

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  09/03/2025
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>(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>Based on observation, interview, and record review, the facility to ensure one of four sampled residents (Resident 4) received timely response to Resident 4's requests and needs in accordance with the facility's policy and procedure (P&amp;P) titled, Answering the Call Light, by failing to ensure: On 8/29/2025, Resident 4's call light was fully connected to the wall and was within reach of Resident 4. This failure caused Resident 4 to not be able to get assistance from staff when Resident 4 needed to be changed. Resident 4 was left soiled in Resident 4's briefs (disposable under garment used for those who have a loss of continence [ability to hold the bladder and bowels]) with urine and/or feces. Findings: During a review of Resident 4's admission Record (AR), the AR indicated the facility admitted Resident 4 on 10/4/2023 with diagnoses that included conversion disorder (CD, a mental illness where a person experiences physical symptoms that cannot be explained by a medical or neurological causes) with mixed symptom presentation, aphonia (inability to produce voiced sounds), and generalized anxiety disorder (persistent feeling of dread or panic that can interfere with daily life). During a review of an untitled Care Plan (CP), initiated on 5/12/2025, the CP indicated Resident 4 preferred the call light to hang from above Resident 4'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). The CP indicated Resident 4 would be able to use the call light by tapping it. The CP interventions indicated educating staff on Resident 4's preference of call light placement, and to ensure Resident 4 was able to reach the call light. During a review of untitled CP, initiated on 10/14/2023 and revised on 3/7/2025, the CP indicated Resident 4 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 4's urges. The CP indicated Resident 4 was at risk for infection, skin breakdown, and was on a check and change program. The CP goals indicated Resident 4 would be kept clean, dry, and odor free daily for three months. The CP interventions indicated that CNAs were to check Resident 4 for bladder incontinence at least every two hours, as needed, and increase frequency as needed, keep Resident 4's call light within reach and answer promptly, to monitor as indicated for redness or skin breakdown, and to report to MD (medical doctor, physician). During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool) dated 7/7/2025, the MDS indicated Resident 4 had intact cognition (ability to think, remember, and function). The MDS indicated Resident 4 was dependent (helper does ALL the effort to complete the activity) with toileting hygiene and chair/bed-to-chair transfers. The MDS indicated Resident 4 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 4 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 8/29/2025 at 4:38 pm, inside Resident 4's room, Resident 4's call light was observed with Licensed Vocational Nurse (LVN) 1. LVN 1 stated Resident 4 was unable to reach the call light. During a concurrent observation and interview on 8/29/2025 at 5:14 pm, inside Resident 4's room, Resident 4's call light was observed with Certified Nurse Assistant (CNA) 1. CNA 1 stated, I let them (Resident 4) I come in because the call light is not working and not within reach. During a concurrent observation and interview on 8/29/2025 at 5:23 pm, inside Resident 4's room, Resident 4's call light was observed with LVN 1. LVN 1 stated, This is the first time I have seen the cord pulled out from the wall. During an interview on 9/3/2025 at 1:49 pm, with the Director of Nursing (DON), the DON stated [maintenance staff] had the call light cord secured to the wall in Resident 4's room, but realized it was still not secured so another piece was bought but had not been installed yet. The DON stated it was noticed the prior week (before the day of interview) that Resident 4's call light was still not secured to the wall, but did not remember the exact date. The DON stated [facility staff] needed to make sure the call light was connected to the wall and within reach to ensure it was working and Resident 4 could ask for help. During a review of the facility's undated policy and procedure (P&amp;P) titled, Answering the Call Light, the P&amp;P indicated the purpose of the procedure was to ensure timely responses to the resident's requests and needs. The P&amp;P indicated to be sure the call light was plugged in and functioning at all times, and to ensure the call light was accessible to the resident when in bed, from the toilet, from the shower, or bathing facility, and from the floor.</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>(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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure two of four sampled residents (Resident 2 and Resident 4), received activities of daily living care according to the facility's policy and procedure (P&amp;P) titled, Activities of Daily Living (ADL), Supporting, by failing to: 1. Ensure Resident 4 was not left soiled with urine and/or feces on 8/29/2025. 2. Ensure Resident 2's hair was regularly brushed and groomed. As a result of these failures, Residents 2's and Resident 4's needs were unmet. Resident 4 was left soiled in Resident 4's brief (disposable under garment used for those who have a loss of continence [ability to hold the bladder and bowels]) with urine and feces. Resident 2's hair was matted (hair that is closely tangled into a dense mass). Resident 2 experienced pain and itching in Resident 2's head. These failures have the potential for Resident 2 and Resident 4 to experience psychosocial (mental, emotional, social, and spiritual effects) harm. Findings: a. During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 8/19/2025 with diagnoses that included lack of coordination and abnormalities of gait and mobility (inability to walk normally due to injuries or underlying conditions). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 8/25/2025, the MDS indicated Resident 2 had moderately impaired cognition. The MDS indicated Resident 2 was dependent with showering/bathing self. The MDS indicated Resident 2 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity and may be provided throughout the activity or intermittently) with oral hygiene and personal hygiene. During a concurrent observation and interview on 9/3/2025 at 11:16 am, inside Resident 2's room, Resident 2 was observed by LVN 5. LVN 5 translated Spanish to English for Resident 2. LVN 5 stated Resident 2's hair was matted and had not been brushed. LVN 5 stated, It takes days for the hair to get matted like that. Resident 2 stated, The last time someone brushed my hair was last week, but they (staff) only brushed the front and not the back. Resident 2 stated, It hurts and it's itchy and in the middle I have to open it because it's itchy. LVN 5 stated Resident 2 had been refused the last two showers, but did not mean Resident 2's could not be brushed. LVN 5 stated Resident 2's hair was supposed to be brushed at least every day and as needed. During a concurrent interview and record review on 9/3/2025 at 11:26 am, with LVN 5, Resident 2's CP and Progress Notes (PN) were reviewed. LVN 5 stated Resident 2's shower days were Tuesdays and Fridays. LVN 5 stated Resident 2 did not have a CP for refusing showers. LVN 5 stated Resident 2 required supervision or touching assistance with personal hygiene which meant staff needed to give Resident 2 a hairbrush and be there to assist if Resident 2 needed help. LVN 5 stated there was Progress Notes (PN) dated 8/26/2025 that Resident 2 refused to shower. LVN 5 stated there were no PN that Resident 2 refused a shower on 8/29/2025 or 9/2/2025. During a concurrent observation and interview on 9/3/2025 at 11:42 am, inside Resident 2's room, CNA 6 observed Resident 2. CNA 6 was observed using a wooden pick in Resident 2's hair. CNA 6 stated CNA 6 was assigned to Resident 2. CNA 6 stated CNA 6 was using lotion and soap to try and untangle Resident 2's hair. CNA 6 stated, It's matted. CNA 6 stated, It (Resident 2's hair) must have been like this for a while. CNA 6 stated when CNA 6 was assigned to Resident 2 on 9/2/2025 CNA 6 thought Resident 2's hair was in a bun. CNA 6 stated, I didn't brush her hair yesterday (9/2/2025). CNA 6 stated (in general) when a resident refused to be showered, CNA 6 could still assist with personal hygiene such as teeth brushing, hair brushing, face washing, under arm washing, or anywhere else. a. During a review of Resident 4's AR, the AR indicated the facility admitted Resident 4 on 10/4/2023 with diagnoses that included conversion disorder (CD, a mental illness where a person experiences physical symptoms that cannot be explained by a medical or neurological causes) with mixed symptoms presentation, aphonia (inability to produce voiced sound), and generalized anxiety disorder (persistent feeling of dread or panic that can interfere with daily life). During a review of untitled Care Plan (CP), initiated on 10/14/2023 and revised on 7/31/2025, the CP indicated Resident 4 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 4's urges. The CP indicated Resident 4 was at risk for infection, skin breakdown, and was on a check and change program. The CP goals indicated Resident 4 would be kept clean, dry, and odor free daily for three months. The CP interventions indicated that CNAs were to check Resident 4 for bladder incontinence at least every two hours, as needed, and to increase frequency as needed, keep Resident 4's call light within reach and answer promptly to monitor as indicated for redness or skin breakdown and to report to MD</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>(continued on next page)</p>

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 3) was given a therapeutic diet (a medically-prescribed meal plan tailored to manage or treat a specific health condition, often by modifying nutrient intake, texture, or food types) according to the facility's policy and procedure (P&amp;P) titled, Therapeutic Diets, by failing to ensure Resident 3, who was prescribed a minced and moist diet (a dietary modification designed for individuals with moderate to severe difficulty swallowing [dysphagia] that adds moisture and small pieces of food aid in swallowing), did not receive toasted bread on Resident 3's lunch tray on 9/2/2025. This failure resulted in Resident 3 being served food that was not minced and moist. This failure had the potential for Resident 3 to be unable to swallow the bread and lead to choking. Findings: During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 8/8/2025 with diagnoses that included dysphagia (difficulty swallowing). The AR indicated Resident 3 had a gastrostomy [tube] (G-tube- tube inserted through the belly that brings nutrition directly to the stomach) status. During a review of Resident 3's Speech Therapy, Speech and Language Pathology (SLP- pathologist who helps residents with speaking, understanding, or using language, and swallowing disorders) Plan of Treatment (SLPPT), dated 8/12/2025, the SLPPT indicated Resident 3 had severe oropharyngeal (middle part of the throat, behind the mouth) dysphagia among thin liquids and beyond puree [food]. The SLPPT indicated the recommendations for Resident 3 included pureed consistency food with nectar thick liquids and close supervision during oral intake. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 8/13/2025, the MDS indicated Resident 3 had severely impaired cognition (ability to think, remember, and function). The MDS indicated eating was not attempted due to medical condition or safety concerns. The MDS indicated Resident 3 experienced coughing or choking during meals or when swallowing medications and had complaints of difficulty or pain with swallowing. The MDS indicated Resident 3 had a mechanically altered diet (required change in texture or liquids such as pureed food and thickened liquids). During a review of Resident 3's Order Summary Report (OSR), active as of 9/3/2025, the OSR indicated Resident 3 had a physician's order, dated 8/28/2025, for fortified (adding nutrients)/high protein/carbohydrate controlled-no added salt diet, minced and moist texture, mildly thick consistency, with Ensure (protein shake). During a concurrent observation and interview on 9/2/2025 at 12:13 pm, inside Resident 3's room, Resident 3's meal tray was observed with Responsible Party (RP) 1. Resident 3's meal tray was observed with toasted bread on the tray, a plate with three scoops of minced and moist food, a separate bowl with yellow-colored paste-like food, and a bowl of soup. RP 1 stated, I told them many times not to bring bread, she (Resident 3) chokes on bread. They bring her bread. During a concurrent interview and record review on 9/2/2025 at 2:42 pm, with the Dietary Service Supervisor (DSS), Resident 3's diet order was reviewed. The DSS stated staff had to follow the diet spreadsheet, to give the right item and provide the correct texture to the residents. The DSS stated, I don't know what happened, I think it (the bread) was accidentally placed (on Resident 3's tray). The DSS stated there was danger of choking by having toasted bread on Resident 3's tray. During an interview on 9/2/2025 at 5:24 pm, with RP 1, RP 1 stated there was bread in a bag on Resident 1's tray this morning. RP 1 stated, Thank God she (Resident 3) did not eat the bread. RP 1 stated RP 1 told nurses (unidentified) about the bread and was told, It's okay. During an interview on 9/3/2025 at 1:39 pm with the Director of Nursing (DON), the DON stated kitchen staff build the resident meals on the trays and the licensed staff were supposed to check the trays before being served. The DON stated staff checked the trays to ensure residents were given the right diet and texture prescribed by the physician. The DON stated if resident trays were not checked appropriately then residents could get served the wrong food and or diet. The DON stated a resident with a minced and moist diet should be given bread that's minced and moist otherwise they could aspirate (the accidental breathing in of food or fluid into the lungs, potentially causing pneumonia [inflammation and fluid in lungs] or other lung problems). The DON stated if a resident aspirated, they could choke, and that was dangerous. During a review of the facility's P&amp;P titled, Therapeutic Diets, revised 12/2008, the P&amp;P indicated the Food Services Manager would establish a tray identification system to ensure that each resident received his or her diet as ordered. During a review of the facility's P&amp;P titled, Tray Identification, undated, the P&amp;P indicated the appropriate identification coding shall be used to identify various diets. The P&amp;P indicated the Food Services Manager, or supervisor would check the trays for correct diets before the food carts were transported to their designated areas. The P&amp;P indicated nursing staff shall</p>		