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	08/05/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility to ensure one of five sampled residents (Resident 1) was provided timely responses to requests and needs according to the facility's policy and procedure (P&P) titled, Answering the Call Light, by failing to ensure:On [DATE], [DATE] and [DATE], Resident 1's call light was fully connected to the wall and was within reach of Resident 1.This failure caused Resident 5 to not be able to get assistance from staff when Resident 1 needed to be changed. Resident 1 was left soiled in Resident 1's briefs (disposable under garment used for those who have a loss of continence [ability to hold the bladder and bowels]) with urine, feces, and/or blood.During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on [DATE] with diagnoses that included conversion disorder (CD- a mental health condition where a person experiences neurological symptoms, like paralysis [the loss of muscle function in part of the body, resulting from problems with how messages travel between the brain and muscles] or blindness [partial or full loss of vision], that cannot be explained by a medical or neurological condition due to the brain converting psychological distress into physical symptoms) with mixed symptom presentation, aphonia, and generalized anxiety disorder (persistent feeling of dread or panic that can interfere with daily life). During a review of an untitled CP, the CP indicated Resident 1 preferred the call light to hang from above Resident 1's head on the trapeze (a mobility aid, often used in healthcare settings, that is suspended above a bed to assist patients with repositioning, transferring in and out of bed, and performing exercises), initiated [DATE]. The CP indicated Resident 1 would continue to be able to use call light by tapping it. The CP interventions indicated educating staff on Resident 1's preference of call light placement, and to ensure Resident 1 was able to reach the call light. During a review of the same untitled CP, the CP indicated Resident 1 was incontinent (inability to control the bladder and bowels) with both bowel and bladder in relation to impaired mobility and inability to alert staff of Resident 1's urges, and was at risk for infection, skin breakdown, and was on a check and change program, initiated [DATE] and revised on [DATE]. The CP goals indicated Resident 1 would be kept clean, dry, and odor free daily for three months. The CP interventions indicated that CNAs were to check Resident 1 for bladder incontinence at least every two hours, as needed, and to increase frequency as needed, keep Resident 1's call light within reach and answer promptly, and to monitor as indicated for redness or skin breakdown, and to report to MD (medical doctor, physician). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated [DATE], the MDS indicated Resident 1 had intact cognition (ability to think, remember, and function). The MDS indicated Resident 1 had the absence of spoken words. The MDS indicated Resident 1 had seven to 11 days (half or more of the days) feeling down, depressed (common and serious illness that negatively affects how one feels, thinks and acts) or hopeless. The MDS indicated Resident 1 was dependent (helper does ALL the effort to complete the activity) with toileting hygiene and chair/bed-to-chair transfers. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort to complete activity) with personal hygiene, showering/bathing self, and rolling left and right (in bed). The MDS indicated the activity was not attempted due to medical condition or safety concerns for sitting to lying, lying to sitting on side of bed, and sitting to standing. The MDS indicated Resident 1 had hereditary (passed down from parent to child) and idiopathic (no identifiable cause) neuropathy (a condition that involves damage to the peripheral nervous system from injury or disease process). During an observation on [DATE] at 9:58 am, inside Resident 1's room, Resident 1 was observed until 10:09 am. Resident 1 was lying in bed with closed eyes. Resident 1's call light was hanging above Resident 1's head on the trapeze. The call light was placed towards the wall on the trapeze, not above Resident 1's head and out of Resident 1's reach. During a concurrent observation and interview on [DATE] at 11 am, in Resident 1's room, Resident 1 was observed. Resident 1 used the surveyor's phone to type Resident 1's responses to questions. Resident 1 typed, I am really wet. I pooped and peed and I can't reach my call light, and I can't communicate with anyone because the tablet they (staff in general) gave me died and no one can understand me. Resident 1 typed that Resident 1's sheets and brief were wet. Resident 1 typed, I am so uncomfortable, and they don't care. During a concurrent observation and interview on [DATE] at 11:27 am, inside Resident 1's room, CNA 1 and CNA 2 were observed with Resident 1. Resident 1 typed on surveyor's phone, I've been wet since 2 am. The night staff wouldn't change and neither of you asked me if I needed to be changed. Resident 1 typed, I need a bath, please. I pooped and peed and I've been asking since you gave me breakfast this morning. I can't

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 1) received activities of daily living care according to the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADL), Supporting, by failing to: Ensure Resident 1 was not left soiled of urine, feces, and/or menstruation fluid on 7/12/2025, 8/1/2025, and 8/5/2025. As a result of these failures, Resident 1 was left soiled in Resident 1's brief (disposable under garment used for those who have a loss of continence [ability to hold the bladder and bowels]) with urine, feces, and/or blood. Cross Reference: F558Findings: 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 (CD- a mental health condition where a person experiences neurological symptoms, like paralysis [the loss of muscle function in part of the body, resulting from problems with how messages travel between the brain and muscles] or blindness [partial or full loss of vision], that cannot be explained by a medical or neurological condition due to the brain converting psychological distress into physical symptoms) with mixed symptoms and suffered from aphonia (a medical condition characterized by the complete loss of voice), with mixed symptom presentation, aphonia, and generalized anxiety disorder (persistent feeling of dread or panic that can interfere with daily life). During a review of the same untitled CP, the CP indicated Resident 1 was incontinent (inability to control the bladder and bowels) with both bowel and bladder in relation to impaired mobility and inability to alert staff of Resident 1's urges, and was at risk for infection, skin breakdown, and was on a check and change program, initiated 10/14/2023, revised on 7/31/25. The CP goals indicated Resident 1 would be kept clean, dry, and odor free daily for three months. The CP interventions indicated that CNAs were to check Resident 1 for bladder incontinence at least every two hours, as needed, and to increase frequency as needed, keep Resident 1's call light within reach and answer promptly, and to monitor as indicated for redness or skin breakdown, and to report to MD (medical doctor, physician). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 7/7/2025, the MDS indicated Resident 1 had intact cognition (ability to think, remember, and function). The MDS indicated Resident 1 had the absence of spoken words. The MDS indicated Resident 1 had seven to 11 days (half or more of the days) feeling down, depressed (common and serious illness that negatively affects how one feels, thinks and acts) or hopeless. The MDS indicated Resident 1 was dependent (Helper does ALL the effort to complete the activity) with toileting hygiene and chair/bed-to-chair transfers. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort to complete activity) with personal hygiene, showering/bathing self, and rolling left and right (in bed). The MDS indicated the activity was not attempted due to medical condition or safety concerns for sitting to lying, lying to sitting on side of bed, and sitting to standing. The MDS indicated Resident 1 had hereditary (passed down from parent to child) and idiopathic (no identifiable cause) neuropathy (a condition that involves damage to the peripheral nervous system from injury or disease process). During a telephone interview on 8/1/2025 at 2:55 pm, with CNA 3, CNA 3 stated that CNA 3 worked the 3 pm to 11 pm shift that day (7/12/2025) and was assigned to Resident 1. CNA 3 stated when CNA 3 started the shift, Resident 1 was really upset. CNA 3 stated Resident 1 was completely soiled, and there were urine and feces that were completed soaked through Resident 1's brief, bed pad, sheets, and gown. CNA 3 stated CNA 3 had to bathe Resident 1. CNA 3 stated CNA 3 worked the 3 pm to 11 pm shift on 7/13/2025 and again, Resident 1's sheets and gown were wet. CNA 3 stated Resident 1 told CNA 3 that the staff on 7 am to 3 pm shift had not changed Resident 1. CNA 3 stated, The CNA that morning was [CNA 1]. CNA 3 stated Resident 1 was panicked because they (CNA 1) did not change Resident 1 during the entire day shift (7 am to 3 pm). CNA 3 stated, every shift CNA 3 have Resident 1, CNA 3 had to change Resident 1's brief and bedding because Resident 1 is soaked wet right when the shift starts. CNA 3 stated it was even worse when Resident 1 was on Resident 1's period because they (staff in general) leave Resident 1 wet and do not change Resident 1. During a concurrent observation and interview on 8/1/2025 at 3:15 pm, inside Resident 1's room, with CNA 4, Resident 1 and the call light were observed. CNA 4 stated Resident 1's call light was unplugged from the wall. CNA 4 stated, It's pretty typical that Resident 1 is soaked through Resident 1's brief with urine and/or feces when CNA 4 come onto my shift. CNA 4 stated Resident 1 was currently soaked through the brief. Resident 1 typed on surveyor's phone, No one has ever used the communication board with me. I don't even know what that is. Resident 1 stated, I'm wet and haven't been offered to be changed since you (points to surveyor) were in here this morning. Resident 1 stated, [CNA 1]

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement its past plan of correction regarding providing means of communication for one of five sampled residents (Resident 1).This deficient practice had the potential for facility staff to inappropriately communicate with residents that could lead to a delay in care, needs being unmet, or neglect. During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on [DATE] with diagnoses that included conversion disorder (CD- a mental health condition where a person experiences neurological symptoms, like paralysis [the loss of muscle function in part of the body, resulting from problems with how messages travel between the brain and muscles] or blindness [partial or full loss of vision], that cannot be explained by a medical or neurological condition due to the brain converting psychological distress into physical symptoms) with mixed symptom presentation, aphonia, and generalized anxiety disorder (persistent feeling of dread or panic that can interfere with daily life). During a review of Resident 1's untitled care plan (CP) initiated [DATE], the CP indicated Resident 1 had a communication problem related to aphonia, dysarthria (a motor speech disorder that makes it difficult to pronounce words clearly) and anarthria (a severe speech disorder characterized by the complete loss of the ability to articulate speech), non-verbal, and utilized Resident 1's phone to make needs known and types responses, usually understands others with episodes of asking staff to repeat questions multiple times, episodes of refusing communication board (a tool that helps residents who have difficulty speaking or understanding spoken language to express themselves), and pen and paper as alternative means of communication. The CP indicated on [DATE], Resident 1 asked the (unknown) Certified Nurse Assistant (CNA) to bring Resident 1 the community phone so Resident 1 could call and talk to Resident 1's parent. The CP indicated on [DATE], Resident 1 refused white communication board as alternative means of communication when [tablet (electronic tablet device)] was low battery. The CP goal indicated Resident 1 would maintain current level of communication function (how, with what assistance i.e. making sounds, using appropriate gestures, responding to yes/no questions appropriately, using communication board, writing messages) through the review date of [DATE]. The CP interventions indicated Resident 1 preferred communicating face to face, while family was present to translate with the cellphone facetime (video call), ensure availability and functioning of adaptive communication equipment, message bard, and telephone, in the event the [tablet] is dead, offer communication board, offer pen and paper, and offer the communication board, and to use [tablet] as means of communication- resident (1) types in and shows it to be ready by other person. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated [DATE], the MDS indicated Resident 1 had intact cognition (ability to think, remember, and function). The MDS indicated Resident 1 had the absence of spoken words. The MDS indicated Resident 1 had seven to 11 days (half or more of the days) feeling down, depressed (common and serious illness that negatively affects how one feels, thinks and acts) or hopeless. The MDS indicated Resident 1 was dependent (helper does ALL the effort to complete the activity) with toileting hygiene and chair/bed-to-chair transfers. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort to complete activity) with personal hygiene, showering/bathing self, and rolling left and right (in bed). The MDS indicated the activity was not attempted due to medical condition or safety concerns for sitting to lying, lying to sitting on side of bed, and sitting to standing. The MDS indicated Resident 1 had hereditary (passed down from parent to child) and idiopathic (no identifiable cause) neuropathy (a condition that involves damage to the peripheral nervous system from injury or disease process). During a concurrent observation and interview on [DATE] at 11 am, in Resident 1's room, Resident 1 was observed. Resident 1 used the surveyor's phone type Resident 1's responses to questions. Resident typed, I am really wet. I pooped and peed and I can't reach my call light, and I can't communicate with anyone because the tablet they (staff) gave me died and no one can understand me. Resident 1 typed that Resident 1 was not provided with the charger to the [tablet] so Resident 1 was unable to charge it when Resident 1 used the [tablet]. Resident 1 typed, the [tablet] did not have the capability to send messages or have a place to type for Resident 1 to communicate with family and with staff. Resident 1 typed that Resident 1 was told Resident 1 would have the [tablet] every day from 2 pm to 10 am the next day. Resident 1 typed that there were days Resident 1 would not receive the [tablet], and times when staff would put the [tablet] on the bedside tray but push the tray away so Resident 1 could not reach it. Resident 1 typed, They (staff) think they know what I need with gestures, but they don't. They don't