar), urinary incontinence (inability to control the flow of urine from the bladder), agitated (irritable/unpleasant) behavior and predisposing conditions (conditions that give way to the development of disease).</p> <p>During a review of Resident 12's History and Physical Examination (H&amp;P), dated 4/16/2024, the H&amp;P indicated Resident 12 did not have the capacity to understand and make decisions.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Residents 12's Physical Therapy (PT- therapy used to preserve, enhance, or restore movement and physical function impaired or threatened by disease, injury, or disability) Encounter Notes (PTEN), dated 6/7/2024, the PTEN indicated Resident 12 required maximal assistance (assisting person performed 75 percent (%) of the task) for bed mobility and transfers.</p> <p>During a review of Resident 12's second untitled CP, initiated on 6/14/2024, and revised on 8/7/2024, the CP indicated Resident 12 had an unwitnessed fall (a fall that occurs when no one is present to see it happen) on 6/14/2024 . The CP interventions included to provide frequent visual checks and keep Resident 12 at the nursing station so staff (all nursing staff) can monitor and help Resident 12 immediately if Resident 12 tries to stand up without assistance.</p> <p>During a review of Resident 12's third untitled CP, initiated on 9/21/2024, the CP indicated Resident 12 had a witnessed fall (when someone sees another person fall down) on 9/21/2024. The CP interventions included to provide frequent visual checks.</p> <p>During a review of Resident 12's Minimum Data Set (MDS, a resident assessment tool), dated 10/26/2024, the MDS indicated Resident 12 had severely impaired cognition (ability to think and process information). The MDS indicated Resident 12 normally used a wheelchair for mobility and was dependent (helper does all the effort) on staff for toileting, and personal hygiene, and chair/bed-to-chair transfer.</p> <p>During a review of Resident 12's Change in Condition Evaluation (CICE), dated 12/28/2024, timed at 12:15 p. m., the CICE indicated on 12/28/2024, untimed, Resident 12 had an unwitnessed fall in the facility's conference room located in front of the nursing station. The CICE indicated Resident 12 suffered a bump to Resident 12's left side of the head. The CICE indicated Resident 12 was awake, alert, verbally responsive, able to follow commands, and answer questions. The CICE indicated Resident 12's vital signs (measurements of the body's most basic functions) were stable and Resident 12 had no neurological deficit (impairment or loss of function affecting the brain, spinal cord [a tube of tissues/nerve fibers that runs from the brain to the lower back. The spinal cord carries nerve signals from the brain to the rest of the body and back], nerves, or muscles). The CICE indicated Registered Nurse (RN) 2 notified Resident 12's physician/medical doctor (MD 1) and MD 1 ordered to transfer Resident 12 to GACH 1 for further evaluation and treatment.</p> <p>During a review of Resident 12's GACH 1 Emergency Note (EN), dated 12/28/2024, timed at 4:10 p.m., the EN indicated Resident 12 was brought in by ambulance from the skilled nursing facility (SNF) where Resident 12 had a mechanical fall (a type of fall caused by an external force or object) out of a wheelchair, and hitting Resident 12's left side of the head and face.</p> <p>During a review of Resident 12's GACH 1 Computed Tomography Scan (CT scan, medical imaging technique used to obtain detailed internal images of the body) Report of Resident 12's cervical spine, dated 12/28/2024, timed at 6 pm, the CT Scan Report indicated Resident 1 had a fracture through the dens (a break in the peg-like [a bolt or pin that holds something in place or marks a location] bone at the top of the C2 in the neck).</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 12's GACH 1 Magnetic Resonance Imaging (MRI- medical imaging technique used to obtain images of the body) Report of Resident 12's cervical spine, dated 12/28/2024, timed at 9:05 pm, the MRI Report indicated Resident 12 had a fracture of the dens of C2. The MRI Report indicated findings were concerning for nerve compression (occurs when a nerve is under too much pressure from surrounding tissues). The MRI Report indicated neurosurgical (relating to or involving surgery performed on the nervous system, especially the brain and spinal cord) consultation was recommended for further evaluation and management guidance.</p> <p>During a review of Resident 12's Neurosurgery Consultation Notes (NCN), dated 12/29/2024, untimed, the NCN indicated Resident 12 presented for evaluation of dens fracture and found to have severe stenosis (narrowing of any channel or passageway in the body) in the lower cervical spine sustained after a fall at the SNF. The NCN indicated Resident 12 was a high risk for postoperative (after surgery) complications due largely to age and comorbidities (the condition of having two or more diseases at the same time). The NCN indicated Resident 12's family would like to manage Resident 12 conservatively with a brace (a device fitted to a weak or injured part of the body, to give support).</p> <p>During a review of Resident 12's GACH 1 Discharge Summary Notes (DS), dated 12/30/2024, untimed, the DS indicated Resident 12 was a high risk for postoperative complications, quality of life, and there was an unclear benefit if Resident 12 were to have surgery. The DS indicated Resident 12 was to continue with cervical collar (C-collar - an instrument used to support the neck and spine and limit head movement after an injury) and follow-up with spine surgery for a repeat CT scan of the spine in four weeks.</p> <p>During an interview on 1/21/2025 at 8:30 a.m. with CNA 4, CNA 4 stated on 12/28/2024, at around 8:30 a.m., CNA 4 got Resident 12 ready for the day, transferred Resident 12 in Resident 12's wheelchair after breakfast, wheeled Resident 12 in the hallway, and left Resident 12 next to the nursing station. CNA 4 stated residents (in general) who needed to be monitored were taken to the nursing station at around 8:30 a.m. (daily) so nurses (any CNAs, LVNs, and RNs) in the nursing station could monitor the residents who were left there (at the nursing station). CNA 4 stated CNA 4 returned to the nursing station at 12 p.m. but CNA 4 did not find Resident 12 in the hallway next to the nursing station where CNA 4 left Resident 12. CNA 4 stated when CNA 4 went to the conference room, the conference room door was closed. CNA 4 stated CNA 4 opened the conference room door and found Resident 12 on the floor next to Resident 12's wheelchair by herself (alone). CNA 4 stated Resident 12 had a large bump on Resident 12's head. CNA 4 stated there was no staff supervising Resident 12 in the conference room and staff were unable to see Resident 12 in the conference room from the nursing station because the conference room door was closed.</p> <p>During an interview on 1/21/2025 at 12 p.m. with RN 2, RN 2 stated on 12/28/2024, after 12 pm, LVN 6 called RN 2 into the conference room and when RN 2 entered the conference room, Resident 12 was on the floor. RN 2 stated Resident 12 should not be left in the conference room unsupervised since Resident 12 was confused and at high risk for falls. RN 2 stated Resident 12 was able to wheel herself (Resident 12) around the facility. RN 2 stated Resident 12 needed frequent monitoring per Resident 12's care plans and staff did not follow Resident 12's care plans.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/22/2025 at 2:30 p.m. with the Administrator (ADM), the ADM stated Resident 12 had history of multiple falls and needed frequent visual checks. The ADM stated Resident 12 was supposed to be at the nursing station for monitoring. The ADM stated all nurses (any CNAs, LVNs, and RNs) at the nursing station were responsible for supervising/monitoring the residents who were around the nursing station. The ADM stated fall risk and confused residents needed to be monitored every one to two hours. The ADM stated the facility did not know how long Resident 12 was inside the conference room alone and unsupervised. The ADM stated no one witnessed Resident 12 going or being taken into the conference room (on 12/28/2024).</p> <p>During a telephone interview on 1/23/2025 at 3:53 p.m. with LVN 6, LVN 6 stated on 12/28/2024, before lunch time, (unable to recall exact time), LVN 6 checked on Resident 12 and Resident 12 was sitting (in Resident 12's wheelchair) in front of the nursing station. LVN 6 stated Resident 12 was able to wheel herself (Resident 12) to the nursing station. LVN 6 stated (on 12/28/2024) after 12 p.m., CNA 4 notified LVN 6 that Resident 12 had fallen in the conference room. LVN 6 stated when LVN 6 arrived in the conference room, Resident 12 was on the floor next to the door. LVN 6 stated Resident 12 had a bump on Resident 12's left side of the head. LVN 6 stated LVN 6 could not remember if there were any nurses at the nursing station monitoring the residents (all residents including Resident 12) at that time (12/28/2024, before lunch time). LVN 6 stated Resident 12 should not be left alone and unsupervised in the conference room. LVN 6 stated Resident 12 needed to be monitored every hour and frequently because Resident 12 was confused and at high risk for falls. LVN 6 stated since Resident 12's fall was unwitnessed in the conference room, Resident 12 was not being supervised. LVN 6 stated LVN 6 did not see Resident 12 going or being taken to the conference room. LVN 6 stated We, (staff including LVN 6) did not follow Resident 12's care plans to monitor Resident 12 frequently.</p> <p>During a review of the facility's P&amp;P titled, Safety and Supervision of Residents, revised 7/2017 (most updated), the P&amp;P indicated, Resident safety supervision and assistance to prevent accidents were facility-wide priorities. The P&amp;P indicated, The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate (sufficient for a specific need or requirement) supervision. The P&amp;P indicated, Implementing interventions to reduce accident risks and hazards included the following: a. Communicating specific interventions to all relevant staff; b. Assigning responsibility for carrying out interventions; c. Providing training, as necessary; d. Ensuring that interventions are implemented . The P&amp;P indicated, Resident supervision is a core component of the systems approach to safety. The type and frequency of supervision may vary among residents and over time for the same residents.</p> <p>During a review of the facility's P&amp;P titled, Fall and Fall Risk, Managing, revised 3/2018 (most updated), the P&amp;P indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The P&amp;P indicated, The staff will implement a resident-centered fall prevention plan to reduce the risk factor(s) of falls for each resident at risk or with a history of falls.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's P&amp;P titled, Care Plans, Comprehensive Person-Centered, revised 3/2022 (most updated), the P&amp;P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&amp;P indicated, The comprehensive, person-centered care plan . describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including . which professional services are responsible for each element of care . builds on the resident's strengths; and reflects currently recognized standards of practice for problem areas and conditions.</p> <p>2. During a review of Resident 17's Admission Record (AR), the AR indicated Resident 17 was admitted to the facility on [DATE], with diagnoses which included conversion disorder (condition where a mental health issue causes physical symptoms), anarthria (loss of speech due to inability to control the muscles used for speaking), and aphonia (loss of voice).</p> <p>During a review of Resident 17's Minimum Data Set (MDS), dated [DATE], the MDS indicated Resident 17 had no speech but was able to express ideas and wants. The MDS indicated Resident 17's cognition was moderately impaired, and Resident 17 was dependent on others for toileting hygiene, lower body dressing, and for putting on/taking off footwear. Resident 17 required substantial/maximal assistance (helper does more than half the effort) with showering/bathing and with personal hygiene.</p> <p>During a review of Resident 17's CP, dated 11/12/2024, the CP indicated Resident 17 had concerns regarding safety and missing belongings. The CP indicated an intervention for Resident 17 to be always approached and cared for by two staff.</p> <p>During a review of the Resident 17's clinical record, the physician's order (PO), dated 7/7/2024, indicated to give Resident 17 thirty (30) milliliters (ml- unit of measure) of [brand name liquid protein] once a day. The PO, dated 9/11/2024, indicated to give Resident 17 Calcium 600 milligrams (mg- unit of measure) with Vitamin D3 10 micrograms (mcg- unit of measure) (Calcium and Vitamin D3 -nutrients needed to keep the body healthy) two times a day.</p> <p>During an interview on 1/23/2025 at 3:01 p.m. with Resident 17, Resident 17 stated LVN 9 did not give Resident 17 a Calcium pill, [brand name liquid protein], and a pain pill as scheduled in the morning. Resident 17 also stated facility staff always came in two at a time in Resident 17's room, and Resident 17 thought it was unnecessary.</p> <p>During an interview on 1/23/2025 at 3:27 p.m. with LVN 9, LVN 9 checked Resident 17's medication administration record (MAR) and stated LVN 9 gave Resident 17 a Calcium tablet and [brand name liquid protein] as scheduled in the morning as indicated by LVN 9's initials on Resident 17's MAR. LVN 9 stated LVN 9 did not give Resident 17 pain medication because LVN 9 did not get any report Resident 17 needed something for pain.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 1/23/2025 at 3:34 p.m. in Resident 17's room, LVN 9 reminded Resident 17 that LVN 9 gave Resident 17 a Calcium tablet and [brand name liquid protein] while Resident 17 was having breakfast. Resident 17 stated Resident 17 could not remember LVN 9 giving Resident 17 a Calcium tablet and [brand name liquid protein] during breakfast. Resident 17 asked LVN 9 what color Calcium tablet LVN 9 gave Resident 17, and LVN 9 stated LVN 9 did not remember the color of the Calcium tablet LVN 9 gave to Resident 17. Resident 17 asked LVN 9 what Resident 17 had for breakfast and the name of the staff who accompanied LVN 9 during medication administration. LVN 9 stated LVN 9 did not remember what Resident 17 had for breakfast and stated no one was with LVN 9 when LVN 9 gave Resident 17 a Calcium tablet and [brand name liquid protein].</p> <p>During an interview on 1/23/2025 at 3:40 pm with LVN 9, LVN 9 stated LVN 9 was supposed to be accompanied by another staff whenever LVN 9 provided care to Resident 17, but LVN 9 forgot.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&amp;P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .The comprehensive, person-centered care plan . describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34273</p> <p>Based on interview and record review, the facility failed to ensure 4 of 18 sampled residents (Residents 3, 8, 17, and 18) who required assistance with activities of daily living (ADLs- activities such as bathing, dressing and toileting, a person performs daily) were provided assistance with ADLs when:</p> <ol style="list-style-type: none"> <li>1. Resident 3's, Resident 8's, and Resident 18's wet and/or dirty incontinence briefs (diapers) were not changed promptly.</li> <li>2. Resident 17's hair was not washed and combed as scheduled.</li> </ol> <p>These failures resulted in Resident 3, Resident 8, Resident 17, and Resident 18 to not receive assistance with ADLs as needed and had the potential to affect Resident 3's, Resident 8's, Resident 17's, and Resident 18's well-being.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of Resident 3's Admission Record (AR), the AR indicated Resident 3 was admitted to the facility on [DATE], with diagnoses which included spina bifida (a birth defect that occurs when the spine and spinal cord don't form properly) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</li> </ol> <p>During a review of Resident 3's History and Physical (H&amp;P, physician's clinical evaluation and examination of the resident), dated 5/16/2024, the H&amp;P indicated Resident 3 can make needs known but cannot make medical decisions.</p> <p>During a review Resident 3's care plan (CP), dated 10/16/2024, the CP indicated Resident 3 had a decline in ADLs performance and the CP interventions included to check Resident 3 for incontinence every 2 hours and as needed, and to change and clean Resident 3 well after each episode of incontinence.</p> <p>During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 11/11/2024, the MDS indicated Resident 3's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) is intact. The MDS indicated Resident 3 was dependent (helper does all the effort) on others for toileting hygiene, showering/bathing, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 3 was always incontinent (lack of voluntary control over urination and/or bowel movement) of bladder and bowel.</p> <ol style="list-style-type: none"> <li>2. During a review of Resident 8's AR, the AR indicated Resident 8 was admitted to the facility on [DATE], with diagnoses which included wedge compression fracture of unspecified thoracic vertebra (a fracture in the spine/backbone where the front of the vertebra [one of the small bones forming the backbone/spine] collapses and forms a wedge shape).</li> </ol> <p>During a review of Resident 8's H&amp;P, dated 12/12/2024, the H&amp;P indicated Resident 8 had the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 8's CP, dated 12/12/2024, the CP indicated Resident 8 had a decline in ADLs performance and the CP interventions included to check Resident 8 for incontinence every 2 hours and as needed, and to change and clean Resident 8 well after each episode of incontinence.</p> <p>During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8's cognition was intact. The MDS indicated Resident 8 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, showering/bathing, upper and lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 8 was frequently incontinent of bowel and bladder.</p> <p>3. During a review of Resident 18's AR, the AR indicated Resident 18 was admitted to the facility on [DATE], with the diagnoses that included myelodysplastic syndrome (a group of blood disorders that affect the bone marrow, the place where blood cells are produced), type 2 diabetes (DM2-health condition that affects how your body turns food into energy), chronic kidney disease stage 4 (CKD-4- a condition where the kidneys have permanently lost most of their function and can no longer adequately filter waste products from the blood).</p> <p>During a review of Resident 18's H&amp;P, dated 12/22/2024, the H&amp;P indicated Resident 18 had decision making capacity.</p> <p>During a review of Resident 18's care plan (CP), dated 12/23/2024, the CP indicated Resident 18 had a decline in: Grooming, feeding, dressing, bathing, toileting, balance, safety, related to decreased functional mobility. CP interventions dated 12/23/2024 indicated Occupational therapy (OT-A healthcare professional that helps people regain or improve their ability to perform daily task) skilled OT services every day for 5 days a week for 4 weeks.</p> <p>During a review of Resident 18's MDS, dated [DATE], the MDS indicated Resident 18 is dependent for toileting, oral hygiene, shower, upper and lower body dressing, and personal hygiene. The MDS indicated Resident 18 did not perform ambulation activity.</p> <p>4. During a review of Resident 17's Admission Record (AR), the AR indicated Resident 17 was admitted to the facility on [DATE], with diagnoses which included conversion disorder (condition where a mental health issue causes physical symptoms), anarthria (loss of speech due to inability to control the muscles used for speaking), and aphonia (loss of voice).</p> <p>During a review of Resident 17's CP, dated 10/5/2023, the CP indicated Resident 3 was at risk for decline in ADLs. The CP interventions included to assist Resident 17 with ADLs every shift.</p> <p>During a review of Resident 17's Minimum Data Set (MDS - a resident assessment tool), dated 1/9/2025, the MDS indicated Resident 17 had no speech but was able to express ideas and wants. The MDS indicated Resident 17's cognition was moderately impaired, and Resident 17 was dependent on others for toileting hygiene, lower body dressing, and for putting on/taking off footwear. Resident 17 required substantial/maximal assistance (helper does more than half the effort) with showering/bathing and with personal hygiene.</p> <p>During an interview on 1/16/2025 at 10:37 a.m. with Family Member (FM) 3, FM 3 stated the nurses were taking 1 hour to change Resident 18's diaper.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/16/2025 at 1:30 p.m. with Resident 3, Resident 3 stated Resident 3 mostly used the call light (a device used by a resident to signal their need for assistance from staff) for a diaper change. Resident 3 stated the longest time Resident 3 waited for a diaper change was an hour. Resident 3 stated the wait to answer the call light and/or to be changed depended on how many residents were assigned to each certified nursing assistants (CNAs). Resident 3 stated the more residents the CNAs had to take care of, the longer it took for CNAs to answer the call lights and to assist other residents.</p> <p>During an interview on 1/16/2025 at 2:49 p.m. with Resident 8, Resident 8 stated on 12/16/2024, Resident 8 reported to a nurse (unidentified) at 8 a.m. and at 9 a.m. Resident 8 had a bowel movement. Resident 8 stated a nurse (unidentified) responded at 9:35 a.m., but Resident 8 did not get cleaned and changed until 10:25 a.m. Resident 8 stated some CNAs were rough when providing care to Resident 8. Resident 8 stated the CNAs were not intentionally rough just in a hurry.</p> <p>During an interview on 1/21/2025 at 2:55 p.m. with the Director of Staff development (DSD), the DSD stated CNAs needed to assist residents with ADLs and were expected to check on residents every 2 hours to turn, reposition, and check residents if residents were dirty or wet.</p> <p>During a concurrent observation and interview on 1/22/25 5:02 p.m. with Resident 17, Resident 17 stated CNA 4 did not wash and comb Resident 17's hair that day. Resident 17's hair was checked with the help of CNA 10. Resident 17's hair was matted and hard.</p> <p>During an interview on 1/23/2025 at 11:15 a.m. with the DSD, the DSD stated CNAs need to do hair care (shampoo, dry, comb) when giving showers to the residents twice a week. The DSD stated Resident 17 did not get up in the shower chair and instead got a bed bath twice a day and got hair care done in bed. The DSD stated Resident 17's hair care schedule was arranged by the Social Services Director (SSD) in accordance with Resident 17's and Resident 17's mother's request.</p> <p>During an interview on 1/23/2025 at 12:26 p.m. with the SSD, the SSD stated during the last meeting with Resident 17 and Resident 17's mother on 12/9/2024, Resident 17 and Resident 17's mother requested for Resident 17's hair to be washed and combed every Wednesday.</p> <p>During an interview on 1/24/2025 at 9:53 a.m. with CNA 13, CNA 13 stated CNA 13 assisted CNA 4 on 1/22/2025, Wednesday, to bathe Resident 17, but CNA 4 and CNA 13 did not wash Resident 17's hair. CNA 13 stated Resident 17's hair was washed and combed every Saturday. CNA 13 stated CNA 15 came in on Saturdays to wash and comb Resident 17's hair. CNA 13 stated CNA 13 was not informed and did not know Resident 17's shampoo days were changed to Wednesdays.</p> <p>During a review of Resident 17's schedule for November 2024, the schedule indicated Resident 17's shampoo day was on Saturdays.</p> <p>During a review of Resident 17's schedule for December 2024, the schedule indicated Resident 17's shampoo day was on Wednesdays.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedure (P&amp;P) titled, Activities of Daily Living (ADL), Supporting, dated 3/2018, the P&amp;P indicated, residents will be provided with care, treatment, and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care .</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34273</p> <p>Based on interview and record review, the facility failed to coordinate with an outside care provider to provide necessary care and services for 1 of 18 sampled residents (Resident 17) when the facility did not obtain an after visit care record or after visit summary (AVS- document which details everything that happened during an appointment, the treatment plan, and any new medications, tests, and instructions from the care provider) from Resident 17's neurologist's (a medical doctor who diagnoses, treats and manages disorders of the nervous system [brain, spinal cord and nerves]) office after Resident 17's appointment on 11/12/2024.</p> <p>This failure had the potential for Resident 17 to not receive the necessary care and services.</p> <p>Findings:</p> <p>During a review of Resident 17's Admission Record (AR), the AR indicated Resident 17 was admitted to the facility on [DATE], with diagnoses which included conversion disorder (condition where a mental health issue causes physical symptoms), anarthria (loss of speech due to inability to control the muscles used for speaking), and aphonia (loss of voice).</p> <p>During a review of Resident 17's Minimum Data Set (MDS - a resident assessment tool), dated 1/9/2025, the MDS indicated Resident 17 had no speech but was able to express ideas and wants. The MDS indicated Resident 17 was dependent (helper does all the effort) on others for toileting hygiene, lower body dressing, and for putting on/taking off footwear. Resident 17 required substantial/maximal assistance (helper does more than half the effort) with showering/bathing and with personal hygiene.</p> <p>During a review of Resident 17's Social Services Director (SSD) Progress Note (SSD PN), dated 10/25/2024 and timed 12:13 p.m., the SSD PN indicated Resident 17 had an appointment with a neurologist on 11/12/2024 at 12:30 p.m.</p> <p>During a review of Resident 17's Nursing Progress Note (NPN), dated 11/12/2024 and timed 11:20 a.m., the NPN indicated Resident 17 was picked up to go to a neurologist appointment at 11:16 a.m. (on 11/12/2024).</p> <p>During a review of Resident 17's NPN, dated 11/12/2024 and timed 1:38 p.m., the NPN indicated Resident 17 returned to the facility from a neurologist appointment at 1:30 p.m. The NPN indicated no documentation if there were any or no new orders for tests, treatments, and or follow-up appointments from the neurologist's office.</p> <p>During an interview on 1/23/2025 at 8:25 a.m. with Resident 17, Resident 17 stated the neurologist wanted Resident 17 to get a magnetic resonance imaging (MRI- a test that creates clear images of the organs inside the body using a large magnet, radio waves and a computer), but Resident 17 has not had one yet.</p> <p>During an interview on 1/23/2025 at 2:33 p.m. with Registered Nurse (RN) 1, RN 1 reviewed Resident 17's electronic medical record and was unable to find a physician's order for Resident 17 to get an MRI. RN 1 stated Resident 17 went out for a neurologist appointment on 11/12/2024.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/24/2025 at 10:44 a.m. with RN 1, RN 1 stated whenever a resident came back from an outside medical appointment without any after visit care records, the licensed vocational nurse (LVN) or the RN supervisor must inform the Medical Records Supervisor (MRS) to contact the doctor's office and obtain the resident's care records. RN 1 stated it was important to get an after-visit care record so the licensed nurse would know if there were any new orders from the doctor.</p> <p>During an interview on 1/24/2025 at 11:20 a.m. with the MDS Coordinator and the MRS, the MDS Coordinator and the MRS stated whenever a resident came back from an outside appointment, it was the licensed nurse's responsibility to collect information and care records or reports from the resident, the family, or the staff who went out to the appointment with the resident. If the licensed nurse was unable to obtain care records, the licensed nurse must inform medical records to request the AVS records. The MRS stated nobody informed the MRS to request the AVS records from Resident 17's neurologist's office visit on 11/12/2024.</p> <p>During a subsequent interview on 1/24/2025 at 12:29 p.m. with the MRS, the MRS stated the facility did not have a specific policy regarding obtaining resident records after an outside medical appointment. The MRS stated the facility practice was whenever a resident came back from an outside appointment without any care records or report, the licensed nurse must call the doctor's office to obtain the records. If the licensed nurse was unable to obtain any records or report from the doctor's office, then the licensed nurse must inform the MRS to request records from the doctor's office.</p> <p>During an interview on 1/24/2025 at 12:33 p.m. with LVN 6, LVN 6 stated Resident 17 came back from a neurology appointment on 11/12/2024 at 1:30 p.m. and LVN 6 did not receive any new orders from the neurologist. LVN 6 stated the only records LVN 6 received when Resident 17 came back from the neurology appointment were the transfer records and a blank progress note page which were sent out with Resident 17 to bring to the appointment. LVN 6 stated there was nothing written on the progress note. LVN 6 stated LVN 6 told the RN Supervisor Resident 17 was back from the neurologist's office and LVN 6 did not receive any new orders from the neurologist. LVN 6 stated LVN 6 and/or the RN Supervisor was supposed to notify medical records to obtain resident records from the doctor's office, and the MRS was supposed to call the doctor's office to request for the resident's records. LVN 6 stated LVN 6 did not notify medical records on 11/12/2024 that LVN 6 did not receive any records after Resident 17's neurology appointment. LVN 6 stated the RN Supervisor was supposed to call the neurologist's office to obtain Resident 17's records because LVN 6 was busy passing medications.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44114</b></p> <p>Based on interview and record review, the facility failed to provide care and services to prevent a fall (move downward, typically rapidly and freely without control, from a higher to a lower level) for one of three sampled residents (Resident 12) as indicated in the facility's policies and procedures (P&amp;P) titled, Falls and Fall Risk, Managing, Safety and Supervision of Residents, and Care Plans, Comprehensive Person-Centered, by failing to:</p> <ol style="list-style-type: none"> <li>1. Ensure Certified Nursing Assistant (CNA) 4 and/or Licensed Vocational Nurse (LVN) 6 provided supervision/monitoring (the act of watching a person) to Resident 12, who was assessed as being high risk for falls and had a history of multiple falls when CNA 4 and LVN 6 failed to prevent Resident 1 from being inside the facility's conference room with the door closed, unsupervised, on 12/28/2024.</li> <li>2. Ensure CNA 4, LVN 6, and all nurses (any CNAs, LVNs, and Registered Nurses [RNs]) in the nursing station implemented Resident 1's untitled care plans for falls when CNA 4, LVN 6, and any nurses who were in the nursing station failed to provide frequent (often, many times) visual checks and keep Resident 12 at the nursing station for monitoring.</li> </ol> <p>As a result, on 12/28/2024 at 12 p.m., Resident 12 fell to the floor inside the facility's conference room. Resident 12 sustained a fracture (a break or crack in a bone) of the dens (bony projection of the spine [line of bones down the center of the back that provides support for the body] that allows the head to rotate) of cervical spine 2 (C2 - the upper portion of the spine located in the neck). Resident 12 was transferred and admitted to General Acute Care Hospital (GACH) 1 on 12/28/2024 at 4:10 p.m. for further evaluation.</p> <p>Cross Reference F656</p> <p>Findings:</p> <p>During a review of Resident 12's Admission Record (AR), the AR indicated the facility admitted Resident 12 to the facility on [DATE], with diagnoses that included congested heart failure (CHF - a heart condition that develops when the heart does not pump enough blood for the body's needs), type 2 diabetes (DM2 - a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and end stage renal disease (ESRD - a condition where the kidneys have permanently lost most of their function and can no longer adequately filter waste products from the blood) with hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed).</p> <p>During a review of Resident 12's first untitled care plan (CP), initiated on 7/14/2023, and revised on 8/2/2024, the CP indicated Resident 12 was at risk for falls related to limited mobility, balance problems, confusion, poor safety awareness, history of multiple falls, and use of psychotropics (medications that affect the mind, emotions, and behavior) and diuretic (medication that causes the kidneys to make more urine). The CP interventions included to anticipate and meet Resident 12's needs, follow facility's fall protocol, and provide a safe environment.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 12's Fall Risk Assessment (FRA), dated 4/15/2024, the FRA indicated Resident 12 was at high risk for falls due to history of falls, use of psychotropics, antihypertensive (medication to treat high blood pressure), and hypoglycemic agents (medications to treat high blood sugar), urinary incontinence (inability to control the flow of urine from the bladder), agitated (irritable/unpleasant) behavior and predisposing conditions (conditions that give way to the development of disease).</p> <p>During a review of Resident 12's History and Physical Examination (H&amp;P), dated 4/16/2024, the H&amp;P indicated Resident 12 did not have the capacity to understand and make decisions.</p> <p>During a review of Residents 12's Physical Therapy (PT- therapy used to preserve, enhance, or restore movement and physical function impaired or threatened by disease, injury, or disability) Encounter Notes (PTEN), dated 6/7/2024, the PTEN indicated Resident 12 required maximal assistance (assisting person performed 75 percent (%) of the task) for bed mobility and transfers.</p> <p>During a review of Resident 12's second untitled CP, initiated on 6/14/2024, and revised on 8/7/2024, the CP indicated Resident 12 had an unwitnessed fall (a fall that occurs when no one is present to see it happen) on 6/14/2024. The CP interventions included to provide frequent visual checks and keep Resident 12 at the nursing station so staff (all nursing staff) can monitor and help Resident 12 immediately if Resident 12 tries to stand up without assistance.</p> <p>During a review of Resident 12's third untitled CP, initiated on 9/21/2024, the CP indicated Resident 12 had a witnessed fall (when someone sees another person fall) on 9/21/2024. The CP interventions included to provide frequent visual checks.</p> <p>During a review of Resident 12's Minimum Data Set (MDS, a resident assessment tool), dated 10/26/2024, the MDS indicated Resident 12 had severely impaired cognition (ability to think and process information). The MDS indicated Resident 12 normally used a wheelchair for mobility and was dependent (helper does all the effort) on staff for toileting, and personal hygiene, and chair/bed-to-chair transfer.</p> <p>During a review of Resident 12's Change in Condition Evaluation (CICE), dated 12/28/2024, timed at 12:15 p. m., the CICE indicated on 12/28/2024, untimed, Resident 12 had an unwitnessed fall in the facility's conference room located in front of the nursing station. The CICE indicated Resident 12 suffered a bump to Resident 12's left side of the head. The CICE indicated Resident 12 was awake, alert, verbally responsive, able to follow commands, and answer questions. The CICE indicated Resident 12's vital signs (measurements of the body's most basic functions) were stable and Resident 12 had no neurological deficit (impairment or loss of function affecting the brain, spinal cord [a tube of tissues/nerve fibers that runs from the brain to the lower back. The spinal cord carries nerve signals from the brain to the rest of the body and back], nerves, or muscles). The CICE indicated Registered Nurse (RN) 2 notified Resident 12's physician/medical doctor (MD 1) and MD 1 ordered to transfer Resident 12 to GACH 1 for further evaluation and treatment.</p> <p>During a review of Resident 12's GACH 1 Emergency Note (EN), dated 12/28/2024, timed at 4:10 p.m., the EN indicated Resident 12 was brought in by ambulance from the skilled nursing facility (SNF) where Resident 12 had a mechanical fall (a type of fall caused by an external force or object) out of a wheelchair, and hitting Resident 12's left side of the head and face.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 12's GACH 1 Computed Tomography Scan (CT scan, medical imaging technique used to obtain detailed internal images of the body) Report of Resident 12's cervical spine, dated 12/28/2024, timed at 6 pm, the CT Scan Report indicated Resident 1 had a fracture through the dens (a break in the peg-like [a bolt or pin that holds something in place or marks a location] bone at the top of the C2 in the neck).</p> <p>During a review of Resident 12's GACH 1 Magnetic Resonance Imaging (MRI- medical imaging technique used to obtain images of the body) Report of Resident 12's cervical spine, dated 12/28/2024, timed at 9:05 pm, the MRI Report indicated Resident 12 had a fracture of the dens of C2. The MRI Report indicated findings were concerning for nerve compression (occurs when a nerve is under too much pressure from surrounding tissues). The MRI Report indicated neurosurgical (relating to or involving surgery performed on the nervous system, especially the brain and spinal cord) consultation was recommended for further evaluation and management guidance.</p> <p>During a review of Resident 12's Neurosurgery Consultation Notes (NCN), dated 12/29/2024, untimed, the NCN indicated Resident 12 presented for evaluation of dens fracture and found to have severe stenosis (narrowing of any channel or passageway in the body) in the lower cervical spine sustained after a fall at the SNF. The NCN indicated Resident 12 was a high risk for postoperative (after surgery) complications due largely to age and comorbidities (the condition of having two or more diseases at the same time). The NCN indicated Resident 12's family would like to manage Resident 12 conservatively with a brace (a device fitted to a weak or injured part of the body, to give support).</p> <p>During a review of Resident 12's GACH 1 Discharge Summary Notes (DS), dated 12/30/2024, untimed, the DS indicated Resident 12 was a high risk for postoperative complications, quality of life, and there was an unclear benefit if Resident 12 were to have surgery. The DS indicated Resident 12 was to continue with cervical collar (C-collar - an instrument used to support the neck and spine and limit head movement after an injury) and follow-up with spine surgery for a repeat CT scan of the spine in four weeks.</p> <p>During an interview on 1/21/2025 at 8:30 a.m. with CNA 4, CNA 4 stated on 12/28/2024, at around 8:30 a.m., CNA 4 got Resident 12 ready for the day, transferred Resident 12 in Resident 12's wheelchair after breakfast, wheeled Resident 12 in the hallway, and left Resident 12 next to the nursing station. CNA 4 stated residents (in general) who needed to be monitored were taken to the nursing station at around 8:30 a.m. (daily) so nurses (any CNAs, LVNs, and RNs) in the nursing station could monitor the residents who were left there (at the nursing station). CNA 4 stated CNA 4 returned to the nursing station at 12 p.m. but CNA 4 did not find Resident 12 in the hallway next to the nursing station where CNA 4 left Resident 12. CNA 4 stated when CNA 4 went to the conference room, the conference room door was closed. CNA 4 stated CNA 4 opened the conference room door and found Resident 12 on the floor next to Resident 12's wheelchair by herself (alone). CNA 4 stated Resident 12 had a large bump on Resident 12's head. CNA 4 stated there was no staff supervising Resident 12 in the conference room and staff were unable to see Resident 12 in the conference room from the nursing station because the conference room door was closed.</p> <p>(continued on next page)</p>		

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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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/21/2025 at 12 p.m. with RN 2, RN 2 stated on 12/28/2024, after 12 pm, LVN 6 called RN 2 into the conference room and when RN 2 entered the conference room, Resident 12 was on the floor. RN 2 stated Resident 12 should not be left in the conference room unsupervised since Resident 12 was confused and at high risk for falls. RN 2 stated Resident 12 was able to wheel herself (Resident 12) around the facility. RN 2 stated Resident 12 needed frequent monitoring per Resident 12's care plans and staff did not follow Resident 12's care plans.</p> <p>During an interview on 1/22/2025 at 2:30 p.m. with the Administrator (ADM), the ADM stated Resident 12 had history of multiple falls and needed frequent visual checks. The ADM stated Resident 12 was supposed to be at the nursing station for monitoring. The ADM stated all nurses (any CNAs, LVNs, and RNs) at the nursing station were responsible for supervising/monitoring the residents who were around the nursing station. The ADM stated fall risk and confused residents needed to be monitored every one to two hours. The ADM stated the facility did not know how long Resident 12 was inside the conference room alone and unsupervised. The ADM stated no one witnessed Resident 12 going or being taken into the conference room (on 12/28/2024).</p> <p>During a telephone interview on 1/23/2025 at 3:53 p.m. with LVN 6, LVN 6 stated on 12/28/2024, before lunch time, (unable to recall exact time), LVN 6 checked on Resident 12 and Resident 12 was sitting (in Resident 12's wheelchair) in front of the nursing station. LVN 6 stated Resident 12 was able to wheel herself (Resident 12) to the nursing station. LVN 6 stated (on 12/28/2024) after 12 p.m., CNA 4 notified LVN 6 that Resident 12 had fallen in the conference room. LVN 6 stated when LVN 6 arrived in the conference room, Resident 12 was on the floor next to the door. LVN 6 stated Resident 12 had a bump on Resident 12's left side of the head. LVN 6 stated LVN 6 could not remember if there were any nurses at the nursing station monitoring the residents (all residents including Resident 12) at that time (12/28/2024, before lunch time). LVN 6 stated Resident 12 should not be left alone and unsupervised in the conference room. LVN 6 stated Resident 12 needed to be monitored every hour and frequently because Resident 12 was confused and at high risk for falls. LVN 6 stated since Resident 12's fall was unwitnessed in the conference room, Resident 12 was not being supervised. LVN 6 stated LVN 6 did not see Resident 12 going or being taken to the conference room. LVN 6 stated We, (staff including LVN 6) did not follow Resident 12's care plans to monitor Resident 12 frequently.</p> <p>During a review of the facility's P&amp;P titled, Safety and Supervision of Residents, revised 7/2017 (most updated), the P&amp;P indicated, Resident safety supervision and assistance to prevent accidents were facility-wide priorities. The P&amp;P indicated, The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate (sufficient for a specific need or requirement) supervision. The P&amp;P indicated, Implementing interventions to reduce accident risks and hazards included the following: a. Communicating specific interventions to all relevant staff; b. Assigning responsibility for carrying out interventions; c. Providing training, as necessary; d. Ensuring that interventions are implemented. The P&amp;P indicated, Resident supervision is a core component of the systems approach to safety. The type and frequency of supervision may vary among residents and over time for the same residents.</p> <p>During a review of the facility's P&amp;P titled, Fall and Fall Risk, Managing, revised 3/2018 (most updated), the P&amp;P indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The P&amp;P indicated, The staff will implement a resident-centered fall prevention plan to reduce the risk factor(s) of falls for each resident at risk or with a history of falls.</p> <p>(continued on next page)</p>		

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, revised 3/2022 (most updated), the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P indicated, The comprehensive, person-centered care plan . describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including . which professional services are responsible for each element of care . builds on the resident's strengths; and reflects currently recognized standards of practice for problem areas and conditions.		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34273</p> <p>Based on interview and record review, the facility failed to ensure sufficient Certified Nursing Assistants (CNAs) provided care and services to four of 18 sampled residents (Residents 3, 8, 17, and 18) in accordance with the facility's policy and procedure (P&amp;P) titled, Staffing, Sufficient and Competent Nursing, and the facility's Facility Assessment Tool (a guide used by the facility to evaluate what resources are necessary to care for the facility's residents), on 12/16/2024, 12/22/2024, 12/23/2024, 12/26/2024, 12/28/2024, 1/4/2025, and 1/7/2025.</p> <p>This failure resulted in residents having to wait for up to an hour for call lights (device used by a resident to signal their need for assistance from staff) to be answered and for residents to be changed and cleaned promptly. This failure also had the potential to result in a decline in the residents' physical and psychosocial well-being due to poor quality of care.</p> <p>Findings:</p> <p>1. During a review of Resident 3's Admission Record (AR), the AR indicated Resident 3 was admitted to the facility on [DATE], with diagnoses which included spina bifida (a birth defect that occurs when the spine and spinal cord don't form properly) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 3's History and Physical (H&amp;P, physician's clinical evaluation and examination of the resident), dated 5/16/2024, the H&amp;P indicated Resident 3 can make needs known but cannot make medical decisions.</p> <p>During a review Resident 3's care plan (CP), dated 10/16/2024, the CP indicated Resident 3 had a decline in ADLs performance and the CP interventions included to check Resident 3 for incontinence every 2 hours and as needed, and to change and clean Resident 3 well after each episode of incontinence.</p> <p>During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 11/11/2024, the MDS indicated Resident 3's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) is intact. The MDS indicated Resident 3 was dependent (helper does all the effort) on others for toileting hygiene, showering/bathing, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 3 was always incontinent (lack of voluntary control over urination and/or bowel movement) of bladder and bowel.</p> <p>2. During a review of Resident 8's AR, the AR indicated Resident 8 was admitted to the facility on [DATE], with diagnoses which included wedge compression fracture of unspecified thoracic vertebra (a fracture in the spine/backbone where the front of the vertebra [one of the small bones forming the backbone/spine] collapses and forms a wedge shape).</p> <p>During a review of Resident 8's H&amp;P, dated 12/12/2024, the H&amp;P indicated Resident 8 had the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 8's CP, dated 12/12/2024, the CP indicated Resident 8 had a decline in ADLs performance and the CP interventions included to check Resident 8 for incontinence every 2 hours and as needed, and to change and clean Resident 8 well after each episode of incontinence.</p> <p>During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8's cognition was intact. The MDS indicated Resident 8 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, showering/bathing, upper and lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 8 was frequently incontinent of bowel and bladder.</p> <p>3. During a review of Resident 18's AR, the AR indicated Resident 18 was admitted to the facility on [DATE], with the diagnoses that included myelodysplastic syndrome (a group of blood disorders that affect the bone marrow, the place where blood cells are produced), type 2 diabetes (DM2-health condition that affects how your body turns food into energy), chronic kidney disease stage 4 (CKD-4- a condition where the kidneys have permanently lost most of their function and can no longer adequately filter waste products from the blood).</p> <p>During a review of Resident 18's H&amp;P, dated 12/22/2024, the H&amp;P indicated Resident 18 had decision making capacity.</p> <p>During a review of Resident 18's care plan (CP), dated 12/23/2024, the CP indicated Resident 18 had a decline in: Grooming, feeding, dressing, bathing, toileting, balance, safety, related to decreased functional mobility. CP</p> <p>During a review of Resident 18's MDS, dated [DATE], the MDS indicated Resident 18 is dependent for toileting, oral hygiene, shower, upper and lower body dressing, and personal hygiene. The MDS indicated Resident 18 did not perform ambulation activity.</p> <p>interventions dated 12/23/2024 indicated Occupational therapy (OT-A healthcare professional that helps people regain or improve their ability to perform daily task) skilled OT services every day for 5 days a week for 4 weeks.</p> <p>4. During a review of Resident 17's Admission Record (AR), the AR indicated Resident 17 was admitted to the facility on [DATE], with diagnoses which included conversion disorder (condition where a mental health issue causes physical symptoms), anarthria (loss of speech due to inability to control the muscles used for speaking), and aphonia (loss of voice).</p> <p>During a review of Resident 17's CP, dated 10/5/2023, the CP indicated Resident 3 was at risk for decline in ADLs. The CP interventions included to assist Resident 17 with ADLs every shift.</p> <p>During a review of Resident 17's Minimum Data Set (MDS - a resident assessment tool), dated 1/9/2025, the MDS indicated Resident 17 had no speech but was able to express ideas and wants. The MDS indicated Resident 17's cognition was moderately impaired, and Resident 17 was dependent on others for toileting hygiene, lower body dressing, and for putting on/taking off footwear. Resident 17 required substantial/maximal assistance (helper does more than half the effort) with showering/bathing and with personal hygiene.</p> <p>During an interview on 1/16/2025 at 10:37 a.m. with Family Member (FM) 3, FM 3 stated the nurses were taking 1 hour to change Resident 18's diaper.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/16/2025 at 1:30 p.m. with Resident 3, Resident 3 stated Resident 3 mostly used the call light (a device used by a resident to signal their need for assistance from staff) for a diaper change. Resident 3 stated the longest time Resident 3 waited for a diaper change was an hour. Resident 3 stated the wait to answer the call light and/or to be changed depended on how many residents were assigned to each certified nursing assistants (CNAs). Resident 3 stated the more residents the CNAs had to take care of, the longer it took for CNAs to answer the call lights and to assist other residents.</p> <p>During an interview on 1/16/2025 at 2:49 p.m. with Resident 8, Resident 8 stated on 12/16/2024, Resident 8 reported to a nurse (unidentified) at 8 a.m. and at 9 a.m. Resident 8 had a bowel movement. A nurse (unidentified) responded at 9:35 a.m., but Resident 8 did not get cleaned and changed until 10:25 a.m. Resident 8 stated some CNAs (unidentified) were rough when providing care to Resident 8. Resident 8 stated the CNAs were not intentionally rough just in a hurry.</p> <p>During an interview on 1/21/2025 at 10:20 a.m. with CNA 3, CNA 3 stated for 7-3 shift (7 a.m. to 3 p.m.), before January 2025, CNAs usually had 10 to 12 residents 3 to 4 times a week because some CNAs would call in sick. CNA 3 stated with 10 to 12 residents CNAs could not provide good care. CNA 3 stated CNAs tried their best but could not do it. CNA 3 stated whenever CNAs had 10 to 12 residents each, residents would not get showered, residents would not get changed right away, and residents were not gotten up out of bed because more CNAs were needed to use the machine to lift the residents out of bed.</p> <p>During an interview on 1/21/2025 at 12:51 p.m. with FM 1, FM 1 stated FM 1 have heard other residents complain to each other about being left wet.</p> <p>During an interview on 1/21/2025 at 2:06 p.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated a resident complained once of call lights not being answered right away because there were only 4 CNAs on the 3-11 (3 p.m. to 11 p.m.) shift. LVN 4 did not remember the name of the resident and/or when the resident complained.</p> <p>During an interview on 1/22/2025 at 11:33 a.m. with FM 2, FM 2 stated how often residents got turned and how soon residents got cleaned depended on how many CNAs were working. FM 2 stated some days, residents were not turned and cleaned every 2 hours.</p> <p>During an interview on 1/22/2025 at 2:44 p.m. with CNA 4, CNA 4 stated when CNAs have 12 or more residents each, it took a long time to change residents.</p> <p>During an interview on 1/23/2025 at 8:07 am with LVN 7, LVN 7 stated sometimes there were only 4 CNAs working in the whole facility on the 11-7 (11 p.m. to 7 a.m.) shift. LVN 7 stated there was a time when there were only three CNAs working. LVN 7 stated not having enough CNAs could result in resident fall and delay in ADL care.</p> <p>During a review of the facility assignment sheet, the assignment sheet indicated the following:</p> <p>a. On 12/16/2024, there were 6 CNAs in the 3 p.m. to 11 p.m. shift. 3 CNAs had 13 residents, 1 CNA had 11 residents, and 1 CNA had 18 residents.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. On 12/16/2024, there were 4 CNAs in the 11 p.m. to 7 a.m. shift. 3 CNAs had 20 residents, and 1 CNA had 22 residents.</p> <p>c. On 12/22/2024, there were 8 CNAs in the 7 a.m. to 3 p.m. shift. 3 CNAs had 12 residents, 2 CNAs had 9 residents, 1 CNA had 10 residents, and 1 CNA had 8 residents.</p> <p>d. On 12/22/2024, there were 4 CNAs on the 11 p.m. to 7 a.m. shift. 1 CNA had 7 residents, 1 CNA had 29 residents, 1 CNA had 28 residents, and 1 CNA had 22 residents.</p> <p>e. On 12/23/2024, there were 7 CNAs in the 7 a.m. to 3 p.m. shift and the 7 CNAs had 12 to 13 residents each. There were 6 CNAs on the 3 p.m. to 11 p.m. shift and the 6 CNAs had 13 to 15 residents each. There were 4 CNAs in the 11 p.m. to 7 a.m. shift and the 4 CNAs had 18 to 22 residents each.</p> <p>f. On 12/26/2024, there were 5 CNAs on the 11 p.m. to 7 a.m. shift. 2 CNAs had 15 residents, 1 CNA had 16 residents, 1 CNA had 17 residents, and 1 CNA had 21 residents.</p> <p>g. On 12/28/2024, there were 4 CNAs on the 11 p.m. to 7 a.m. shift. 2 CNAs had 20 residents, and 2 CNAs had 21 residents.</p> <p>h. On 1/4/2025, there were 4 CNAs on the 11 p.m. to 7 a.m. shift. 1 CNA had 19 residents, 2 CNAs had 20 residents, and 1 CNA had 21 residents.</p> <p>i. On 1/7/2025, there were 5 CNAs on the 11 p.m. to 7 a.m. shift. 2 CNAs had 16 residents, 1 CNA had 17 residents, 1 CNA had 18 residents, and 1 CNA had 19 residents.</p> <p>During a review of the facility's P&amp;P titled, Staffing, Sufficient and Competent Nursing, dated 8/2022, the P&amp;P indicated, staffing numbers and the skill requirements of direct care staff (CNAs) are determined by the needs of the residents based on each resident's plan of care, the resident assessment, and the facility assessment .</p> <p>During a review of the facility's document titled, Facility Assessment, dated 8/2024, the Facility Assessment indicated the total number of CNAs needed for each shift were: 7 to 10 residents per CNA on the 7 a.m. to 3 p.m. shift; 10 to 13 residents per CNA on the 3 p.m. to 11 p.m. shift; and 12 to 16 residents on the 11 p.m. to 7 a.m. shift.</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34273</p> <p>Based on interview and record review, the facility failed to ensure certified nursing assistants (CNAs) turned and cared for 2 of 18 sampled residents (Resident 7 and Resident 8) according to the CNAs training when:</p> <ol style="list-style-type: none"> <li>1. CNAs (unable to identify) did not use a draw sheet (lift sheet- small sheet used to reposition patients in bed) to turn Resident 7 and Resident 8 in bed.</li> <li>2. CNAs (unable to identify) roughly and hurriedly turned Resident 8 to Resident 8's side while changing Resident 8 in bed.</li> </ol> <p>These failures resulted in Resident 7 and Resident 8 to have pain during care provision and had the potential to affect Resident 7's and Resident 8's well-being.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of the Admission Record (AR) for Resident 7, the AR indicated Resident 7 was admitted to the facility on [DATE], with diagnoses which included dislocation of internal right hip prosthesis (an artificial device or implant used to replace or enhance a missing or damaged body part or function).</li> </ol> <p>During a review of Resident 7's History and Physical (H&amp;P, physician's clinical evaluation and examination of the resident), dated 1/5/2025, the H&amp;P indicated Resident 7 had capacity to understand and make decisions.</p> <p>During a review of Resident 7's Minimum Data Set (MDS - a resident assessment tool), dated 1/10/2025, the MDS indicated Resident 7's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated Resident 7 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene and upper body dressing and was dependent (helper does all of the effort) on others for showering/bathing, lower body dressing, and putting on/taking off footwear.</p> <p>During an interview on 1/16/2025 at 2:40 p.m. with Resident 7, Resident 7 stated some of the CNAs (unable to identify) in the facility pushed on Resident 7's skin instead of using a draw sheet whenever the CNAs turned Resident 7 in bed. Resident 7 stated it was painful when CNAs do not use a draw sheet to turn Resident 7.</p> <ol style="list-style-type: none"> <li>2. During a review of Resident 8's AR, the AR indicated Resident 8 was admitted to the facility on [DATE], with diagnoses which included wedge compression fracture of unspecified thoracic vertebra (a fracture in the spine/backbone where the front of the vertebra [one of the small bones forming the backbone/spine] collapses and forms a wedge shape).</li> </ol> <p>During a review of Resident 8's H&amp;P, dated 12/12/2024, the H&amp;P indicated Resident 8 had the capacity to understand and make decisions.</p> <p>(continued on next page)</p>

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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)		
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8's cognition was intact. The MDS indicated Resident 8 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, showering/bathing, upper and lower body dressing, and putting on/taking off footwear.</p> <p>During an interview on 1/16/2025 at 2:49 p.m. with Resident 8, Resident 8 stated some CNAs (unable to identify) pushed and held on to Resident 8's skin whenever the CNAs turned Resident 8 in bed. Resident 8 stated it was painful when CNAs pushed on Resident 8's skin to turn Resident 8. Resident 8 stated some CNAs were rough when providing care to Resident 8. Resident 8 stated the CNAs were not intentionally rough just in a hurry.</p> <p>During an interview on 1/21/2025 at 2:55 p.m. with the Director of Staff Development (DSD), the DSD stated the facility checked the CNAs skills competency last October 2024 which included how to turn and reposition residents, how to transfer residents from bed to wheelchair and wheelchair to bed, and to handle residents gently and unhurriedly. The DSD stated CNAs were taught to use a draw sheet to turn residents to their side when changing and repositioning. The DSD stated CNAs were expected to do what they were taught.</p> <p>During a review of the facility document titled, Competency Assessment Repositioning, dated 5/2013, the document indicated to use two people and a draw sheet to avoid shearing while turning or moving the resident up in bed .</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Staffing, Sufficient and Competent Nursing, dated 8/2022, the P&amp;P indicated the facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans .Competency requirements and training for nursing staff are established and monitored by nursing leadership with input from the medical director to ensure that .education topics and skills needed are determined based on the resident population .</p>		