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	03/03/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise the care plan interventions for one of four sampled residents (Resident 1) who had a weight loss of 24 pounds (lbs.) in one month.This deficient practice placed Resident 1 at risk for continued weight loss and had the potential for Resident 1 to receive inappropriate care and treatment.Findings:During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was initially admitted to the facility on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness in the arm, leg, and face on one side of the body) following cerebral infarction (stroke, loss of blood flow to a part of the brain) affecting left non-dominant side (damage to the right hemisphere of the brain, causing left-sided motor impairment) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 9/8/25, the MDS indicated Resident 1 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 1 was dependent on staff with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During record review of Resident 1's Weights and Vitals Summary, Resident 1's weights were as follows:9/4/25 - admitted to facility at 225 lbs.9/11/25 at 219 pounds (lbs. - unit of weight measurement) 9/18/25 at 213 lbs. 10/2/25 at 201 lbs. 11/8/25 at 189 lbs. 11/13/25 at 184 lbs. 11/21/25 at 183 lbs. 12/9/25 at 183 lbs. 1/4/26 at 182 lbs. 2/10/26 at 178 lbs. During the 5-month period from 9/4/25 to 2/10/26, Resident 1 lost 47 lbs. (from 225 lbs. to 178 lbs.).During a review of Resident 1's care plan for unplanned/unexpected weight loss of 24 lbs. x 1 month [from 9/4/25 - 10/2/25] related to poor food intake (date initiated 10/14/25 and revised on 10/19/25) the interventions indicated the following: If weight decline persists, contact physician and dietician immediately (date intervention initiated 10/19/25; date revised 2/5/25).Monitor and evaluate any weight loss. Determine percentage lost and follow facility protocol for weight loss (date intervention initiated 10/19/25; date revised 2/5/25).During a review of Resident 1's Weights and Vitals Summary, Resident 1 lost 19 lbs. from 11/8/25 to 1/4/26. No care plan for unplanned/unexpected weight loss was updated for Resident 1 until 1/21/26.During a record review of Resident 1's care plans, there were no care plans to indicate Resident 1 planned to lose -47 lbs. in 5 months.During an interview with Dietary Supervisor (DS) on 2/25/26 at 2:22 p.m., DS stated, Resident 1 is very alert, gets food from outside, most of the time, (Resident 1) orders out.DS stated, Resident 1's had a puree diet initially and now she is on a regular diet.DS stated, In the beginning Resident 1 was eating puree (only eating 24%).During an interview with Resident 1 on 3/26/26 at 11:15 a.m., Resident 1 stated, (Resident 1) orders food from outside of the facility because (Resident 1) doesn't like the facility food. Resident 1 denied losing any weight.During an interview with Registered Dietician 1 (RD 1) on 3/3/26 at 9:35 a.m., RD 1 stated, Resident 1 had a goal of losing weight and (Resident 1's) ideal weight was 170 lbs.RD 1 stated before RD 1worked at the facility, Resident 1 had lost 19 lbs. in 3 months then 1 lb. in a month after RD 1 started working at the facility in December 2025.RD 1 stated Resident 1 was non-compliant with Resident 1's diet and was ordering a lot of food from outside of the facility.

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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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide podiatry (treatment of the feet and feet disorders) care to one of four sampled residents (Resident 1).This deficient practice resulted in Resident 1 not getting treatment for long and thickened toenails for 112 days (from 11/20/25 to 3/2/26) and placed Resident 1 at risk for ingrown toenails (when the nail grows into the surrounding skin), pain, injury, and infection.Findings:During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 FFwas initially admitted to the facility on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness in the arm, leg, and face on one side of the body) following cerebral infarction (stroke, loss of blood flow to a part of the brain) affecting left non-dominant side (damage to the right hemisphere of the brain, causing left-sided motor impairment) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 9/8/25, the MDS indicated Resident 1 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 1 was dependent on staff with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During a record review of Resident 1's Oder Summary Report (OSR), dated 3/2/26, the OSR indicated a physician order (PO) for Podiatry (branch of medicine focused on the diagnosis, treatment, and prevention of foot, ankle, and lower leg disorders) consult and treatment as needed. On hold. Order date: 11/2/25. During an interview with Resident 1 on 3/2/26 at 11:15 am in Resident 1's room, Resident 1 stated Resident 1's only concern was about a podiatrist (doctor who practices podiatry care) appointment. Resident 1 stated it was last week when a facility staff (unidentified) was going to make the podiatry appointment for Resident 1 and Resident 1 had not heard back from the facility on the status of the appointment.During concurrent record review and interview with Licensed Vocational Nurse 3 (LVN 3) on 3/3/26 at 10:26 am, LVN 3 stated Resident 1 went to the hospital on [DATE], and all of Resident 1's POs were put on hold. LVN 3 stated when Resident 1 returned to the facility on [DATE], all POs were resumed except for the podiatry consult. LVN 3 stated, It looks like that order (podiatry consult) was missed when Resident 1 returned to the facility and that order (podiatry consult) was not active (order) as a result.During an interview with LVN 2 on 3/3/26 at 1:15 pm, LVN 2 stated LVN 2 was aware of Resident 1's long and thickened toenails on 11/20/25, the day LVN 2 completed a Change of Condition report for Resident 1's left and right heel redness. LVN 2 stated LVN 2 did not complete a change of condition report and did not inform Resident 1's physician regarding Resident 1's long and thickened toenails. LVN 2 stated Resident 1 was diabetic, and staff (in general) would not be able to trim Resident 1's toenails because Resident 1 was at high risk for infection.During a concurrent interview and observation with Resident 1 and Certified Nursing Assistant (CNA) 2 on 3/3/26 at 4:35 pm, Resident 1's feet were uncovered and both feet were observed with toenails that were thickened and long.During a review of the facility policy & procedure (P&P) titled, Resident Rights, dated 2/2021, the P&P indicated, Policy Interpretation and Implementation: Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to a dignified existence; be notified of his or her medical condition and of any changes in his or her condition; and be informed of, and participate in, his or her care planning and treatment.During a review of the facility P&P titled, Change in a Resident's Condition Status, dated 2/2021, the P&P indicated, The nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition.A ?significant change' of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of four sampled residents (Resident 2) had the resident's hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) pressure dressing on the right upper arm removed in accordance with the physician order.This deficient practice placed Resident 2 at risk for forming a blood clot in the right upper arm dialysis fistula (a surgically created connection between an artery and a vein, typically in the arm, designed for long-term hemodialysis [dialysis] access) which could result in Resident 2 missing life-saving hemodialysis treatment.Findings:During a review of Resident 2's admission Record (AR), the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease (ESRD-irreversible kidney failure) and dependence on renal dialysis.During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 2/23/26, the MDS indicated Resident 2 had severely impaired cognition (thinking, knowing, and being aware) for daily decision making. The MDS indicated Resident 2 was dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 2's Order Summary Report (OSR), dated 3/2/26, the OSR indicated a physician order (PO), dated 2/22/26, to remove Resident 2's dialysis pressure dressing four (4) hours after return from dialysis treatment.During a review of Resident 2's Nursing Progress Note (NPN), dated 2/24/26 and timed at 2:15 pm, the NPN indicated Resident 2 returned from dialysis to the facility with right upper arm fistula intact, no swelling, and no signs or symptoms of infection.During a review of Resident 2's NPN, dated 2/24/26 and timed at 10:50 pm, the NPN indicated, Pressure dressing removed and new dressing applied for (Resident 2).During a phone interview with Licensed Vocational Nurse (LVN) 5 on 3/12/26 at 1:25 pm, Resident 2's NPN, dated 2/24/26 and timed at 2:15 pm, was reviewed with LVN 5. LVN 5 stated Resident 2 returned from dialysis appointment on 2/24/26 at approximately 2:15 pm and Resident 2's right upper arm fistula site was intact with no swelling and no signs or symptoms of infection. During a phone interview with Licensed Vocational Nurse 6 (LVN 6) on 3/12/26 at 4:50 pm, Resident 2's NPNs and Resident 2's physician order, dated 2/22/26, were reviewed with LVN 6. LVN 6 stated on 2/24/26, LVN 6 documented Resident 2's pressure dressing removal and application of a new dressing on the dialysis fistula site. LVN 6 stated LVN 6 looked at Resident 2's right upper arm at 4 pm on 2/24/26 to assess Resident 2's pressure dressing after the previous shift's nurse informed LVN 6 that Resident 2 had returned from dialysis. LVN 6 stated there was no leaking or signs of infection on the right upper arm at the time LVN 6 checked Resident 2. LVN 6 stated according to Resident 2's physician order, dated 2/22/26, Resident 2's pressure dressing should be removed four (4) hours after Resident 2 returned from dialysis treatment to the facility. LVN 6 stated LVN 6 did not remove Resident 2's pressure dressing on the right upper arm on 2/24/26 until approximately 8 pm and applied a new dressing due to a scant amount of bleeding on the top of the fistula site. LVN 6 stated LVN 6 documented the dressing change on the NPN on 2/24/26 at 10:50 pm. LVN 6 reviewed Resident 2's NPN created by LVN 5 on 2/24/26 and stated the NPN indicated Resident 2 returned from dialysis treatment on 2/24/26 at approximately 2:15 pm. LVN 6 stated the pressure dressing on Resident 2's dialysis fistula should be changed 4 hours after Resident 2's return from dialysis according to the physician order. LVN 6 stated there was an increased risk of clotting the longer the pressure dressing was left on Resident 2's dialysis fistula site.During a review of the facility's policy & procedure (P&P) titled, End-Stage Renal Disease, Care of a Resident with, dated September 2010, the P&P indicated, Policy Statement: Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. Education and training of staff includes, specifically: the care of grafts and fistulas .