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	04/24/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 50203 Based on observation, interview, and record review, the facility failed to develop a person-centered comprehensive care plan (a plan that outlines resident-specific interventions used to guide a resident ' s care for a given area of concern), with measurable objections for one of three sampled residents (Resident 6) to ensure Resident 6 was monitored and interventions were identified for her non-compliance to wear Resident 6's facemask during a SARS-Co2-V (COVID-19) outbreak in the facility. This failure had the potential to result in Resident 6 not receiving the necessary care and interventions for non-compliance that could lead to a decline in the resident ' s physical and psychosocial well-being. Findings: During a review of Resident 6 ' s Admission Records, the facility admitted Resident 6 on 8/24/2024 with diagnoses that included Alzheimer ' s disease (a disease characterized by a progressive decline in mental abilities), generalized muscle weakness, and displaced fracture of second cervical vertebra (spinal fracture). During a review of Resident 6 ' s History and Physical (H&P, a comprehensive physician ' s note regarding the assessment of the resident ' s health status), dated 8/24/2024, the H&P indicated Resident 6 did not have the capacity to understand and make decisions. During a review of Resident 6 ' s Minimum Data Set (MDS, a resident assessment tool), dated 2/28/2025, the MDS indicated Resident 3 ' s cognitive (a person ' s mental process of thinking, learning, remembering, and using judgement) skills were severely impaired. The MDS indicated Resident 6 was dependent (helper does all the effort) on staff assistance to perform her activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily) and for Resident 6's functional mobility (a person ' s ability to move safely and independently within their environment) such as turning to the left and right side and returning to Resident 6 back on the bed. During a review of Resident 6 ' s care plan, initiated on 4/14/2025, the care plan indicated Resident 6 was exposed to the COVID-19 virus. The care plans interventions included to educate resident on hand hygiene, benefits of wearing masks or covering mouth, and social distances. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/22/2025 at 12:08PM by Residents 6 room, a purple Novel Respiratory Precautions isolation sign was posted on the door. During an observation on 4/22/2025 at 12:09PM in the hallway of Resident 6 ' s room, Resident 6 was observed in the hallway sitting in Resident 6's wheelchair (a chair with feels for use as a means of transport) interacting with other residents and staff members not wearing a face mask. During an observation on 4/23/2025 at 11:23AM in the hallway of Resident 6 ' s room, Resident 6 was observed in the hallway sitting in Resident 6's wheelchair not wearing a face mask. During an observation on 4/23/2025 at 12:13PM in the hallway of Resident 6 ' s room, Resident 6 was observed in the hallway sitting in Resident 6's wheelchair with a face mask position under Resident 6's chin, not covering Resident 6's nose or mouth. During an interview on 4/23/2025 at 1:48PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, Resident 6 was compliant and stayed in Resident 6's room for the first few days after the positive COVID exposure. LVN 1 stated, it became hard to keep Resident 6 in Resident 6's room because Resident 6 wanted to be in the hallway. LVN 1 stated, Resident 6 needed frequent reminders to stay in Resident 6's room or to wear a mask in the hallway. During an interview on 4/23/2025 at 4:30PM with the Infection Preventionist (IP), the IP stated, Resident 6 was exposed to a positive COVID-19 resident on 4/14/2025. The IP stated, for the first couple days post-exposure, Resident 6 was complaint and stayed in Resident 6's room. The IP stated, Resident 6 started leaving Resident 6's room and going into the hallways starting 4/18/2025. The IP nurse stated, Resident 6 needed constant reminders to wear a face mask in the hallway or to stay in Resident 6's room. During an interview on 4/23/2025 at 4:40PM with the IP, the IP stated a care plan was not created on 4/18/2025 related to Resident 6 ' s non-compliance. The IP stated, a care plan should have been created on 4/18/2025 because Resident 6 had a known behavior related to Resident 6's non-compliance of not wearing a face mask. The IP stated, it was important to create a care plan to ensure there were interventions and a plan in place to prevent Resident 6 from exposing other patients and staff to COVID-19. The IP stated, care plans were important for nurses to follow the plan and to implement interventions for patients who may be confused, nonverbal, or forgetful. During a review of the facility ' s policies and procedures (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated a 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, which reflects currently recognized standards of practice for problems areas and conditions. During a review of the facility ' s P&P titled, Care Plan, Comprehensive Person-Centered, dated 3/2022, the P&P indicated assessments of residents are ongoing and care plans are revised as information about the resident and the residents conditions change.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50203 Based on observations, interview, and record review, the facility failed to follow its infection control measure for three of three sampled residents (Residents 6, 7, and 8) by failing to ensure: 1. Certified Nurse Assistant (CNA) 2 used proper hand hygiene after handling Resident 8 ' s dirty food tray. 2. CNA 2 used proper hand hygiene before handling Resident 6 and 7 ' s food tray to CNA 1. 3. CNA 1 used proper personal protective equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) in a SARS-CoV-2 (COVID-19) exposed room 4. CNA 1 used proper hand hygiene before tray-set up and in-between Resident 6 and 7. These failures had the potential to contribute to poor infection control and had the potential to result on the continued widespread infection (a process when a microorganism, such as a bacteria, fungi, or a virus, enters a person ' s body and causes harm) of COVID-19 affecting residents, staff members, and visitors to the facility. Findings: During a review of Resident 8 ' s Admission Records, the facility admitted Resident 8 on 7/9/2022 and readmitted Resident 8 on 2/7/2023 with diagnoses of epilepsy (two or more unprovoked seizures [a sudden, uncontrolled electrical disturbance in the brain, which can cause uncontrolled jerking, blank stares, and loss of consciousness]), hypertension (blood pressure), and gastro-esophageal reflux disease (GERD, backward flow of stomach acid into the tube that connects the stomach to the throat). During a review of Resident 8 ' s Order Summary Report (physician orders), an order, with a start date of 2/7/2023, indicated Resident 8 had a no-added salt, with ground meat-like texture, mechanical soft (foods that require minimal chewing and easily swallowed) diet. During a review of Resident 8 ' s Minimal Data Set (MDS, a resident assessment tool), dated 2/21/2025, the MDS indicated Resident 8 ' s cognitive (a resident ' s mental process of thinking, learning, remembering, and using judgement) skills were severely impaired. The MDS indicated Resident 8 required set up or clean up assistance (helper assists only prior to or after the activity) when eating and required dependent (helper does all the effort) assistance with performing activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 8 ' s History and Physical (H&P, a comprehensive physician ' s note regarding the assessment of the resident ' s health status), dated 4/24/2025, Resident 8 did not have the capacity to understand and make decisions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 7 ' s Admission Records, the facility admitted Resident 6 on 10/26/2021 with diagnoses which included vascular dementia (decrease blood supply to the brain leading to brain tissue damage and impaired cognitive function), localized osteoporosis (weak and brittle bones due to lack of calcium and vitamin D), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 7 ' s Order Summary Report, an order, with a start date of 8/11/2024, indicated Resident 7 had a fortified (added nutrients) and high protein, with ground meat-like texture), mechanical soft diet. During a review of Resident 7 ' s MDS, dated [DATE], the MDS indicated Resident 7 ' s cognitive skills were moderately impaired. The MDS indicated Resident 7 required maximal assistance (helper does more than half the effort) to perform her ADLs and for functional mobility (a person ' s ability to move safely and independently within their environment) such turning to the left and right side and returning to her back on the bed. During a review of Resident 7 ' s H&P, dated 4/11/2025, the H&P indicated Resident 7 made her needs known but cannot make medical decisions. During a review of Resident 6 ' s Admission Records, the facility admitted Resident 6 on 8/24/2024 with diagnoses which included muscle weakness, Alzheimer ' s disease (a disease characterized by a progressive decline in mental abilities), and displaced fracture of the second cervical vertebra (spinal fracture). During a review of Resident 6 ' s Order Summary Report, an order, with a start date of 10/22/2024, indicated Resident 6 had a fortified regular no-added salt, ground meat-like texture, mechanical soft diet. During a review of Resident 6 ' s H&P, dated 8/24/2024, the H&P indicated Resident 6 did not have the capacity to understand and make decisions. During a review of Resident 6 ' s MDS, dated [DATE], the MDS indicated Resident 3 ' s cognitive skills were severely impaired. The MDS indicated Resident 6 was dependent on assistance to perform her ADLs and for her functional mobility such as turning to the left and right side and returning to her back on the bed. During an observation on 4/23/2025 at 12:07PM, in the hallway outside Resident 8 ' s room, Certified Nurse Assistant (CNA) 2 was observed walking out of Resident 8 ' s room without wearing gloves, holding Resident 8 ' s finished food tray, and putting it in the transport tray cart (wheeled device used to carry trays). CNA 2 was observed not sanitizing his hands with alcohol-based hand rub before handling and passing Resident 7 ' s clean food tray to CNA 1. During an observation on 4/23/2025 at 12:08PM by Residents 6 and 7 ' s room, a purple Novel Respiratory Precautions isolation sign was posted on the door. CNA 1 was observed standing in the doorway not wearing gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/23/2025 at 12:10PM by Residents 6 and 7 ' s room, CNA 2 passed Resident 7 ' s clean food tray to CNA 1. CNA 1 accepted the clean food tray, proceed to enter Resident 6 and 7 ' s room, and set-up Resident 7 ' s food tray on the overbed table (a small, mobile table designed to be placed over a bed or chair). CNA 1 was observed not sanitizing CNA 1's hands with alcohol-based hand rub before accepting Resident 7 ' s clean food tray. During an observation on 4/23/2025 at 12:15PM, by Resident 6 and 7 ' s room, CNA 2 passed Resident 6 ' s clean food tray to CNA 1. CNA 1 accepted Resident 6 ' s clean food tray, proceeded to enter Resident 6 and 7 ' s room, and set up Resident 6 ' s food tray on the overbed table. CNA 1 was observed not sanitizing CNA 1's hands with alcohol-based hand rub before accepting Resident 6 ' s clean lunch tray and in-between setting up Resident 6 and 7 ' s food trays. During an interview on 4/23/2025 at 1:02PM with CNA 2, CNA 2 stated, CNA 2 did not wash CNA 2's hands or use alcohol-based hand rub when exiting Resident 8 ' s room with a dirty food tray and putting it in the transport tray cart. CNA 2 stated, CNA 2 did not use alcohol-based hand rub to sanitize CNA 2's hands before removing Resident 6 or Resident 7 ' s clean lunch tray from the transport tray cart and passing the clean food trays (Resident 6 and 7) to CNA 1. During an interview on 4/23/2025 at 1:15PM with CNA 1, CNA 1 stated, the rooms with the purple Novel Respiratory precautions isolation sign and a yellow sticker by the resident ' s name indicated the resident had been exposed to COVID-19. CNA 1 stated, it was important to wear all PPE in these rooms which consist of N95 mask, gown, gloves, face shield, or eye protection. CNA 1 stated, CNA 1 was not wearing gloves when accepting Resident 6 and 7 ' s food trays from CNA 2. CNA 1 stated, CNA 1 did not wear gloves or use alcohol-based hand sanitizer in-between tray set-ups for Resident 6 and Resident 7. During an interview on 4/23/2025 at 4:00PM with the Infection Preventionist (IP), the IP stated, for residents who were exposed to COVID 19, it was important for the staff to wear their PPE, which included gown, gloves, eye goggles/ face shields, and an N95 mask to prevent the spread of infections such as COVID 19 to other residents, staff members, and visitors. During an interview on 4/23/2025 at 4:15PM with the IP, the IP stated, the CNAs should practice good hand hygiene such as washing hands or using alcohol-based hand rub when handling resident ' s food trays, before and after entering a resident ' s room, providing cares in-between residents, and touching the resident ' s environment. The IP stated, good hand hygiene was important for infection control and to prevent the spread of germs, bacteria, and viruses between residents, staff members, and visitors. During a review of the facility ' s P&P titled Coronavirus Disease (COVID-19) - Identification and Management of Ill Residents, dated 5/2023, the P&P indicated staff who enter the room of a resident with suspected or confirmed SARS-VoC-2 infection will adhere to standard precautions and use a NIOSH (National Institute for Occupational Safety and Health, federal agency responsible for work-related injuries, illness, disability, and death) approved particulate respiratory with N95 filters or higher, gown, gloves, and eye protection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s policies and procedures (P&P) titled Handwashing/Hand Hygiene, dated 10/2023, the P&P indicated, all personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. The P&P indicated, hand hygiene was practiced [.] after touching the resident ' s environment.