

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 10/31/2025
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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an allegation of abuse was reported to the California Department of Public Health (CDPH) within two hours of being notified, for 1 of 1 sampled resident (Resident 1), when Resident 1 had right eye discoloration on 10/10/25. Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility 10/4/2023 with diagnoses including conversion disorder (thought to be caused by the mind converting psychological stress or trauma into physical symptoms, often after a stressful event) and major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy). During a review of Resident 1's History and Physical (H&P), dated 9/4/25, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 10/6/25, the MDS indicated Resident 1's cognition (ability to understand and process information) was intact. During an interview conducted 10/27/2025 at 10:52 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated on 10/10/25, the police told LVN 1 Resident 1 had discoloration on Resident 1's right eye. During an interview with the Director of Nursing (DON) 10/27/25 at 4:25 PM, the DON stated the facility became aware Resident 1 had a discolored eye upon return to the facility from the hospital on [DATE]. The DON stated [the abuse allegation] had not been reported to the CDPH. During a review of Resident 1's General Acute Care Hospital 1's (GACH 1) Patient Visit Information (PVI), dated 10/10/25, the PVI indicated Resident 1 was seen for right periorbital (around the eye) hematoma (bruise- mark on the skin caused by blood trapped under the surface as a result of injury to small blood vessels but no break on the skin). During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised September 2022, the P&P indicated all reports of resident abuse are reported to the local, state, and federal agencies (as required by current regulations). The P&P indicated reporting allegations to the administrator and authorities when the individual is making an abuse allegation immediately to the state licensing department. During a review of the facility's policy and procedure (P&P) titled, Identifying Types of Abuse, revised September 2022, the P&P indicated staff are trained on abuse reporting as well as on requirements to report reasonable suspicion of crime. The P&P indicated facial injuries like black eyes and bruising as physical abuse.</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
---	-------	-----------