

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 09/17/2025
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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain the dignity of one of three sampled residents (Resident 1) when Certified Nursing Assistant (CNA) 1 left Resident 1 in soiled diapers following an episode of stool incontinence (lack of voluntary control over urination or defecation). This failure resulted in Resident 1 feeling frustrated and helpless and had the potential for Resident 1 to experience a decline in health and wellbeing. Findings: During a review of Resident 1's admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including conversion disorder (a mental health condition characterized by unexplained neurological symptoms that are not caused by a physical medical condition) with mixed symptoms presentation, aphonia (loss of ability to speak), and general anxiety disorder (mental health disorder characterized by feelings of worry, or fear that are strong enough to interfere with one's daily activities). During a review of Resident 1's care plan titled, Resident is incontinent with both bowel and bladder., initiated 10/5/2023, the care plan indicated CNA's (in general) needed to check Resident 1 for episodes of incontinence at least every two hours and change diaper as needed. 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 no impairment in cognitive skills (the ability to think and make daily decisions) and was dependent (helper does all the effort) on staff for dressing and toileting hygiene. During an interview on 9/16/2025 at 12:23 PM, CNA 1 stated CNA 1 was assigned to care for Resident 1 on 9/16/2025 since 7 AM. CNA 1 stated Resident 1 was currently upset with CNA 1 and wanted a different CNA instead of CNA 1 to be assigned to care for Resident 1. CNA 1 stated CNA 1 did not know why Resident 1 was upset with CNA 1. During an observation on 9/16/2025 at 1:30 PM, Resident 1 was in bed. There was a foul odor of stool in the room. During a concurrent interview, Resident 1 communicated by typing on an iPad. Resident 1 had soiled herself earlier in the morning and requested to be changed by CNA 1 since 8 AM. Resident 1 indicated CNA 1 did not change Resident 1's soiled diaper and Resident 1 felt frustrated and helpless when CNA 1 left Resident 1 in a soiled diaper. During a review of Resident 2's admission record, the admission record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including heart failure (condition in which the heart cannot pump enough blood to all parts of the body). During a review of Resident 2's History and Physical (H&P) dated 9/12/2025, the H&P indicated Resident 2 could make her own decisions. During an interview on 9/16/2025 at 1:35 PM, Resident 2 (Resident 1's roommate) stated Resident 2 smelled stool in the room starting around 10 AM. During an interview on 9/16/2025 at 2:01 PM, CNA 2 stated CNA 2 replaced CNA 1 to provide care to Resident 1 at 12:30 PM on 9/16/2025. CNA 2 stated Resident 1 was soiled when the CNA entered Resident 1's room at 12:30 PM. CNA 2 stated the CNA assigned to Resident 1 should check Resident 1 every two hours to check if the resident needed to be changed after incontinent episodes. During a follow up interview on 9/16/2025 at 2:06 PM, CNA 1 stated CNA 1 had not changed Resident 1 from 7 AM until 12:30 PM when CNA 1 was reassigned to other residents (in general). CNA 1 stated CNA 1 did not check Resident 1 at least every two hours to see if Resident 1 had soiled herself. During a review of the facility's Policy and Procedure (P&P) titled, Dignity, dated February 2021, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The P&P indicated, Individual needs and preferences of the resident are identified through the assessment process.</p>