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	10/31/2024

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307 Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 34) was treated with dignity by failing to provide privacy while accessing Resident 34's G-tube (gastrostomy tube, a tube inserted through the belly to bring nutrition and/or medications directly to the stomach) during medication administration. This deficient practice resulted in exposure of Resident 34's portion of the abdomen (belly) and had the potential to result in Resident 34's value as human being not respected. Findings: During a review of Resident 34's Admission Record (AR), the AR indicated, Resident 34 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including sepsis (a serious condition in which the body responds improperly to an [infection, refers to an invasion of the body by harmful microorganisms]), unspecified organism, gastrostomy status (the presence of a G-tube) and essential (primary) hypertension (high blood pressure). During a review of Resident 34's History and Physical (H&P), dated 6/19/2024, the H&P indicated, Resident 34 did not have the capacity to understand and make decisions. During a review of Resident 34's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/15/2024, the MDS indicated, Resident 34's cognitive (ability to think and process information) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated, Resident 34 was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity) for all activities of daily living. The MDS indicated, Resident 34 had a feeding tube (e.g., nasogastric or abdominal [PEG]). During a review of Resident 34's Order Summary Report (OSR), dated active orders as of 10/31/2024, the OSR indicated, Resident 34 had an enteral (food or drug administration via the human gastrointestinal tract) feed order and oral medication orders via G-tube. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 10/30/2024 at 8:46 AM with Licensed Vocational Nurse 2 (LVN) 2, during medication administration, Resident 34 was lying in bed in a multi-bed occupancy room with two roommates. LVN 2 drew the privacy curtain between Resident 34 and Resident 34's roommate's bed. LVN 2 did not draw the privacy curtain located on the left side of Resident 34 completely and around Resident 34's foot of the bed. LVN 2 lifted Resident 34's gown and exposed a portion of Resident 34's abdomen. LVN 2 assessed Resident 34's G-tube to administer Resident 34's medications. LVN 2 stated, Resident 34's privacy curtain was partially drawn and should be [drawn] all the way for privacy. During an interview on 10/30/2024 at 1:02 PM with the Registered Nurse Supervisor (RNS), the RNS stated, when accessing a resident's (in general) G-tube, the privacy curtain should be drawn and closed all the way 100% for privacy and dignity especially if the roommates are mobile and because somebody always gonna go by, doing rounds, visitors. During a review of the facility's policy and procedure (P&P) titled, Dignity, revised date February 2021, the P&P indicated, residents were treated with dignity and respect at all times. The P&P indicated, residents' private space and property were respected at all times. During a review of the facility's P&P titled, Resident Rights, revised date February 2021, the P&P indicated, Federal and state laws guaranteed certain basic rights to all residents of this facility that included the resident's right to a dignified existence and be treated with respect, kindness, and dignity. During a review of the facility's undated P&P titled, Administration of Medication via Feeding Tube, the P&P indicated, one of the procedures was to screen patients for privacy.

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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	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729 Based on observation, interview, and record review the facility failed to accommodate to the needs of two of two sampled residents (Resident 36 and Resident 26) when: a. The facility failed to ensure a toilet paper dispenser was installed in the restroom for Resident 36. b. The facility failed to ensure Resident 26 had footrests when transported via the wheelchair. This deficient practice led to pain in Resident 36's shoulder when reaching for toilet paper and resulted in Resident 26 feeling uncomfortable during transport. Findings: a. During a review of Resident 36's Admission Record, (AR) dated 10/17/2024, the AR indicated Resident 36 was admitted on [DATE] with diagnoses encephalopathy (disorder of the brain often causing confusion, memory loss, and coma in severe cases) and lack of coordination (not able to move different parts of the body well or easily.) During a review of Resident 36's Minimum Data Set (MDS -a federally mandated resident assessment tool) dated 10/17/2024, indicated Resident 36 had intact cognition (ability to think, reason and plan) and required moderate assistance (helper does less than half the effort) for toileting hygiene and transferring to and from the toilet. During a concurrent observation and interview on 10/30/2024 at 9:30 AM with Resident 36 in Resident 36's restroom, the toilet paper was observed on top of the toilet tank. Resident 36 stated there had not been a toilet paper holder since Resident 36 had been in Resident 36's room which was a few months. Resident 36 stated when Resident 36 reached behind to get the toilet paper located on the toilet tank, it caused pain Resident 36's shoulder on of the arm used to reach. During an interview on 10/31/2024 at 1:55 PM with Certified Nursing Assistant (CNA) 6, CNA 6 stated CNA 6 had noticed the toilet paper was on top of the toilet tank in Resident 36's restroom. CNA 6 stated it would be better if the toilet paper was more easily accessible to Resident 36 and was placed on the side of the toilet. During a concurrent observation and interview on 10/31/2024 at 2:15 PM with the Maintenance Supervisor (MS) in Resident 36's restroom, the toilet paper was observed on top of the toilet tank. The MS stated there was no toilet paper holder in Resident 36's restroom and there should be. The MS stated if there was no toilet paper holder, it would be harder for Resident 36 to use [the toilet paper], and it could potentially be out of reach. During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADL), Supporting, dated 3/2018, the P&P indicated residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal hygiene. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	42307 b. During a review of Resident 26's AR, the AR indicated, Resident 26 was admitted to the facility on [DATE] with multiple diagnoses including unspecified dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), unspecified severity, with agitation, other abnormalities of gait (walking patterns in humans) and mobility, and history of falling. During a review of Resident 26's History and Physical (H&P), dated 6/8/2024, the H&P indicated Resident 26 did not have the capacity to understand and make decisions. During a review of Resident 26's MDS, dated [DATE], the MDS indicated, Resident 26's cognition (ability to think and process information) status was moderately impaired. The MDS indicated, Resident 26 required substantial/maximal assistance (helper does more than half the effort) to supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for all activities of daily living. The MDS indicated, Resident 26 used a manual wheelchair. During a concurrent observation and interview on 10/28/2024 at 9:34 AM in Resident 26's room, CNA 2 was transporting Resident 26 on a wheelchair out of Resident 26's room. The wheelchair did not have a footplate/rest-foot pedal (part of the wheelchair to rest the user's feet) and Resident 26's feet were being dragged on the floor while being transported. Resident 26 had to raise Resident 26's feet off the floor as Resident 26 was being wheeled out of Resident 26's room. Resident 26 stated, the wheelchair did not have a foot plate it doesn't have one, to rest Resident 26's feet while being transported. Resident 26 stated, Resident 26 felt uncomfortable sometimes when having to raise Resident 26's feet off the floor during wheelchair transports. CNA 2 stated, CNA 2 would let the facility know about how Resident 26 felt and a need for a footrest. During an interview on 10/30/2024 at 1:02 PM with the Registered Nurse Supervisor (RNS), the RNS stated, Resident 26's wheelchair should have had a footrest when assisting residents (in general) on wheelchairs and transporting from one room to another for comfort and safety. The RNS stated, the facility encouraged the independent residents to self-propel. During a review of the facility's untitled P&P titled, Assistive Devices and Equipment, the P&P indicated, the facility maintained and supervised the use of assistive devices and equipment for residents. The P&P indicated, certain devices and equipment that assist with resident mobility, safety, and independence are provided for residents that included mobility devices (wheelchairs, walkers and canes).

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729 Based on interview and record review, the facility failed to ensure two of two sampled residents (Resident 14 and 40) and/ or their representatives were informed of their right to formulate an advanced directive as indicated in the facility's policy and procedure (P&P) titled, Advanced Directives. This deficient practice infringed on the resident's and/or the representatives' right to be fully informed of the option to formulate an advance directive and had the potential to cause conflict with the residents' wishes regarding health care decision making. Findings: During a review of Resident 14's Admission Record, (AR), the AR indicated Resident 14 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included end stage renal disease (condition in which a person's kidney's stop functioning on a permanent basis) and type 2 diabetes (long standing disease that affects the way one's body processes sugar). During a review of Resident 14's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/4/2024, the MDS, indicated Resident 14 had intact cognition (ability to think, reason, plan) and was dependent (helper does all the effort) on staff for toileting and personal hygiene. During a review of Resident 40 's AR, the AR, indicated Resident 40 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking to an extent that it interferes with a person's daily life and activities.) and hypertension (condition where one's blood is pumping with more force than normal through the arteries). During a review of Resident 40's, MDS, dated [DATE], the MDS, indicated Resident 40 had moderately impaired cognition and required maximal assistance (helper does more than half the effort) for toileting and bathing. During a concurrent interview and record review on 10/30/2024 at 11 AM with the Social Services Director (SSD), Resident 14's and Resident 40's Advanced Healthcare Directive Acknowledgment Forms (AHDAF), undated, were reviewed. The AHDAF indicated Resident 14, and Resident 40 did not have an advanced healthcare directive. The SSD stated the AHDAF did not indicate Resident 14 and Resident 40 and/or their representative had received written information regarding their rights to formulate an advance directive. The SSD stated an email was sent to Resident 14's and Resident 40's responsible party on 10/23/2024 and the email was the first documented proof that the representatives had received written information about the right to accept or refuse medical or surgical treatment or to formulate an advanced directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/30/2024 at 11 AM with Social Services Director (SSD), the facility's policy and procedure (P&P) titled, Advanced Directives, dated 9/2022 was reviewed. The P&P indicated under Determining Existence of Advanced Directive 1. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his legal representative, about the existence of any written advance directives. 2. The resident or representative is provided written information concerning the right to refuse or accept medical or surgical treatment and to formulate and advance directive if he or she chooses to do so. The SSD stated the SSD could not confirm the SSD had reached out to Resident 14 or Resident 40's representative regarding formulating an advance directive. The SSD stated according to facility policy, the resident's representatives should have received the written information upon admission. The SSD stated it can affect the care of Resident 14 and 40 because if either resident became incapacitated, the representative may not be informed of their rights to refuse or accept medical treatment.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50016 Based on interview and record review, the facility staff failed to promptly notify the physician that a resident had broken bottom dentures which caused difficulty with eating for one of one sampled resident (Resident 73). This deficient practice resulted in a delay in the provision of necessary care and services. Findings: During a review of Resident 73's Admission Record (AR), the AR indicated Resident 73 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnosis that included acute respiratory failure (ARF, a condition that occurs when the body's respiratory system can't supply enough oxygen to the blood and organs, or remove enough carbon dioxide [a colorless, odorless gas that's naturally present in the air, essentially a waste product that we breathe out when we exhale] from the body), type 2 diabetes mellitus (T2DM, a disease that occurs when your blood glucose [blood sugar], is too high), and congestive heart failure (CHF, a serious condition that occurs when the heart can't pump enough blood to meet the body's needs). During a review of Resident 73's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 10/15/2024, the MDS indicated Resident 73 had severe cognitive (the ability to thin and process information) impairment. The MDS indicated Resident 73 required substantial/maximal assistance (helper does more than half the effort and helper lifts or holds trunk or limbs and provides more than half the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and was dependent (helper does all the effort) in mobility. During an interview on 10/28/2024 at 10:04 AM, with Resident 73, Resident 73 stated that she had been without her bottom dentures for almost a week. Resident 73 stated that on the week prior on Thursday the 24th of October at around 4 AM, Certified Nursing Assistant (CNA) 5, took her bottom dentures for a wash and cleanse. Resident 73 stated that CNA 5 did not return right away and about 20 minutes later that morning returned with the Licensed Vocational Nurse (LVN) 4. Resident 73 stated LVN 4 and CNA 5 notified her that the dentures had been accidentally dropped and had broken in half. Resident 73 was also notified that that the Director of Nursing (DON) had been notified. Resident 73 stated that later that morning the Social Services Director (SSD) informed her that the facility would request a dental consult for evaluation. During an interview on 10/30/2024 at 9:38 AM, with the DON, the DON stated she was notified about Resident 73's broken bottom dentures on 10/24/24 at approximately 04:36 AM, by LVN 4. The DON stated that the facility did not complete a change of condition (COC) and notify the medical doctor (MD) in a timely manner about Resident 73's broken dentures and the possible complications. The DON stated completing a COC in a timely manner helps address potential complications, prevent further decline, and provide the necessary adjustments to the diet, to maintain Resident 73's quality of life. The DON stated changes that are not reported can lead to serious outcomes including medical complications. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 73's Change in Condition Evaluation, dated 10/30/2024, indicated Resident 73's lower dentures were broken, and Resident 73 requested a diet texture change to facilitate chewing and swallowing meals easier. During a review of the facility's P&P titled, Change in Resident Condition or Status, dated revised 2/2021, the P&P indicated: 3. The facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). 4. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 40913 Based on interview and record review, the facility failed to ensure bed hold (holding or reserving a resident's bed during periods of absence) notification was provided to one of one sampled resident (Resident 83) or the resident's representative when Resident 83 was transferred to the General Acute Care Hospital (GACH) on 9/7/2024. This deficient practice had the potential to result in Resident 83 or the resident's representative to not be aware of the option to return to the facility following hospitalization . Findings: During a review of Resident 83's Admission Record (AR), the AR indicated the facility admitted the Resident 83 on 8/31/2024, with diagnoses that included encephalopathy (disease that affects the function or structure of the brain), acute lymphoblastic leukemia (cancer of the blood that affects the bone marrow and blood cells). During a review of Resident 83's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/3/2024, the MDS indicated Resident 83 was able to understand, be understood (able to express ideas and wants) by others and had severe cognitive impairment. The MDS indicated Resident 83 was dependent with toileting hygiene and required maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) with bed mobility; rolling left to right and sit to lying. During a concurrent review of the Notice of Transfer and Discharge (NTD), dated 9/5/2024, and interview with the Director of Nursing (DON) on 10/31/2024 at 2:36 PM, the Notice of Transfer and Discharge had a portion for Bed-Hold Notification. The NTD, section B: Bed Hold Section, dated 9/7/2024, indicated this section was to be completed for transfers only. The NTD's Bed Hold Section B, 1 to 3 were left blank. The DON stated Resident 83's transfer to GACH was an emergency and Resident 83's RP was not notified of the option for a bed hold. The DON stated bed hold notifications needed to be completed to indicate the resident (in general) or the resident's RP was notified regarding bed holds and the date of the notification. The DON stated the resident or resident representative would be informed regarding the facility's bed hold policy upon admission and when a resident was transferred to the hospital. During a review of the facility's Policy and Procedure (P&P) titled Bed-Holds and Returns, dated October 2022, the P&P indicated all residents/representatives are provided written information regarding the facility and stated bed-hold policies, which addressed holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice: a. notice 1: well in advance of any transfer (e.g., in the admission packet); and b. notice 2: at the time of transfer (or, if the transfer was an emergency, withing 24 hours.)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729 Based on observation, interview and record review, the facility failed to ensure an accurate assessment was conducted for one of one sampled resident (Resident 40). Resident 40 did not have physical restraints as indicated on Resident 40's Minimum Data Set (MDS - a federally mandated resident assessment tool). This deficient practice led to an inaccurate assessment of Resident 40's status during the observation period captured on the MDS and had the potential to result in incorrect care and services provided to Resident 40. Findings: During a review of Resident 40's Admission Record, (AR), the AR, indicated Resident 40 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking to an extent that it interferes with a person's daily life and activities) and hypertension (condition where one's blood is pumping with more force than normal through the arteries). During a review of Resident 40's, Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/9/2024, the MDS, indicated Resident 40 had moderately impaired cognition and required maximal assistance (helper does more than half the effort) for toileting and bathing. During an observation on 10/29/2024 at 1:23 PM outside of Resident 40's room, Resident 40 was sitting up in wheelchair with no restraints noted and no devices or equipment limiting Resident 40's movement. Resident 40 stated Resident 40 was doing well and could not remember any time Resident 40 felt staff purposefully limited their movement. During an interview on 10/30/2024 at 2:34 PM with Restorative Nurse Assistant (RNA) 3, RNA 3 stated restraints had not been used on Resident 40 as far as RNA 3 was aware. During a concurrent interview and record review on 10/30/2024 at 4:38 PM with the MDS nurse (MDSRN), Resident 40's MDS dated [DATE], and question history of question text Trunk restraint, dated from 1/16/2023 to 5/9/2024 was reviewed. The MDS dated [DATE] indicated Resident 40 used a trunk restraint less than daily. The MDSRN stated the facility did not use physical restraints and the previous MDSRN marked the MDS [to indicate Resident 40 used a trunk restraint] document in error. The MDSRN stated all previous MDS documents did not indicate the use of trunk restraints. During an interview on 10/31/2024 at 12:05 PM with the Director of Nursing (DON), the DON stated the facility did not use physical restraints on the residents at the facility.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729 Based on interview and record review, the facility failed to implement the intervention to monitor and document peripheral edema (swelling caused by fluid trapped in the body such as the hands, legs and feet) for one of one sampled resident (Resident 14) as indicated in Resident 14's care plan (CP - document developed that describes the supports, services and interventions for a person's care) titled, At risk for fluid/ electrolyte (type of mineral found in fluids and body) imbalance, at risk for peripheral edema. This deficient practice had the potential to lead to Resident 14 developing shortness of breath and fluid overload (when the body has too much fluid). Findings: During a review of Resident 14's Admission Record, (AR), the AR indicated Resident 14 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included end stage renal disease (condition in which a person's kidney's stop functioning on a permanent basis) and dependence on renal dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). During a review of Resident 14's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/4/2024, the MDS, indicated Resident 14 had intact cognition (ability to think, reason, plan) and was dependent (helper does all the effort) on staff for toileting and personal hygiene. During an interview on 10/30/2024 at 9:52 AM with the Registered Nurse Supervisor (RNS), the RNS stated Resident 14 had a doctor that ordered fluid restriction and the dietary department was instructed to give only certain amounts of fluid during each meal tray and nursing was instructed to only give a certain amount of fluids during their shifts. The RNS stated Resident 14 was aware of the fluid limitations but continued to drink sodas and extra fluids sometimes brought by family members. During a concurrent interview and record review on 10/31/2024 at 12:08 PM with the Director of Nursing (DON) Resident 14's CP titled, At risk for fluid/ electrolyte imbalance, at risk for peripheral edema, dated 4/14/2018 was reviewed. The CP indicated to monitor/ document for peripheral edema. The DON stated Resident 14 was not being monitored for edema but should be because it was indicated on the CP. The DON further stated Resident 14 should be monitored for edema because Resident 14 was frequently non-compliant with fluid restrictions and could develop shortness of breath and fluid overload potentially leading the heart to work too hard. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P, indicated each resident's comprehensive person-centered care plan is consistent with the resident's right to participate in the development and implementation of his or her plan of care, including the right to: 4.g. receive the services and/or items included in the plan of care.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307 Based on observation, interview, and record review, the facility failed to ensure one of one sampled residents (Resident 27) was provided with appropriate treatment and services in accordance with the physician's orders and as outlined in the resident's plan of care (CP [provides direction on the type of nursing care an individual needs that include goals of treatment, specific nursing interventions [actions, treatments, procedures, or activities designed to meet an objective] and an evaluation plan]) to maintain, restore or improve the functional ability for Resident 27. This deficient practice had the potential for Resident 27's contracture (shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement) of the left hand to get worsened and cause considerable pain, strength loss and muscle atrophy (partial or complete wasting away). Findings: During a review of Resident 27's Admission Record (AR), the AR indicated, Resident 27 was originally admitted to the facility on [DATE] and last readmitted on [DATE] with multiple diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one entire side of the body) following cerebral infarction (also known as stroke when area of the brain dies due to blocked or reduced blood supply) affecting left non-dominant side, unspecified dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), unspecified severity without behavioral disturbance, psychotic (a mental disorder characterized by a disconnection from reality) disturbance, mood disturbance, and anxiety (intense, excessive, and persistent worry and fear about everyday situations) and contracture left hand. During a review of Resident 27's CP, titled, RNA (Restorative Nurse Assistant), initiated on 7/1/24, the CP indicated for Resident 1 to reduce the risk of deformity and or contracture progression and or formation. The interventions were for RNA to apply L (left) resting hand splint (a medical device that stabilizes a part of your body and holds it in place to help reduce pain and promote healing) to Resident 27 for up to 8 hours or as tolerated QD (every day) 3x/week (3 times per week). During a review of Resident 27's Order Summary Report (OSR), dated 7/21/24, the OSR indicated, as of 10/31/24, Resident 27 had an active order for RNA to apply L resting hand splint for up to 8 hours or as tolerated QD 3x/week. During a review of Resident 27's History and Physical (H&P), dated 8/21/24, the H&P indicated, Resident 27 could make needs known but could not make medical decisions. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 27's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/21/24, the MDS indicated, Resident 27's BIMS (Brief Interview for Mental Status) Summary Score for cognitive (ability to think and process information) status was severely impaired. The MDS indicated, Resident 27 was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity) for all activities of daily living. The MDS indicated, Resident 27 had no number of days of restorative program performed such as a splint or brace assistance. During a concurrent observation and interview on 10/28/24 at 9:30 a.m. in Resident 27's room, Resident 27 was sitting up in a wheelchair parked on the left side of Resident 27's bed. Resident 27 had a slurred speech, left sided facial droop, left sided paralysis with left wrist/hand contracted without a splint on and resting on her abdomen (belly). Resident 27 stated, Resident 27 was not getting therapy or splint for Resident 27's contracture (on the left hand). During an observation on 10/29/24 at 10 a.m. in the Dining Room, multiple residents including Resident 27 were in the Dining Room for activity. Resident 27 was sitting up in a wheelchair without a splint on her contracted left hand. During an observation on 10/29/24 at 3:11 p.m. in the Dining Room, multiple residents including Resident 27 were in the Dining Room for Bingo activity. Resident 27 was sitting up in a wheelchair without a splint on her contracted left hand. During an observation on 10/30/24 at 12:12 p.m. in the Dining Room for activity, Resident 27 was in a wheelchair and Resident 27's left hand had a blue green colored soft splint on. During a concurrent interview and record review on 10/31/24 at 9:23 a.m. with RNA 2, Resident 27's Restorative Nursing Flow Sheet (RNFS), dated 10/1/24 - 10/31/24 was reviewed. RNA 2 stated, Resident 27 was supposed to get g exercise, hand roll (a rolled up wash cloth or towel placed in the hand to prevent hand contractures) and splint for treatment of Resident 27's stroke/contracture. RNA 2 stated, sometimes Resident 27 did not get the exercise/splint because RNA 2 was utilized as a CNA (Certified Nursing Assistant) and was so busy, and was by myself. RNA 2 stated, it was important for Resident 27 to get the exercise and splint for Resident 27's contracture (on the left hand). During a review of the facility's policy and procedure (P&P) titled, Restorative Nursing Services, with a date revised of July 2017, the P&P indicated, residents would receive restorative nursing care as needed to help promote optimal safety and independence.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913 Based on observation, interview and record review, the facility failed to ensure three of three sampled residents (Residents 34, 48 and Resident 79) received appropriate care, treatment, and services to meet each resident's physical, mental, and psychosocial needs when the facility failed to: a. Initiate 72-hour monitoring when Resident 79 experienced a change of condition (COC, a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains) and when Resident 79 was found with bruising and a scab on Resident 79's left eye and left eyebrow. b. Follow physician's order for Resident 34's doxazosin (medication used to treat high blood pressure and used to treat an enlarged prostate). These deficient practices could have resulted in Resident 34's blood pressure to drop and for Resident 79 not to receive treatment and services needed for Resident 79's left eye. Findings: a. During a review of Resident 79's Admission Record(AR), the AR indicated the facility admitted Resident 79 on 6/4/2024 with diagnoses that included lack of coordination, history of transient ischemic attack (mild stroke, a temporary blockage of blood flow to the brain) and cerebral infarction (stroke - a lack of blood flow to the brain that will eventually cause permanent brain damage) without residual effects. During a review of Resident 79's Minimum Data Set (MDS) dated [DATE], the MDS indicated Resident 79 had severe cognitive (ability to think and process information) impairment. The MDS indicated Resident 79 required moderate assistance (helper does less than half the effort. Helper lifts or holds, or supports trunk or limbs, but provides less than half the effort) with toileting hygiene, chair/bed-to-chair transfers, bed mobility such as rolling left and right, sit to lying, lying to sitting on the side of the bed and sit to stand. The MDS indicated Resident 79 was always incontinent (having no or no voluntary control over urination or defecation [discharge of feces from the body]) of bowel and bladder. During a review of Resident 79's Post-Event Review, date and time of event 10/21/2024 at 10:14 AM, the review indicated Resident 79 fell asleep and hit Resident 79's forehead against the table. The review indicated Resident 79 had a bump with redness above the left eyebrow and a small skin tear. The review indicated Resident 79's doctor ordered continued monitoring for Resident 79. During an observation on 10/28/2024 at 11:31 AM, Resident 79 was lying on Resident 79's bed, Resident 79 had a bruise that was dark purple, brown about one inch in size under Resident 79's left eye (from the inner eye to the middle of the eye) and a scab that measured 0.5 cm (centimeters, unit of length) above Resident 79's left eyebrow. During an observation on 10/30/2024 at 12:26 PM, Resident 79 was eating lunch, Resident 79 had Resident 79's head bent forward and Resident 79's face was very close to Resident 79's plate. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review and interview on 10/31/2024 at 1:09 PM, with the Medical Records Staff (MRS), Resident 79's Change of Condition records were reviewed, there was no documentation that indicated Resident 79's left eye discoloration or that indicated a scab above Resident 79's left eyebrow. The MRS stated there were two existing change of condition records for Resident 79, but the records were not related to the discoloration or scab. During an interview on 10/31/2024 at 1:19 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 79 got the bruise while Resident 79 was in the dining room, Resident 79 fell asleep, and hit Resident 79's face on the table. During an interview on 10/31/2024 at 1:47 PM with the Treatment Nurse (TN), the TN stated the TN did not create a change of condition record because the TN was not the one who identified Resident 79's bruising and scab. During a concurrent observation and interview on 10/31/2024 at 1:51 PM with the Director of Nursing (DON), the DON stated there was a purple and brown discoloration under Resident 79's left eye and a scab above Resident 79's left eyebrow. The DON stated a new bruise needed to be investigated and the staff needed to create a change of condition record [Resident 79's bruise and scab was a change of condition for Resident 79] for staff to be able to monitor further changes experienced by Resident 79. The DON stated the DON investigated immediately and found out the cause of the bruise was Resident 79's positioning when Resident 79 sat down, Resident 79 tended to position his head close to the table and Resident 79 fell asleep and hit Resident 79's head on the table. The DON stated 72-hour monitoring for Resident 79's bruising and scab was done. The DON stated creating a COC was important so the facility could monitor residents (in general) for 72 hours after the change of condition occurred. During a review of the facility's Policy and Procedure (P&P) titled Change in a Resident's Condition or Status revised February 2021, the P&P indicated the facility will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. 42307 b. During a review of Resident 34's AR, the AR indicated, Resident 34 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including sepsis (a serious condition in which the body responds improperly to an [infection, refers to an invasion of the body by harmful microorganisms]), unspecified organism, gastrostomy status (the presence of a G-tube) and essential (primary) hypertension (high blood pressure). During a review of Resident 34's Order Summary Report (OSR), dated 6/12/24, the OSR indicated, as of 10/31/24, Resident 34 had enteral (food or drug administration via the human gastrointestinal tract) feed and oral medication orders via G-tube that included an order on 6/12/24 for Doxazosin Mesylate (medication used to treat hypertension [HTN, high blood pressure]) oral tablet 2 MG (milligrams - a measure of weight), give 1 tablet via G-tube one time a day for HTN, hold if SBP (systolic blood pressure) less than 110 millimeters of mercury (mmHg) or HR (heart rate) less than 60 (beats per minute). During a review of Resident 34's History and Physical (H&P), dated 6/19/24, the H&P indicated, Resident 34 did not have the capacity to understand and make decisions. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 34's MDS, dated [DATE], the MDS indicated, Resident 34's cognitive skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated, Resident 34 was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity) for all activities of daily living. During a concurrent interview and record review on 10/31/24 at 10:42 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 34's Medication Administration Record (MAR), dated 10/1/24 - 10/31/24 was reviewed. The MAR indicated, Resident 34's blood pressure (BP) was 106/66 mmHg on 10/7/24, Resident 34's BP was103/83 mmHg on 10/27/24 and Resident 34's BP was 106/66 mmHg on 10/29/24. A check mark with LVN 2's initials was documented for the 9 a.m. medication administration time on 10/6/24 and 10/29/24. A check mark with LVN 3's initials was documented for the 9 a.m. medication administration time on 10/27/24. The MAR indicated, different chart codes including a check mark for Administered. LVN 2 stated, a check mark indicated Doxazosin was given/administered. LVN 2 stated, the number 13 documented on the MAR indicated the medication was either held (not given/administered) because it (blood pressure) was not within the parameters from the physician's order. LVN 2 stated, the process of safe medication administration included the right dose, right patient, right route, route medication, right time, and parameters for the resident's BP. LVN 2 stated, Resident 34's Doxazosin should have been held because Resident 34's BP could drop. During a concurrent interview and record review on 10/31/24 at 10:58 a.m. with the DON, Resident 34's MAR, dated 10/1/24 - 10/31/24 was reviewed. The DON stated, Doxazosin should not be given for Resident 34's safety because Resident 34's BP was already low. The DON stated giving the Doxazosin to Resident 34 could lower Resident 34's BP. The DON stated, the process of safe medication administration included checking the BP's parameters for the medication as ordered. During a review of the facility's P&P titled, Medication Administration-General Guidelines, with an effective date of October 2017, the P&P indicated, medications were administered as prescribed in accordance with good nursing principles and practices. The P&P indicated, medications were administered in accordance with written orders of the attending physician. The P&P indicated, the individual who administered the medication dose records the administration on the resident's MAR directly after the medication was given. The P&P indicated, the resident's MAR was initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913 Based on observation, interview and record review, the facility failed to ensure facility provided care and services to prevent pressure ulcers for two of four sampled residents (Resident 47 and Resident 79.) As a result, Resident 47 developed a recurrent Associated Skin Damage (MASD, an erosion or inflammation of the skin caused by long-term exposure to moisture and irritants such as urine or stool) and Resident 79 developed a skin rash on the scrotum and buttocks. Cross Reference F690 Findings: a. During a review of Resident 47's Admission Record, the Admission Record indicated the facility admitted the resident on 5/25/2021, with diagnoses that included hemiplegia and hemiparesis following cerebral infarction (paralysis/weakness of one side of the body following a stroke,) type 2 diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine.) During a review of Resident 47's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 5/24/2024, the MDS indicated Resident 47 had intact cognition. The MDS indicated Resident 47 was totally dependent with toileting hygiene and transfers and required maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with bed mobility such as rolling left and right, lying to sitting on the side of the bed, and sit to lying. The MDS indicated Resident 47 was always incontinent. During a review of Resident 47's Braden Scale for Predicting Pressure Ulcer Risk, dated 8/23/2024, the Braden Scale indicated Resident 47 had a score of 14 (a score of 13-14 indicated moderate risk for the development of pressure ulcer). During a review of Resident 47's care plan for being at risk for unavoidable pressure ulcer or potential for pressure ulcer development related to impaired mobility and incontinence with both bowel and bladder, dated 7/21/2024, the care plan indicated the goal was for the resident to have intact skin, free from redness, blisters, or discoloration. The care plan had interventions that included to monitor/document/report to the physician changes in skin status and to monitor nutritional status. The care plan interventions did not indicate ways to prevent the development of pressure ulcer related to the following risk factors, immobility, and incontinence. During an observation on 10/30/2024 at 9:07 AM, Resident 47 was asleep, lying in bed on his back. During an observation on 10/30/2024 at 11:07 AM, Resident 47 was asleep, lying in bed on his back. During an observation on 10/30/2024 at 12:50 PM. Resident 47 was asleep after lunch, lying on his back. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During multiple observations of Certified Nursing Assistant 1 (CNA 1) who was assigned to care for Resident 47. CNA 1 did not enter Resident 47's room from 9:07 am to 1:04 pm. 10/30/2024 09:20 AM, CNA 1 was standing in the hallway. 10/30/2024 10:00 AM, CNA 1 was off the floor for lunch break. 10/30/2024 10:15 AM, two others CNAs were on the floor, CNA 1 was still on break. 10/30/2024 10:30 AM, CNA 1 was back on the floor, standing in the hallway. 10/30/2024 10:47 AM, CNA 1 was standing in the hallway. 10/30/2024 10:48 AM, CNA 1 was answered call light in room [ROOM NUMBER] 10/30/2024 10:51 AM, CNA 1 was standing in the hallway. 10/30/2024 11:03 AM, CNA 1 checked another resident, a roommate of Resident 47. 10/30/2024 11:07 AM, Resident 47 was asleep, lying in bed on his back. 10/30/2024 11:08 AM, CNA 1 repositioned another resident. 10/30/2024 11:09 AM, CNA 1 answered room [ROOM NUMBER]'s call light 10/30/2024 11:11 AM, CNA 1 went to a room across Resident 47. 10/30/2024 11:16 AM, CNA 1 was standing in the hallway, talking to someone. 10/30/2024 11:22 AM, CNA 1 left the floor, to the nurse's station. 10/30/2024 11:25 AM, CNA 1 was back on the floor. 10/30/2024 11:33 AM, CNA 1 was inside Resident 47's room, talking to Resident 47's roommate. 10/30/2024 11:43 AM, CNA 1 was standing in the hallway. 10/30/2024 11:56 AM, CNA 1 answered a call light adjacent to Resident 47's room. 10/30/2024 12:05 PM, CNA 1 was at the Nurse's station. 10/30/2024 12:16 PM, CNA 1 was distributing lunch trays, then assisted another resident with lunch. 10/30/2024 12:50 PM, Resident 47 was asleep, lying in bed on his back. 10/30/2024 12:52 PM, CNA 1 was assisting a resident adjacent to Resident 47's room. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/30/2024 1:08 PM, CNA 1 and the Treatment Nurse (TN) was preparing to help Resident 47 with incontinence care. Resident 47's incontinent pad was wet with urine. During a concurrent observation and interview on 10/30/2024 at 1:08 PM, the Treatment Nurse (TN) and Certified Nursing Assistant 1 (CNA 1) went inside Resident 47's room for incontinence care. The incontinence pad was wet with urine and there was pink, peeling area around the sacrococcyx and the buttocks. There were two open areas on the right buttocks and 1 open area on the left buttocks. The TN stated Resident 47 had MASD in the past, the TN stated it looked like Resident 47 had a recurrence of the MASD. During an observation of Resident 47 on 10/30/2024 at 1:14 PM, there were no positioning pillows inside Resident 47's room, CNA 1 left the room and came back with 2 pillows. TN and CNA 1 positioned Resident 47 on his left side. During an interview on 10/30/2024 at 1:21 PM, Resident 47 stated the staff were not repositioning the resident. Resident 47 stated the staff would change the incontinence pad and would apply cream to the buttocks. Resident 47 stated he did not refuse care such as repositioning. During a review of Resident 47's Change of Condition (COC) dated 10/30/2024 at 1:17 PM, the COC indicated a change in skin color or condition, a pale, pinkish patchy redness with moist erosion of the skin on the right and left buttocks measuring 5.5 X 6.4 (unit of measurement was not listed). During an observation on 10/31/2024 at 9:57 AM, the opened areas of the right and left buttocks were measured as follows: Length of the open area on the right buttocks measured: 1 inch. Width of the open area on the right buttocks measured: 0.5 inch. Length of the open area on the left buttocks measured 2.2 inches. Width of the open area on the left buttocks measure 2.2 inches. During the same observation, the right and left buttocks had peeling skin with the above open areas on the right and left buttocks. The Treatment Nurse (TN) cleaned the whole area of the right and left buttocks then applied nystatin cream (anti-fungal medication.) During an interview on 10/30/2024 at 2:57 PM, CNA 1 stated facility practice was to reposition residents every 2 hours and showed the repositioning schedule that she had attached to the identification badge. CNA 1 stated CNA 1 asked Resident 47 after breakfast to reposition and CNA 1 did not ask again because Resident 47 was sleeping. CNA 1 did not report Resident 47's refusal to the Charge Nurse or the TN. During an interview on 10/31/2024 at 10:20 AM, The TN stated the measurement on the COC was the measurement of the entire area of the right and left buttocks that the skin was peeling. The TN did not measure the open area on the right and left buttocks. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/31/2024 at 10:36 AM, the TN stated a pressure ulcer is a change in skin integrity related to pressure, a resident could get a pressure ulcer from steady/constant pressure to an area. The moisture from urine could irritate the skin exposed to the urine and could break down the skin. The TN stated the exposure to the moisture could cause a fungal infection of the skin. The TN stated the assigned CNA was responsible for changing and repositioning Resident 47 , and the assigned charge nurse and the Registered Nurse Supervisor need to monitor to ensure Resident 47 was changed and repositioned. During an interview on 10/31/2024 at 10:48 AM, the Registered Nurse Supervisor (RNS) stated a pressure ulcer is a skin decline due to being in one position for more than two hours. The RNS stated moisture could open the skin and could cause a fungal rash. The RNS stated the open area on the buttocks could cause by moisture, or a fungal infection or it could be pressure because of the location of the open areas on the buttocks. The RNS stated the weight of the body would be on the pressure areas such as the occipitus (back of the head, the back of the shoulders, the coccyx, the buttocks, and the heels. b. During a review of Resident 79's Admission Record, the Admission Record indicated the facility admitted the resident on 6/4/24, with diagnoses that included lack of coordination, history of transient ischemic attacks (mild stroke, a temporary blockage of blood flow to the brain) and cerebral infarction (stroke - a lack of blood flow to the brain that will eventually cause permanent brain damage) without residual effects. During a review of Resident 79's MDS dated [DATE], the MDS indicated Resident 79 had severe cognitive impairment. The MDS indicated Resident 79 required moderate assistance (helper does less than half the effort. Helper lifts or holds, or supports trunk or limbs, but provides less than half the effort) with toileting hygiene, chair/bed-to-chair transfers, bed mobility such as rolling left and right, sit to lying, lying to sitting on the side of the bed and sit to stand. The MDS indicated Resident 79 was always incontinent of bowel and bladder. During a review of Resident 79's Braden Risk for Predicting Pressure Sore Risk dated 9/10/2024, the Braden Risk indicated a score of 15 (a score of 15-18 indicated at risk for the development of pressure ulcer). During an observation on 10/30/2024 at 9:20 AM, Resident 79 was not in Resident 79's room. Certified Nursing Assistant 1 (CNA 1) who was assigned to care for Resident 79 stated Resident 79 was in the dining room for Activities. During an observation on 10/30/2024 at 11:06 AM, Resident 79 was not in Resident 79's room. During an observation on 10/30/2024 at 12:26 PM, Resident 79 was eating lunch in the dining room. During multiple observations from 9:20 am to 1:57 PM, CNA 1did not assist Resident 79 back to Resident 79's room to change Resident 79's incontinence pad. 10/30/2024 09:20 AM, CNA 1 was standing in the hallway. 10/30/2024 10:00 AM, CNA 1 was off the floor for lunch break. (continued on next page)

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	055367	A. Building B. Wing	10/31/2024

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/30/2024 10:15 AM, two others CNAs were on the floor, CNA 1 was still on break. 10/30/2024 10:30 AM, CNA 1 was back on the floor, standing in the hallway. 10/30/2024 10:47 AM, CNA 1 was standing in the hallway. 10/30/2024 10:48 AM, CNA 1 answered call light in room [ROOM NUMBER] 10/30/2024 10:51 AM, CNA 1 was standing in the hallway. 10/30/2024 11:03 AM, CNA 1 checked another resident, a roommate of Resident 47. 10/30/2024 11:08 AM, CNA 1 repositioned another resident. 10/30/2024 11:09 AM, CNA 1 answered room [ROOM NUMBER]'s call light 10/30/2024 11:11 AM, CNA 1 went to a room across Resident 47. 10/30/2024 11:16 AM, CNA 1 was standing in the hallway, talking to someone. 10/30/2024 11:22 AM, CNA 1 left the floor, to the nurse's station. 10/30/2024 11:25 AM, CNA 1 was back on the floor. 10/30/2024 11:33 AM, CNA 1 was inside Resident 47's room, talking to Resident 47's roommate. 10/30/2024 11:43 AM, CNA 1 was standing in the hallway. 10/30/2024 11:56 AM, CNA 1 answered a call light adjacent to Resident 47's room. 10/30/2024 12:05 PM, CNA 1 was at the Nurse's station. 10/30/2024 12:16 PM, CNA 1 was distributing lunch trays, then assisted another resident with lunch. 10/30/2024 12:52 PM, CNA 1 was assisting a resident adjacent to Resident 47's room. 10/30/2024 1:08 PM, CNA 1 and the TN were preparing for Resident 47's incontinence care. During an observation of Resident 79 on 10/30/2024 1:57 PM, Resident 79 was sitting on the wheelchair in a hallway away from Resident 79's room. Licensed Vocational Nurse 5 (LVN 5) stated LVN 5 would wheel Resident 79 back to the activity room. LVN 5 stated she did not know if Resident 79 had not received incontinence care. During a concurrent observation and interview on 10/30/2024 at 2:20 PM, there were open areas on Resident 79's right and left buttocks and on the scrotum. Registered Nurse Supervisor (RNS) stated the open areas looked like excoriated skin. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 79's COC dated 10/30/2024, the COC indicated a fungal skin rash of the scrotum, right and left buttocks. During an interview on 10/30/2024 at 2:56 PM, CNA 1 stated facility practice was for staff to check incontinence residents every 2 hours. CAN 1 stated if the incontinence pad was wet and has urine or bowel movement staff need to change the pad. CNA 1 did not give a reason why CNA 1 failed to check on Resident 79's incontinence pad. CNA 1 stated Resident 79 needed to be back to the Resident 79's bed after lunch at around 1-1:30 PM for incontinence care, CNA 1 stated CNA 1 failed to bring Resident 79 back to his room in the morning for incontinence care and to relieve the pressure from sitting down for long hours. During a review of the facility's Policy & Procedure (P&P) titled, Prevention of Pressure Injuries, dated February 2024. The P&P indicated to reposition all resident with or at risk for pressure injuries. The P&P indicated to provide skin care that included to keep the skin clean and hydrated and to clean promptly after episodes of incontinence.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913 Based on observation, interview, and record review, the facility failed to ensure incontinent (having no or no voluntary control over urination or defecation [discharge of feces from the body]) care was provided for two of two sampled residents (Resident 47 and Resident 79). This deficient practice resulted in Resident 47 and Resident 79 to develop Moisture Associated Skin Damage (MASD, an erosion or inflammation of the skin caused by long-term exposure to moisture and irritants such as urine or stool), this failure had the potential to result in physical declines to Residents 47 and 79. Cross Reference F686 Findings: a. During a review of Resident 47's Admission Record (AR), the AR indicated the facility admitted the resident on 5/25/2021, with diagnoses that included hemiplegia and hemiparesis following cerebral infarction (paralysis/weakness of one side of the body following a stroke,) type 2 diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine). During a review of Resident 47's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 5/24/2024, the MDS indicated Resident 47 had intact cognition. The MDS indicated Resident 47 was totally dependent with toileting hygiene and transfers and required maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with bed mobility such as rolling left and right, lying to sitting on the side of the bed, and sit to lying. The MDS indicated Resident 47 was always incontinent. During an observation on 10/29/2024 at 08:15 AM, at 9:54 AM and at 12:08 PM, Resident 47 was asleep on Resident 47's bed and Resident 47 was lying on Resident 47's back. During an observation on 10/30/2024 at 9:07 AM, and at 11:07 AM, Resident 47 was asleep on Resident 47's bed and Resident 47 was lying on Resident 47's back. During a after lunch observation on 10/30/2024 at 12:50 PM. Resident 47 was asleep on Resident 47's bed and Resident 47 was lying on Resident 47's back. During a review of Resident 47's care plan (CP) on bowel and bladder incontinence related to impaired mobility and inability to anticipate toileting needs, at risk for altered skin integrity and complications, initiated 7/1/2022. The CP indicated Resident 47 would remain free of skin breakdown due to incontinence and [adult] brief use. The CP indicated interventions to check Resident 47 every shift and as required for incontinence. The CP indicated to wash, rinse, and dry the perineum (the thin layer of skin between your genitals [outer sexual organs]). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During multiple observations on 10/30/2024 of Certified Nursing Assistant 1 (CNA 1), CNA 1 was assigned to Resident 47. CNA 1 did not enter Resident 47's room from 9:07 AM to 1:04 PM. On 10/30/2024 09:20 AM, CNA 1 was standing in the hallway. On 10/30/2024 10 AM, CNA 1 was not on the floor [hallway area where resident rooms are located] and was on for lunch break. On 10/30/2024 at 10:15 AM, two other CNA's (unidentified) were on the floor, CNA 1 was on lunch break. On 10/30/2024 at 10:30 AM, CNA 1 was back on the floor and was standing in the hallway. On 10/30/2024 at 10:47 AM, CNA 1 was standing in the hallway. On 10/30/2024 at 10:48 AM, CNA 1 answered a call light in room [ROOM NUMBER]. On 10/30/2024 at 10:51 AM, CNA 1 was standing in the hallway. On 10/30/2024 at 11:03 AM, CNA 1 checked on Resident 47's roommate [entered Resident 47's room]. On 10/30/2024 at 11:07 AM, Resident 47 was asleep and lying on Resident 47's back. On 10/30/2024 at 11:09 AM, CNA 1 answered room [ROOM NUMBER]'s call light. On 10/30/2024 at 11:11 AM, CNA 1 entered a room located across Resident 47's room. On 10/30/2024 at 11:16 AM, CNA 1 was standing in the hallway. On 10/30/2024 at 11:22 AM, CNA 1 left the hallway and walked toward the nurse's station. On 10/30/2024 at 11:25 AM, CNA 1 was back on the floor. On 10/30/2024 at 11:33 AM, CNA 1 was inside Resident 47's room talking to Resident 47's roommate. On 10/30/2024 at 11:43 AM, CNA 1 was standing in the hallway. On 10/30/2024 11:56 AM, CNA 1 answered a call light adjacent to Resident 47's room. On 10/30/2024 at 12:05 PM, CNA 1 walked toward the nurse's station. On 10/30/2024 at 12:16 PM, CNA 1 distributed lunch trays, then assisted another resident (unidentified) with lunch. On 10/30/2024 at 12:50 PM, Resident 47 was asleep on Resident 47's bed and lying on Resident 47's back. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/30/2024 at 12:52 PM, CNA 1 assisting a resident (unidentified) who's room was adjacent to Resident 47's room. On 10/30/2024 at 1:08 PM, CNA 1 and the Treatment Nurse (TN) prepared to do Resident 47's incontinent care. Resident 47's incontinent pad was wet with urine. During a concurrent observation and interview on 10/30/2024 at 1:08 PM, with the TN, the TN and CNA 1 went inside Resident 47's room to perform incontinent care. The incontinent pad was wet with urine and there was an area that had pink, peeling around the sacrococcyx (sacral [a triangular shaped bone at the bottom of the spine] coccyx [tailbone]) and on the buttocks, there were two open areas on the right buttock and one open area on the left buttock. The TN stated Resident 47 had MASD in the past. The TN stated it looked like Resident 47 had a recurrence of the MASD. During a review of Resident 47's Change in Condition Evaluation (COC, a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains), dated 10/30/2024 at 1:17 PM, the COC indicated a change in skin color or condition, a pale, pinkish patchy redness with moist erosion of the skin on the right and left buttocks measuring 5.5 X 6.4 [no unit of measurement indicated in the COC, wounds measured in centimeters]. During an interview on 10/30/2024 at 2:56 PM with CNA 1, CNA 1 stated facility practice was for staff to check incontinent residents every two hours and if the incontinent pad was wet, [the CNA] changed the pad if the resident urinated or had a bowel movement. CNA 1 stated the last time CNA 1 checked Resident 47 and provided incontinent care was after breakfast around 8 am. CNA 1 stated CNA 1 did not ask Resident 47 [if Resident 47 needed an adult brief change] again because Resident 47 was sleeping. During an observation of Resident 47's buttocks area with the TN on 10/31/2024 at 9:57 AM, Resident 47's opened areas on the right and left buttocks measured as followed: Length, the right buttock measured: 1 inch (unit of length). Width, the right buttock measured: 0.5 inch. Length on the left buttock measured 2.2 inches. Width on the left buttock measure 2.2 inches. During this same observation, the right and left buttocks had peeling skin. The Treatment Nurse (TN) cleaned the right and left buttock area and applied nystatin cream (anti-fungal medication). Resident 47 grimaced in pain and stated Resident 47 stated Resident 47's bottom hurt a 9/10 pain (pain scale 0 to 10, 0 means no pain and 10 means the worst possible pain felt) and described the pain as sharp. During an interview on 10/31/2024 at 10:52 AM, with the Registered Nurse Supervisor (RNS), the RNS stated moisture could open the skin and moisture could cause a fungal rash. The open area on Resident 47's buttocks could be caused by moisture, or a fungal infection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 79's AR, the AR indicated the facility admitted Resident 79 on 6/4/2024 with diagnoses that included lack of coordination, history of transient ischemic attack (mild stroke, a temporary blockage of blood flow to the brain) and cerebral infarction (stroke - a lack of blood flow to the brain that will eventually cause permanent brain damage) without residual effects. During a review of Resident 79's MDS, dated [DATE], the MDS indicated Resident 79 had severe cognitive impairment. The MDS indicated Resident 79 required moderate assistance (helper does less than half the effort. Helper lifts or holds, or supports trunk or limbs, but provides less than half the effort) with toileting hygiene, chair/bed-to-chair transfers, bed mobility such as rolling left and right, sit to lying, lying to sitting on the side of the bed and sit to stand. The MDS indicated Resident 79 was always incontinent (having no or no voluntary control over urination or defecation [discharge of feces from the body]) of bowel and bladder. During a review of Resident 79's CP on bowel and bladder incontinence related to confusion, impaired mobility, and inability to communicate needs. The CP's goal indicated Resident 79 would remain free from skin breakdown. The CP indicated CNA interventions to change disposable briefs every shift and as needed, to check Resident 79 frequently and as required for incontinence, and to wash, rinse and dry the perineum. During an observation on 10/29/2024 at 8:11 AM, Resident 79 was sitting on Resident 79's wheelchair. During an observation on 10/29/2024 at 10:27 AM and at 12:06 PM, Resident 79 was not in Resident 79's room. CNA 1 stated Resident 79 was in the dining room for activities. During an observation on 10/30/2024 at 9:20 AM, Resident 79 was not in Resident 79's room. CNA 1 who was assigned to Resident 79 stated Resident 79 was in the dining room for Activities. During an observation on 10/30/2024 at 11:06 AM, Resident 79 was not in Resident 79's room. During an observation on 10/30/2024 at 12:26 PM, Resident 79 was eating lunch in the dining room. During multiple observations on 10/30/2024 from 9:20 AM to 1:57 PM, CNA 1 (assigned to care for Resident 79) did not bring Resident 79 back to Resident 79's room to check for incontinence or to change Resident 79's adult brief, CNA 1's activity included, On 10/30/2024 09:20 AM, CNA 1 was standing in the hallway. On 10/30/2024 10 AM, CNA 1 was not on the floor [hallway area where resident rooms are located] and was on for lunch break. On 10/30/2024 at 10:15 AM, two other CNA's (unidentified) were on the floor, CNA 1 was on lunch break. On 10/30/2024 at 10:30 AM, CNA 1 was back on the floor and was standing in the hallway. On 10/30/2024 at 10:47 AM, CNA 1 was standing in the hallway. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/30/2024 at 10:48 AM, CNA 1 answered a call light in room [ROOM NUMBER]. On 10/30/2024 at 10:51 AM, CNA 1 was standing in the hallway. On 10/30/2024 at 11:03 AM, CNA 1 checked on Resident 47's roommate [entered Resident 47's room]. On 10/30/2024 at 11:07 AM, Resident 47 was asleep and lying on Resident 47's back. On 10/30/2024 at 11:09 AM, CNA 1 answered room [ROOM NUMBER]'s call light. On 10/30/2024 at 11:11 AM, CNA 1 entered a room located across Resident 47's room. On 10/30/2024 at 11:16 AM, CNA 1 was standing in the hallway. On 10/30/2024 at 11:22 AM, CNA 1 left the hallway and walked toward the nurse's station. On 10/30/2024 at 11:25 AM, CNA 1 was back on the floor. On 10/30/2024 at 11:33 AM, CNA 1 was inside Resident 47's room talking to Resident 47's roommate. On 10/30/2024 at 11:43 AM, CNA 1 was standing in the hallway. On 10/30/2024 11:56 AM, CNA 1 answered a call light adjacent to Resident 47's room. On 10/30/2024 at 12:05 PM, CNA 1 walked toward the nurse's station. On 10/30/2024 at 12:16 PM, CNA 1 distributed lunch trays, then assisted another resident (unidentified) with lunch. On 10/30/2024 at 12:50 PM, Resident 47 was asleep on Resident 47's bed and lying on Resident 47's back. On 10/30/2024 at 12:52 PM, CNA 1 assisting a resident (unidentified) who's room was adjacent to Resident 47's room. During an observation and interview on 10/30/2024 at 1:57 PM, with Licensed Vocational Nurse 5 (LVN 5). Resident 79 was sitting on the Resident 79's wheelchair in a hallway. LVN 5 stated LVN 5 would wheel Resident 79 back to the activity room. LVN 5 stated LVN 5 did not know if Resident 79"s adult brief was changed. During a concurrent observation and interview on 10/30/2024 at 2:20 PM, with the Registered Nurse Supervisor (RNS), Resident 79 had open areas located on the right buttock, the left buttock, and on the scrotum (the bag of skin that holds and helps protect the testicles). The RNS stated the open areas looked like excoriated skin. (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/30/2024 at 2:56 PM with CNA 1, CNA 1 stated facility practice was for staff to check incontinent residents every two hours and if the incontinent pad was wet, [the CNA] changed the pad if the resident urinated or had a bowel movement. CNA 1 did not answer when asked why CNA 1 failed to check Resident 79 for incontinence. CNA 1 stated Resident 79 needed to be back in Resident 79's bed after lunch around 1-1:30 PM for incontinent care, CNA 1 stated CNA 1 failed to bring Resident 79 back to Resident 79's room for incontinent care and to relieve the pressure [off Resident 79's buttocks] from sitting down. During a review of the facility's Policy and Procedure titled Activities of Daily Living, Supporting dated March 2018, the P&P indicated residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729 Based on observation, interview, and record review the facility failed to honor the food preferences of one of one sampled resident (Resident 69) and ensure Boost (nutritional supplement shake) was given to Resident 69 on 10/29/2024. This deficient practice led to Resident 69's decreased appetite and potentially contributed to significant weight loss. Findings: During a review of Resident 69's Admission Record, (AR), the AR indicated Resident 69 was admitted to the facility on [DATE] with diagnoses that included conversion disorder (a psychiatric disorder characterized by symptoms affecting sensory or motor function) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 69's Care Plan (CP - document developed that describes the supports, services and interventions for a person's care) titled, The resident has a potential nutritional problem, dated 4/17/2024, and revised 7/12/2024, the CP indicated interventions to provide, serve diet as ordered and dietary to review food preferences as needed. The CP also indicated to give Boost two times a day for supplement. During a review of Resident 69's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/11/2024, the MDS indicated Resident 69 had moderately impaired cognition (ability to think, reason, plan) and required maximal assistance (helper does more than half of the effort) for bathing and personal hygiene. Resident 69 had the ability to eat without assistance. During a review of Resident 69's Nutrition Assessment (NA), dated 10/25/2024, the NA indicated Resident 69 had a weight loss of 18% (49 pounds) in the past six months. The NA indicated Resident 69 reported poor appetite and not getting requested foods from the kitchen despite the kitchen having Resident 69's food preferences. During an interview on 10/28/2024 at 2 PM with Restorative Nursing Assistant (RNA) 3, RNA 3 stated it was true that Resident 69 did not always get Resident 69's preferred food items. RNA 3 stated when the kitchen was asked in the past about the wrong or missing items the kitchen staff responded the kitchen does not have those items. During a concurrent observation and interview on 10/30/2024 at 1:45 PM with the Dietary Supervisor (DS) and the [NAME] (CK), Resident 69's lunch tray was observed. The DS and the CK stated that Resident 69's meal ticket did not match the items on Resident 69's tray and it should. The DS stated tray instructions to include fresh fruit and slice lemon were reasonable requests but were not included on the lunch tray and they should be. The CK stated the meal ticket indicated barbeque pork, but chicken was placed on the tray. The CK stated the meal ticket did not match the tray and it should so there was no confusion. The DS stated when a resident did not get their preferred food items it could lead to decreased appetite and potentially weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/2024 at 2 PM with Resident 69, Resident 69 stated Resident 69 was tired of going back and forth with the kitchen to get Resident 69's preferred foods and the conflict sometimes decreased Resident 69's appetite. During a concurrent interview and record review on 10/30/2024 at 2:57 PM with Licensed Vocational Nurse (LVN) 5, Resident 69's Medication Administration Record (MAR) dated 10/1/2024 - 10/31/2024 was reviewed. The MAR indicated on 10/29/2024, Resident 69's 9 AM scheduled Boost was administered to Resident 69. LVN 5 stated LVN 5 first documented Resident 69 received the shake with the intention of giving the resident the shake afterwards but forgot to administer it and also forgot to fix the documentation. LVN 5 stated staff were supposed to document after a medication or shake was administered and not before. LVN 5 stated documenting incorrectly could affect Resident 69 by obstructing whether Resident 69's interventions were working and could potentially lead to further weight loss. During a review of the facility's policy and procedure (P&P) titled, Resident Food Preferences, undated, the P&P indicated, the food services department will offer a variety of foods at each scheduled meal, as well as access to nourishing snacks throughout the day and night.

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Monrovia Gardens Healthcare Center	615 W. Duarte Rd. Monrovia, CA 91016

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 42307 Based on interview and record review, the facility failed to ensure there was sufficient nursing aides to provide care and respond to each resident's basic needs for two of two sampled residents (Residents 29 and 51). This failure resulted in Residents 29, 51 felt frustrated and the residents not receiving the care or receiving delayed care and treatments. Findings: During an interview on 10/29/24 at 9:52 a.m. with the Restorative Nurse Assistant (RNA) 1, RNA 1 stated, staff felt short-staffed especially when some staff called in sick or came to work late and facility's administrative staff did not have time to call for coverage. RNA 1 stated, facility's administrative staff would take an RNA to work as a CNA (Certified Nursing Assistant) on the floor when the facility was short-staffed. RNA 1 stated, only certain licensed nurses helped. During an interview on 10/29/24 at 10:37 a.m. with the residents (present) conducted during the Resident Council Meeting (RCM), Resident 51 stated, staff on the night shift would ignore the call light or would turn the call light off and say I will tell the CNA. Resident 51 stated, Resident 51 told staff to prepare the resident for the RCM today but Resident 51 was ignored by staff and Resident 51 was not able to take a shower today. Resident 51 stated, staff, especially staff on the night shift were not responding to call lights in a timely manner. Resident 51 stated Resident 51 brought up the concern of staff not responding to call lights in a timely manner during last month's RCM, but it was still an on-going issue. Resident 51 stated Resident 51 believed it (call light late response) was a result of staffing issues. Resident 29 stated, Resident 29 had become frustrated and had problems on Resident 29's shower days as the aides kept Resident 29 wait a long time for shower. During an interview on 10/29/24 at 11 a.m. with the residents during the RCM, Resident 51 stated, residents had to wait for thirty (30) minutes to an hour. Resident 51 stated, nobody wants to wait. During an interview on 10/30/24 at 11:14 a.m. with CNA 1, CNA 1 stated, the facility had a staffing shortage and facility's administrative staff did not call registry (a person or organization that maintains a list of nursing staff) for coverage. CNA 1 stated, CNAs (in general) had an average of ten (10) residents to care for per shift and CNAs would try their best to complete the tasks. During an interview on 10/31/24 at 8 a.m. with the Director of Staff Development (DSD), the DSD stated, the facility had a contract with two (2) companies for registries, but the facility did not utilize the registries because staff would call off on the last minute and the registries needed four (4) hours notification prior to the start of each shift. During an interview on 10/31/24 at 9:15 a.m. with RNA 2, RNA 2 stated, residents would not get the exercise (restorative therapy) when RNA 2 was the only RNA scheduled to work and would work as a CNA on the floor when the facility was short-staffed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/31/24 at 10:58 a.m. with the Director of Nursing (DON), the DON stated, the facility was short of CNA and RNA for the last two (2) months since ten (10) CNAs had left. The DON stated, I have to be honest with you. The DON stated the facility currently was short of (six) 6 CNAs. The DON stated, short staffing would affect the care of the residents. The DON stated, the facility did not utilize registries since the facility has had bad experiences with registry staff such as no call, no show and registry staff had attitude of having no responsibility. During an interview on 10/31/24 at 12:50 p.m. with the DSD, the DSD stated, the DSD accepted that the facility had a staffing shortage, mostly CNAs. The DSD stated, short staffing affected the care of the residents. The DSD stated, we need to take care of residents. During an interview on 10/31/24 at 2:21 p.m. with the DSD, the DSD stated, CNA 4 was scheduled as a CNA on 10/28/24 but CNA 4 was utilized as a back-up RNA. During a review of the facility's RCM Minutes (RCMM), dated 9/18/24, the RCMM indicated, residents had expressed that different CNAs would come to the resident rooms to answer call lights and would end up telling the residents that CNAs would be back but never came back to attend to the residents' needs. During a review of the facility's policy and procedure (P&P) titled, Staffing, Sufficient and Competent Nursing, date revised August 2022, the P&P indicated, the facility provided sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents and responding to resident needs.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50016 Based on observation, interview and record review, the facility failed to promptly provide dental services for one out of one sampled resident (Resident 73). This deficient practice had the potential to result in the inability to effectively chew foods, weight loss, lack of energy and loss of muscle mass for Resident 73. Findings: During a review of Resident 73's Admission Record (AR), the AR indicated Resident 73 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnosis that included acute respiratory failure (ARF, a condition that occurs when the body's respiratory system can't supply enough oxygen to the blood and organs, or remove enough carbon dioxide [a colorless, odorless gas that's naturally present in the air, essentially a waste product that we breathe out when we exhale] from the body), type 2 diabetes mellitus (T2DM, a disease that occurs when your blood glucose [blood sugar], is too high), and congestive heart failure (CHF, a serious condition that occurs when the heart can't pump enough blood to meet the body's needs). During a review of Resident 73's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 10/15/2024, the MDS indicated Resident 73 had severe cognitive (the ability to thin and process information) impairment. The MDS indicated Resident 73 required substantial/maximal assistance (helper does more than half the effort and helper lifts or holds trunk or limbs and provides more than half the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and was dependent (helper does all the effort) with mobility. During an interview on 10/28/2024 at 10:04 AM, with Resident 73, Resident 73 stated that she had been without her bottom dentures for almost a week. Resident 73 stated that on the week prior on Thursday the 24th of October at around 4 AM, Certified Nursing Assistant (CNA) 5, took her bottom dentures for a wash and cleanse. Resident 73 stated that CNA 5 did not return right away and about 20 minutes later that morning returned with the Licensed Vocational Nurse (LVN) 4. Resident 73 stated LVN 4 and CNA 5 notified her that the dentures had been accidentally dropped and had broken in half. Resident 73 was also notified that that the Director of Nursing (DON) had been notified. Resident 73 stated that later that morning the Social Services Director (SSD) informed her that the facility would request a dental consult for evaluation. During a concurrent observation and interview on 10/28/2024 at 12:33 PM, Resident 73 was observed having difficulty chewing her chicken on her lunch plate. Resident 73 was unable to continue eating the chicken and was only able to partially consume the rice and broccoli on her lunch plate. Resident 73 stated that she has difficulties eating certain meals without her bottom dentures. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/2024 at 9:19 AM, with the Social Services Director (SSD), the SSD stated that the DON had verbally notified her that Resident 73's dentures had fell to the ground and had broken in half on 10/24/24. The SSD met with Resident 73 to inform her that she would request a dental consult for evaluation. The SSD stated she met with Resident 73 to inform her that she would notify her insurance about replacement coverage. The SSD stated that she also inquired about the cost of the bottom denture replacement with the dentist and would cost the facility about $200 to replace. The SSD stated that she was unable to provide documentation of the referral made to the dentist for the dental consultation. The SSD stated that she did not document the referral made to dentist in the progress notes of Resident 73's medical record. The SSD stated she was unable to specify the time and date of when the referral was made to the dentist, as she was unable to locate the email referral request. The SSD stated that she was unable to provide an email confirmation from the dentist responding to the referral request. The SSD stated that documentation is critical for ensuring accountability, preserving information, and enhancing communication which ensures that the residents' quality of life is maintained. The SSD stated that if it's not documented, then it didn't happen. During an interview on 10/30/24 at 9:38 AM, with the DON, the DON stated completing a Change in Condition (COC) in a timely manner helps address potential complications, prevent further decline, and provide the necessary adjustments, like the diet, to maintain Resident 73's quality of life. The DON stated changes that are not reported can lead to serious outcomes including medical complications. The DON stated that Resident 73 had not been assessed to ensure that she was able to eat and drink adequately while she was waiting for her bottom denture replacements. During a record review of Resident 73's Order Summary, dated 10/30/2024, indicated Resident 73 had an active diet order that started on 7/8/2024, and consisted of reduced concentrated sugars, no added salt, regular texture, and thin consistency. During a record review of Resident 73's Order Summary, dated 10/30/2024, indicated Resident 73 had an active diet order that started on 10/30/2024 and consisted of reduced concentrated sugars, no added salt, mechanical/soft ground meat texture, thin consistency, temporary texture change. During a review of the facility's P&P titled, Dental Services, dated revised 12/2016, the P&P indicated: 3. Lost or damaged dentures will be replaced at the resident's expense unless an employee or contractor of the facility is responsible for accidentally or intentionally damaging the dentures. 4. If dentures are damaged or lost, residents will be referred for dental services within three (3) days. If the referral is not made within three days, documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink adequately while awaiting the dental services; and the reason for the delay.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50016 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 68), was honored, and served her food preferences during tray-line observation of the kitchen. This deficient practice had the potential to negatively impact Resident 68's nutritional status. Findings: During a review of the admission record indicated Resident 68 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnosis including but not limited to, congestive heart failure (CHF, a serious condition that occurs when the heart can't pump enough blood to meet the body's needs), end stage renal disease (ESRD, is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis), and type 2 diabetes mellitus (T2DM, a disease that occurs when your blood glucose [blood sugar], is too high. During a review of Resident 68's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/23/2024, the MDS indicated Resident 68's cognition (the ability to think and process information) was severely impaired. The MDS indicated Resident 68 was dependent (helper does all the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and was dependent with mobility. During a review of Resident 68's Dietary Profile/Preferences, dated 10/15/2024, indicated that Resident 68 had a list of cultural, ethnic, and religious food preferences consisting of the Asian menu. During a review of Resident 68's Noon Meal Ticket, dated 10/29/2024, indicated Resident 68's tray instructions was highlighted with the Asian menu. During a review of the Facility's Weekly Menu, dated 10/29/2024, indicated the noon menu consisted of meatloaf with ketchup sauce, scalloped potatoes, roasted cauliflower, biscuit, and pound cake. The weekly menu indicated that the noon alternate Asian menu consisted of Polynesian chicken, steamed rice, roasted brussels sprouts, and fruit medley. During an observation on 10/29/2024 at 12:26 PM, in the kitchen, the [NAME] (CK) served Resident 68 meatloaf with ketchup sauce, scalloped potatoes, roasted cauliflower, and biscuit. The kitchen aide (KA) placed the plate on the tray cart and stated it was clear to be sent out to the unit. During an interview on 10/29/2024 at 12:28 PM, with the KA, the KA stated the resident was served meatloaf with ketchup sauce, scalloped potatoes, roasted cauliflower, and biscuit. The KA stated the resident should have been served the Asian menu. The KA stated he made a mistake and did not read off the meal ticket correctly. The KA stated he did not verify the plate with the meal ticket to ensure they both matched before placing it on the delivery tray cart. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/29/2024 at 12:50 PM, with the CK, the CK stated that the tray-line process is a team effort. The CK stated that she should have verified and crossed check with the KA before serving the meal on the plate. The CK stated serving a resident the wrong food goes against the resident's food gratification and dietary preferences which can affect overall satisfaction and quality of life in the facility. During an interview on 10/29/2024 at 3:15 PM, with the Dietary Supervisor (DS), the DS stated that the kitchen staff must double check and verify each tray with the meal ticket to ensure the accuracy of meal before any tray carts are distributed to the units and dining area. The DS stated that ensuring residents get the correct food preferences helps maintain or improve their health, and well-being. The DS stated that ensuring residents get their food preferences ensures residents can eat their food of choice while retaining their dignity. The DS stated that staff should also be checking to ensure that residents aren't served food that may go against their food allergies or dislikes which could have a negative impact on their health. During a review of the facility's policy and procedure (P&P) titled Food and Nutrition Services, dated revised 10/2017, indicated food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50016 Based on observation, interview, and record review, the facility failed to ensure food were stored, prepared, and distributed under sanitary conditions for all the residents in the facility by failing to: C. Ensure food past it's use-by date was not stored in one of two freezers observed in the kitchen. D. Check the quaternary sanitizing solution (ammonium solution used for sanitizing surfaces) with the quaternary test strip according to the manufacturer's instructions for one of two Kitchen Aides observed. These deficient practices placed the residents at risk for an outbreak of foodborne illnesses (refers to illness caused by the ingestion of contaminated food or beverages). Findings: During an observation on 10/28/2024 at 08:30 AM, in the kitchen, Freezer 1 had ice cream cups stored in a clear plastic bag that were past the used by date and to use by 10/25/2024. During an interview on 10/28/2024 at 08:32 AM, with the [NAME] (CK), the CK stated food past the use-by date should not be stored in the freezer, and should be discarded, as it could potentially cause a foodborne illness if served to the residents. During a review of the facility's policy and procedure (P&P) titled Food Receiving and Storage, dated revised 11/2022, indicated that foods shall be received and stored in a manner that complies with safe food handling practices. The P&P indicated that refrigerated/frozen storage foods are labeled, dated, and monitored so they are used by their use-by date, frozen, or discarded. During an observation on 10/28/2024 at 8:42 AM, in the kitchen, the kitchen aide (KA) dipped the quaternary test strip into the bucket of quaternary sanitizing solution for three seconds and removed the strip and read the result. The results of the quaternary test strip indicated the testing solution was 150 ppm (ppm, parts per million). During an observation on 10/28/2024 at 8:45 AM, in the kitchen, the KA dipped the quaternary test strip into the bucket of quaternary sanitizing solution for five seconds and removed the strip and read the result. The results of the quaternary test strip indicated the testing solution was 300 ppm (ppm, parts per million). During an interview on 10/29/2024 at 3:15 PM, with the Dietary Supervisor (DS), the DS stated that food that is past the use-by date should not be stored in the freezer and should be thrown away. The DS stated eating food past its use-by date can lead to foodborne illnesses and serious health consequences. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/29/2024 at 3:15 PM, with the DS, the DS stated that the quaternary test strip is used to check that the sanitizing solution is effective. The DS stated the strip should be in the solution for at least ten seconds before the results are checked as stated on the manufacturer's instructions. The DS stated that the quaternary solution should be checked accurately to ensure it is at the correct concentration for effective disinfection. The DS stated serving food to residents past the use-by date puts them at risk for exposure to bacteria that can make you sick and may cause food poisoning. During a review of the Hydrion QT-10 test strip instructions indicated to immerse the test strip paper for ten seconds in the sanitizing solution. During a review of the facility's policy and procedure (P&P) titled Sanitization, dated and revised 11/2022, indicated chemical sanitizing solutions (e.g., chlorine, iodine, quaternary ammonium compound) are used according to manufacturer's instructions.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307 Based on observation, interview, and record review, the facility failed implement infection (the invasion and growth of germs in the body) control practice and protocols for six of six sampled residents (Residents 16, 21, 32, 34, 42, 71) by failing to: a. Ensure an open and unlabeled personal toiletry was not stored inside the shared restroom of Residents 16, 32 and 42. b. Ensure Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO, bacteria that have become resistant to certain antibiotics, and these antibiotics can no longer be used to control or kill the bacteria]) were implemented while nursing staff providing care to Residents 34 and 21. c. Ensure Resident 71's oxygen nasal cannula tubing (device used to deliver supplemental oxygen placed directly on a resident's nostrils) was stored in a sanitary manner for continued resident use of the equipment. These failures had the potential to spread pathogens (any organism that causes disease) and result in cross contamination (process by which bacteria can be transferred from one area to another) among residents and healthcare workers and further compromise Residents 16, 21, 32, 34, 42, 71's physical well-being. Findings: a. During a review of Resident 16's Admission Record (AR), the AR indicated, Resident 16 was admitted to the facility on [DATE] with multiple diagnoses including essential (primary) hypertension (high blood pressure), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic (a mental disorder characterized by a disconnection from reality) disturbance, mood disturbance, and anxiety (intense, excessive, and persistent worry and fear about everyday situations), and personal history of COVID-19 (Coronavirus, an infectious disease that can cause mild to severe respiratory illness and is a virus that spreads from person to person). During a review of Resident 16's History and Physical (H&P), dated 11/30/23, the H&P indicated, Resident 16 did not have the capacity to understand and make decisions. During a review of Resident 16's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/30/24, the MDS indicated, Resident 16's cognitive (ability to think and process information) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated, Resident 16 was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity) for all activities of daily living. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 32's AR, the AR indicated, Resident 32 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, type 2 diabetes mellitus (adult on-set high levels of sugar in the blood) and personal history of COVID-19. During a review of Resident 32's H&P, dated 8/21/24, the H&P indicated, Resident 32 did not have the capacity to understand and make decisions. During a review of Resident 32's MDS, the MDS dated [DATE], the MDS indicated, Resident 32's cognitive skills for daily decision making was severely impaired. The MDS indicated, Resident 32 was dependent for all activities of daily living. During a review of Resident 42's AR, the AR indicated, Resident 42 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including acquired absence of right leg below knee, acquired absence of left leg below knee, chronic pain syndrome and impulse disorder, unspecified. During a review of Resident 42's H&P, dated 7/30/24, the H&P indicated, Resident 42 had the capacity to understand and make decisions. During a review of Resident 42's MDS, dated [DATE], the MDS indicated, Resident 34's BIMS (Brief Interview for Mental Status) Summary Score for cognitive (ability to think and process information) status was intact. The MDS indicated, Resident 42 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) to setup or clean-up assistance (helper sets up or cleans up; resident completes activities) for all activities of daily living. During a concurrent observation and interview on 10/28/24 at 9:22 a.m. with Certified Nursing Assistant (CNA) 1, inside the shared restroom of Residents 16, 32 and 42, an opened and unlabeled Remedy (name brand) Cleanse Shampoo & Body Wash was stored on top of the toilet. CNA 1 stated the toiletry was the facility's supply and the toiletry was not supposed to be there for infection control since staff would not know who does the toiletry belonged to. CNA 1 stated each resident (in general) was supposed to get their own toiletry and kept at the bedside. During an interview on 10/30/24 at 1:37 p.m. with the Infection Preventionist (IP), the IP stated, each resident should have their own toiletry in the resident's possession such as in the resident's bedside drawer. The IP stated, the toiletry did not need to be labeled when the toiletry was kept at the resident's bedside but the facility preferred to label toiletry so staff would know who the toiletry belonged to. The IP stated, leaving the unlabeled toiletry in the restroom was not ok for infection control. b. During a review of Resident 34's AR, the AR indicated, Resident 34 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including sepsis (a serious condition in which the body responds improperly to an [infection, refers to an invasion of the body by harmful microorganisms]), unspecified organism, gastrostomy status (the presence of a G-tube) and essential (primary) hypertension (high blood pressure). (continued on next page)

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	055367	A. Building B. Wing	10/31/2024

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 34's Order Summary Report (OSR), dated 6/11/24, the OSR indicated, as of 10/31/24, Resident 34 had orders for EBP related to G-Tube every shift. During a review of Resident 34's H&P, dated 6/19/24, the H&P indicated, Resident 34 did not have the capacity to understand and make decisions. During a review of Resident 34's MDS, dated [DATE], the MDS indicated, Resident 34's cognitive skills for daily decision making was severely impaired. The MDS indicated, Resident 34 was dependent for all activities of daily living. The MDS indicated, Resident 34 had a feeding tube (e.g., nasogastric, or abdominal [PEG]) while a resident. During a review of Resident 21's AR, the AR indicated, Resident 21 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including pressure ulcer (PU, bed sores, areas of damage and injury to skin and underlying tissue resulting from prolonged pressure on the skin) of left buttock, stage 3 (full thickness tissue loss), pressure ulcer of right buttock stage 4 (severe tissue damage to the bones), pneumonia (an infection in your lungs caused by bacteria), unspecified organism and sepsis (a life-threatening complication of an infection) due to streptococcus pneumoniae (a type of bacteria). During a review of Resident 21's H&P, dated 9/22/24, the H&P indicated, Resident 21 could make needs known but could not make medical decisions. During a review of Resident 21's MDS, dated [DATE], the MDS indicated, Resident 21's BIMS Summary Score for cognitive status was severely impaired. The MDS indicated, Resident 21 was dependent for all activities of daily living. The MDS indicated, Resident 21 had stage 3 and stage 4 PU and receiving PU/injury care. During a review of Resident 21's OSR, dated 9/29/24, the OSR indicated, as of 10/31/24, Resident 21 had orders for EBP related to unhealed wound every shift. During a concurrent observation and interview on 10/30/24 at 8:46 a.m. with Licensed Vocational Nurse (LVN) 2, during medication administration, Resident 34 was in bed in a multi-bed occupancy room with two (2) roommates. The room had an EBP signage posted and an over the door organizer of PPE supply outside of room. LVN 2 entered Resident 34's room without donning gown and gloves, made contact with Resident 34's hands while taking Resident 34's vital signs. LVN 2 stated, LVN 2 forgot to don PPE. During an interview on 10/30/24 at 1:37 p.m. with the Infection Preventionist (IP), the IP stated, for residents on EBP, staff was supposed to wear gloves and gown when staff would have contact with the residents, the bed, surroundings and for residents who had medical devices like Foley (a catheter device that drains urine from your bladder into a collection bag outside of your body), G-Tube and wounds like PU for infection control. The IP stated, staff should still be wearing PPE (personal protective equipment, like gown and gloves you wear to create a barrier between you and germs) when taking resident's vital signs (e.g. blood pressure, heart rate) because you never know if the patient needs to be repositioned, and if there was an emergency with the resident, at least you're already ready. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation on 10/31/24 at 8:26 a.m. with Registered Nurse (RN) 1 and the Treatment Nurse (TN), in Resident 21's room, Resident 21's room was a double-occupancy bed with one (1) roommate. The room had an EBP signage posted and an over the door organizer of PPE supply outside of the room. The TN donned a gown, and the gown was not covering the TN's back side. The TN did not don gloves as the TN and RN 1 were turning and preparing Resident 21 for PU care. The TN opened and checked Resident 21's diaper. The TN did hand hygiene, placed Resident 21's bedside table with the wound care supplies against the wall on the right side of Resident 21's bed. The TN donned gloves and stayed on Resident 21's right side and between the bedside table of wound care supplies during the treatment. RN 1 was on Resident 21's left side assisting and holding Resident 21 on Resident 21's left side. The TN's back side was touching Resident 21's bed each time the TN turned around to get wound care supplies from Resident 21's bedside table during the PU treatment. During a concurrent observation and interview on 10/31/24 at 9:11 a.m. with the TN and the IP, the TN stated, the gown did not fit my bottom is big and facility would need to order an extra-large size gown. The TN was asked to try a new gown and the gown fit and covered the TN's back side. The TN stated, it was important to don PPE properly because Resident 21 was already compromised and we don't want cross contamination. During a review of the facility's policy and procedure (P&P) titled, Infection Control, revised date October 2018, the P&P indicated, the facility's infection control P&P was intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. The P&P indicated, one of the objectives of the facility's infection control P&P was to prevent, detect, investigate, and control infections in the facility. During a review of the facility's P&P titled, Enhanced Barrier Precautions, dated October 2018, the P&P indicated, EBP were utilized to prevent the spread of MDROs to residents. The P&P indicated, EBP's employed targeted gown and glove use during high contact resident care activity when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). 50016 c. During a review of Resident 71's AR, the AR indicated the facility admitted Resident 71 on 3/26/2024, and readmitted on [DATE], with diagnoses that included pneumonia (an infection of the lungs that may be caused by bacteria, viruses, or fungi), quadriplegia (a condition that causes partial or total paralysis [the loss of the ability to move some or all of the body] of all four limbs and the torso), neuralgia (a sharp, burning, or stabbing pain that occurs in a nerve pathway and is caused by nerve damage or irritation), and neuritis (inflammation of a nerve or nerves). During a review of Resident 71's MDS, dated [DATE], indicated Resident 71 was dependent (helper does all of the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and dependent with mobility. During a review of Resident 71's H&P, dated 10/27/2024, indicated Resident 71 had the capacity to understand and make decisions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/28/2024 at 09:51 AM, Resident 71's oxygen nasal cannula tubing connected to the oxygen concentrator (a medical device that separates nitrogen from the air around you so you can breathe up to 95% pure oxygen) was found resting over the oxygen concentrator and was not stored in the plastic bag. During an interview on 10/29/2024 at 9:24 AM, with the Infection Preventionist (IP), the IP stated that the oxygen nasal cannula tubing should always be properly stored after each use and placed in a clean dry plastic bag at the bedside. The IP stated the oxygen nasal cannula tubing in Resident 71's room was susceptible to bacterial pathogens (harmful species that cause bacterial infections and contagious diseases that result in many serious complications) and could have worsen Resident 71's pneumonia (an infection of the lungs that may be caused by bacteria, viruses, or fungi) infection. During a review of Resident 71's physician order, dated 11/01/2024, indicated to provide oxygen at two (2) liters per minute via nasal cannula continuously every shift for acute hypoxia (a condition where someone is exposed to low oxygen levels for a short period of time, usually a few minutes to a few hours) due to community pneumonia for one week. During a review of the facility's policy and procedure (P&P) titled Infection Control, dated revised 10/2018, indicated the facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. The P&P indicated that the objectives of the facility's infection control policies and practices is to provide guidelines for the safe cleaning and reprocessing of reusable resident care-equipment.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident's (Resident 27) call light (a device used by a resident to signal the need for assistance) system was within reach in accordance with Resident 27's care plan (CP, provides direction on the type of nursing care an individual needs that include goals of treatment, specific nursing interventions [actions, treatments, procedures, or activities designed to meet an objective] and an evaluation plan]) and the facility's policy and procedure (P&P) titled, Call Lights. This failure had the potential to result in Resident 27 to not have Resident 27's needs met in a timely manner and/or Resident 27 to experience harm if Resident 27 was unable to alert staff during an emergency. Findings: During a review of Resident 27's Admission Record (AR), the AR indicated Resident 27 was originally admitted to the facility on [DATE] and last readmitted on [DATE] with multiple diagnoses including hemiplegia (paralysis of one side of the body), hemiparesis (weakness of one entire side of the body) following cerebral infarction (also known as stroke when area of the brain dies due to blocked or reduced blood supply) affecting left non-dominant side, unspecified dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), unspecified severity without behavioral disturbance, psychotic (a mental disorder characterized by a disconnection from reality) disturbance, mood disturbance, anxiety (intense, excessive, and persistent worry and fear about everyday situations) and contracture (shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement) of the left hand. During a review of Resident 27's History and Physical (H&P), dated 8/21/2024, the H&P indicated Resident 27 could make needs known but could not make medical decisions. During a review of Resident 27's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/21/2024, the MDS indicated, Resident 27's cognitive (ability to think and process information) status was severely impaired. The MDS indicated, Resident 27 was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity) for all activities of daily living. During a concurrent observation and interview on 10/28/2024 at 9:39 AM with Certified Nursing Assistant 1 (CNA 1) in Resident 27's room, Resident 27 was sitting up in a wheelchair parked on the left side of Resident 27's bed. Resident 27 had slurred speech, left sided facial droop, left sided paralysis with the left wrist/hand contracted resting on Resident 27's abdomen (belly). Resident 27 had limited right-side movement and could not reach Resident 27's call light. CNA 1 stated, Resident 27 could not reach the call light located in the middle of Resident 27's bed and the call light should be close to Resident 27. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/2024 at 1:02 PM with the Registered Nurse Supervisor (RNC), the RNC stated, resident's (in general) call light should always be here (gesturing to the abdomen [belly]) at all times and within reach so residents could call for help when needed and do not try to get out of bed and for resident's safety. During a review of Resident 27's CP, titled, BLADDER AND BOWEL, date initiated 12/27/2019, the CP indicated, one of the interventions was for Resident 27's call light to be within reach and answered promptly. During a review of the facility's P&P titled, Call Lights, date revised January 2024, the P&P indicated, each resident was provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. The P&P indicated, upon admission and as needed, resident call light should be within reach.