

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 05/13/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>40913</p> <p>Based on observation, interview, and record review, the facility failed to ensure the call light was plugged in and functioning for one of two sampled residents (Resident 1).</p> <p>This deficient practice had the potential to result in unmet needs for Resident 1.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident 1 on 10/4/2023, with diagnoses that included conversion disorder (a psychiatric disorder characterized by symptoms affecting sensory or motor function which are inconsistent with patterns of known neurologic diseases or other medical conditions) and aphonia (voice disorder, loss of voice).</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/8/2025, the MDS indicated Resident 1 had intact cognition (ability to understand and process information). The MDS indicated Resident 1 was dependent on staff with toileting hygiene and required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort).</p> <p>During an observation on 5/12/25 at 1:55 PM, the call light button was hanging on the trapeze (the overhead device features a triangular handle for patients with limited mobility to hold onto while lifting themselves into a new position in the bed or into a mobility device) handle, the call light plug was pulled out from the wall outlet. Licensed Vocational Nurse 1 (LVN 1) connected the call light plug to the wall outlet. LVN 1 stated LVN 1 had just noticed the call light plug was not connected so LVN 1 pushed the plug into the wall outlet so the call light would work. LVN 1 stated LVN 1 was inside Resident 1's room between 8 AM to 9 AM and did not check the call light plug at that time. Resident 1 was unable to move the right side of Resident 1's body, the wall outlet used to connect the call light was located on the head part of the bed and toward the right side.</p> <p>During an interview on 5/12/25 at 3:23 PM, Certified Nursing Assistant 7 (CNA 7) stated Resident 1 usually called [for assistance] a lot. CNA 7 stated CNA 7 wondered why Resident 1 was not calling [by pressing the call light button] for assistance on 5/12/2025. CNA 7 stated CNA 7 did not check Resident 1's call light. CNA 7 stated CNA 7 needed to check if the call light was working so Resident 1 would call for assistance in the case of an emergency.</p> <p>During an interview on 5/12/2025 at 3:55 PM with the Director of Nursing (DON), the DON stated the call light needed to be within resident's reach and functioning.</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 0558</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 undated Policy and Procedure (P&P) titled, Answering the Call Light, the P&P indicated to ensure the call light is plugged in and functioning at all times.</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>40913</p> <p>Based on interview and record review the facility failed to ensure the facility's Policy and Procedure (P&P) titled, Abuse, Neglect, Exploitation, and Misappropriation Prevention Program included screening of potential employees, previous employers, and/or current employers. The facility failed to maintain documentation indicating screening of 3 of 6 sampled employees (Certified Nursing Assistant [CNA] 1, CNA 2 and CNA 3).</p> <p>This deficient practice had the potential to result in hiring of employees that were involved in resident abuse incidents and the potential to jeopardize the safety of the residents.</p> <p>Findings:</p> <p>During a record review of Employee Files and a concurrent interview with the Director of Staff Development (DSD) on 5/9/2025 at 1:52 PM. Six employee files were reviewed. The employee files indicated 3 out of 6 employees did not have reference checks.</p> <p>a. (CNA) 1 had no reference check and the Pre-Employment Reference Checklist (PRC) was left blank.</p> <p>b. CNA 2 had no reference check and there was no PRC in CNA 2's employee file.</p> <p>c. CNA 3 had no reference check and there was no PRC in CNA 3's employee file.</p> <p>There were previous employee files stacked on the floor, the files were reviewed with the DSD. There were no other documents found that indicated reference checks were completed for CNA 1, 2, and CNA 3.</p> <p>During an interview on 5/9/2025 at 3 PM, the DSD stated during reference checks, the DSD inquired about the employee's attitude at work, for any history of allegations of abuse at the previous employer, and if the previous employer would hire the employee back.</p> <p>During an interview on 5/9/2025 at 3:10 PM, the Administrator (ADM) stated the facility did background screening (checks) when asked regarding reference checks.</p> <p>During an interview on 5/13/2025 at 12:50 PM, the ADM stated the facility conducted reference checks for new employees and did not know what happened with the previous DSD. The ADM stated new hires had reference checks in their files and the ADM personally called the reference check for CNA 2. The ADM did not have documented evidence that indicated the date and time of CNA 2's reference check or the previous employer's reference feedback.</p> <p>During a review of the facility's document titled Pre-Employment Reference Checklist the PRC indicated the facility obtained at least two (2) reference checks for each applicant.</p> <p>(continued on next page)</p>		

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<p>F 0607</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 Policy and Procedure (P&P) titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated April 2021, the P&P did not indicate screening potential employees for a history of abuse, neglect, exploitation, or misappropriation of resident property including attempting to obtain information from previous employers and/or current employers.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>40913</p> <p>Based on observation, interview, and record review, the facility failed to ensure Certified Nursing Assistant (CNA) 7 and CNA 8 provided incontinent (loss of bladder control, varying from a slight loss of urine after sneezing, coughing, or laughing to complete inability to control urination) care to one of two sampled residents (Resident 1).</p> <p>This deficient practice had the potential to result in a rash or skin irritation to Resident 1.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident 1 on 10/4/23, with diagnoses that included conversion disorder (a psychiatric disorder characterized by symptoms affecting sensory or motor function which are inconsistent with patterns of known neurologic diseases or other medical conditions) and aphonia (voice disorder, loss of voice).</p> <p>During a review of Resident 1's care plan (CP), initiated 10/14/23, the CP indicated Resident 1 was incontinent with both bowel and bladder secondary to impaired mobility and inability to alert staff. The CP's interventions indicated CNAs to check for bladder incontinence at least every two hours as needed and to increase frequency as needed.</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/8/2025, the MDS indicated Resident 1 had intact cognition (ability to understand and process information). The MDS indicated Resident 1 was dependent on staff with toileting hygiene and required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort).</p> <p>During an observation on 5/12/2025 at 1:18 PM, Resident 1 communicated through gestures to check Resident 1's gown, Resident 1 held up the left side of Resident 1's gown, the gown was wet, and there was a smell of urine when standing a foot away from Resident 1. The pad underneath Resident 1 was wet. Resident 1 wrote on a tablet [electronic device], They do not change me, they leave me like this and if I complain, they will say I am lying and that I spilled water. In Resident 1's room, there were two water pitchers that were heavy and filled with water.</p> <p>During an interview on 5/12/2025 at 2:04 PM, with CNA 7, CNA 7 stated Resident 1 was asleep when CNA 7 came to check on Resident 1's roommate at 9 AM. CNA 7 stated Resident 1 was asleep when CNA 7 went inside Resident 1's room to check on Resident 1's roommate at 11 AM. CNA 7 stated CNA 7 knew when Resident 1 was asleep because Resident 1 usually opened the curtain facing the door but Resident 1 did not open the curtain during those times. CNA 7 stated around lunch time, CNA 7 removed the breakfast tray and left 2 cups of strawberry milkshake on Resident 1's table. CNA 7 stated CNA 7 did not check if Resident 1 needed a diaper (adult brief) change.</p> <p>During an observation on 5/12/2025 at 2:17 PM, CNA 7 and the Case Manager (CM) prepared to change Resident 1's adult brief. While CNA 7 prepared a bucket for soap and water. Resident 1 asked the CM using gestures to check Resident 1's gown, the CM touched Resident 1's gown and stated the gown was damp. Resident 1 asked the CM through gestures to lower the CM's mask, the CM pulled down the CM's mask and stated the CM could smell urine.</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 - Few</p>	<p>During an observation on 5/12/2025 at 2:44 PM, Resident 1's adult brief was wet, there was a yellowish tinge color on the adult brief. The CM stated the adult brief was wet. CNA 7 with the CM assisting with the change proceeded to provide a bed bath to Resident 1.</p> <p>During an interview on 5/12/2025 at 3:23 PM, with CNA 7, CNA 7 stated Resident 1 was known to be very demanding and particular with Resident 1's care. CNA 7 stated CNA 7 was planning to provide care to Resident 1 at the end of CNA 7's rounds after CNA 7 saw and provided care to the rest of CNA 7's assigned residents (8). CNA 7 stated CNA 7 had to provide 4 showers that day. CNA 7 stated CNA 7 asked 2 co-workers to assist CNA 7 with Resident 1's care but the two CNAs could not help. CNA 7 stated CNA 7 needed to check residents assigned to CNA 7 more than once per shift for incontinence care, because residents could develop rashes, skin irritation, or a urinary tract infection urinary tract infections (an infection in any part of the urinary system: kidneys, bladder [reservoir for urine], or urethra [tube through which the urine leaves the body]) when residents did not receive incontinent care as needed.</p> <p>During an interview on 5/12/2025 at 3:55 PM, the Director of Nursing (DON) stated the CNA's (in general) needed to check their assigned residents [adult briefs] every 2 hours and as needed. The DON stated when a resident requested an adult brief change, the CNA or the nurse needed to communicate with other staff to find out who could provide the care if the assigned CNA was not available.</p> <p>During an observation on 5/13/2025 at 8:17 AM, Resident 1 typed on the tablet I need to be changed. LVN 1 stated LVN 1 would notify CNA 8 who was providing a shower to another resident.</p> <p>During an observation on 5/13/2025 at 10:20 AM, Resident 1 shook Resident 1's head (side to side to indicate no) when asked if CNA 8 had changed Resident 1's adult brief.</p> <p>During an observation on 5/13/2025 at 10:40 AM, CNA 8 and the CM were preparing to change Resident 1's adult brief, CNA 8 checked Resident 1's adult brief and the brief was neatly closed with no signs of tearing on the sides. CNA 8 opened the adult brief and the brief expanded. CNA 8 checked the pad located underneath Resident 1, CNA 8 stated the pad was wet.</p> <p>During an interview on 5/13/2025 at 11:35 AM, CNA 8 stated this was the first time CNA 8 changed Resident 1's adult brief today. CNA 8 stated when LVN 1 informed CNA 8 Resident 1 needed incontinent care, CNA 8 did not change Resident 1's adult brief because CNA 8 was with attending to and showering other residents.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Activities of Daily Living, Supporting dated March 2018, the P&P indicated appropriate care and services will be provided for residents who are unable to carry out Activity of Daily Living (ADL, term used in healthcare that refers to self-care activities) independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressings, grooming, and oral care) elimination (toileting) .</p>		