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	12/19/2025

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 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** Based on observation, interview, and record review, the facility failed to ensure three of four sampled residents (Resident 10, Resident 1, and Resident 51), had information regarding Advance Directives (AD - legal document indicating resident preference on end-of-life treatment decisions) filed in Resident 10, Resident 1, and Resident 51's medical records as indicated in the facility's policy and procedure (P&P) titled, Advance Directives.This deficient practice had the potential to cause confusion among the healthcare providers in the event Resident 10, Resident 1 and Resident 51 required immediate medical care and/treatment and had the potential for the residents to receive inadequate or medically unnecessary care and/or treatment/services regarding life-sustaining treatment. Findings:During a review of Resident 10's admission Record (AR), the AR indicated, Resident 10 was originally admitted to the facility on [DATE] and readmitted the resident on 11/4/2025 with multiple diagnoses including acute (sudden) respiratory failure (when the lungs can't release enough oxygen into your blood), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), unspecified, and essential (primary) hypertension (HTN - high blood pressure).During a review of Resident 10's Minimum Data Set (MDS - a resident assessment tool), dated 10/12/2025, the MDS indicated Resident 10's cognitive skills (ability to think and process information) for daily decision making were moderately impaired. The MDS indicated Resident 10 was dependent (helper does all of the effort) to required set up or clean-up assistance (helper sets up or cleans up; resident completes activity) with activities of daily living (ADLs).During a review of Resident 10's History and Physical Examination (H&P), dated 11/9/2025, the H&P indicated, Resident 10 had the capacity to understand and make decisions. During a review of Resident 1's AR, the AR indicated Resident 1 was admitted to the facility on [DATE] with multiple diagnoses including type 2 diabetes mellitus (DM II - adult onset disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high blood sugar), essential (primary) hypertension, and unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, without behavioral disturbance, psychotic disturbance (losing touch with reality), mood disturbance, and anxiety (a feeling of fear, worry, and uneasiness).During a review of Resident 1's H&P, dated 11/10/2025, the H&P indicated, Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 1 was dependent to required partial/moderate assistance (helper does less than half the effort) with ADLs.During a review of Resident 51's AR, the AR indicated, Resident 51 was admitted to the facility on [DATE] with multiple diagnoses including type 2 diabetes mellitus with hyperglycemia, alcohol abuse, uncomplicated, and essential (primary) hypertension.During a review of Resident 51's H&P, dated 12/10/2025, the H&P indicated, Resident 51 had the capacity to understand and make decisions.During a review of Resident 51's MDS, dated [DATE], the MDS indicated Resident 51's cognitive skills for daily decision making were intact. The MDS indicated Resident 51 required substantial/maximal assistance (helper does more than half the effort) to requiring set up or clean-up assistance with ADLs.During an interview on 12/17/2025 at (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1:24 PM with Resident 51, Resident 51 stated, Resident 51 had an AD and Resident 51's brother had Resident 51's AD.During a concurrent interview and record review on 12/17/2025 at 1:39 PM with the Social Services Director (SSD), Resident 10, Resident 1, and Resident 51's medical records were reviewed. The SSD stated, an AD was when a resident assigned somebody to make medical decisions when the resident could not make the decision. The SSD stated, residents were screened for information regarding the AD upon admission by the Registered Nurse Supervisor (RN, unnamed) and the SSD would normally ask the resident [if there was an existing AD]. The SSD stated an Advanced Healthcare Directive Acknowledgement Form (AHDAF) was filled out and completed upon admission. The SSD stated Resident 10 had two AHDAF on file [in the medical record]. An AHDAF dated 10/7/2025 signed by Resident 10 and RN 2 indicated, Resident 10 did not have an AD. An AHDAF dated 11/5/2025, signed by Resident 10 and RN 1 was incomplete and did not indicate whether Resident 10 had or did not have an AD. The SSD stated the facility ideally went by the latest AHDAF. The SSD stated, Resident 10's AHDAF, dated 11/5/2025 should have been filled out and completed by whoever screened Resident 10 since filling out and completing Resident 10's latest AHDAF, was important because the information might have changed, maybe she [Resident 10] has an AD. The SSD stated Resident 1 was admitted on [DATE] and Resident 1 did not have an AHDAF on file. The SSD stated Resident 51 was admitted on [DATE] and did not have an AHDAF on file. The SSD stated, there should have been an AHDAF for Residents 1 and 51 and it was important to have AHDAFs on file for the facility to have a record of who was responsible to make medical decisions in the event something happens to Resident 1 and Resident 51. During an interview on 12/18/2025 at 9:12 AM with Resident 10, Resident 10 stated, Resident 10's daughter took care of AHDAF [matters]. Resident 10 stated, Resident 10 did not have an AD.During a review of the facility's P&P titled, Advance Directives, date revised 9/2022, the P&P indicated, prior to or upon admission of a resident, the social services director or designee inquires with the resident, his/her family members, and/or his or legal representative, about the existence of any written advance directives. The P&P indicated, information about whether or not the resident had executed an advance directive was displayed prominently in the medical record in a section of the record that was retrievable by any staff.

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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** Based on interview and record review the facility failed to ensure necessary care and services were provided for two of two sampled residents (Residents 48 and 51) by failing to:a. Ensure Resident 48's neurology (the branch of medicine that deals with the brain, spinal cord, and nerves) consult (getting expert opinion or advice about a patient's condition) was ordered in a timely manner.b. Ensure Resident 51 did not self-administer Pepto Bismol Ultra (a double-strength medication used to relieve nausea, heartburn, indigestion, upset stomach and diarrhea) brought from home and kept at Resident 51's bedside without a physician's order. This deficient practice resulted in the delay of care for Resident 48 and had the potential to result in unmet physical needs to Resident 48. The deficient practice could have potentially resulted in Resident 51 taking the incorrect Pepto Bismol Ultra dose and result in drug interactions leading to serious physical harm to Resident 51. Findings: a. During a review of Resident 48's admission Record (AR), the AR indicated the facility originally admitted Resident 48 on 8/24/2024 and readmitted the resident on 11/10/2025 with diagnoses including unspecified disorientation (a condition referring to confusion or lack of awareness without a clearly identified reason) and lack of coordination (difficulty in moving smoothly or controlling body movements). During a review of Resident 48's History and Physical (H&P), dated 8/25/2025, the H&P indicated Resident 48 had the capacity to understand and make decisions. During a review of Resident 48's Minimum Data Set (MDS- a resident assessment tool), dated 11/28/2025, the MDS indicated Resident 48's cognitive (the ability to think and process information) skills for daily decision making were severely impaired. During a review of Resident 48's Office Visit Note (OVN), date of encounter 11/19/2025, the OVN's plan indicated Resident 48 was to follow up with neurology to rule out an acute (sudden) cardiovascular accident (CVA-a medical condition where blood flow to the brain is disrupted, causing brain and tissue damage). During a review of Resident 48's OVN Physician Order (PO), dated 11/19/2025, the PO indicated a follow up with the Neurologist was ordered for Resident 48. During a review of Resident 48's Progress Note (PN) titled Physician's Order Note, dated 12/16/2025, timed at 2:30 PM, the PN indicated, New order Neurology consult [regarding]: [rule out] acute CVA per Cardiologist [a doctor who specializes in treating heart and blood vessel problems]. During an interview on 12/17/2025 at 2:44 PM with Registered Nurse Supervisor (RN) 1, RN 1 stated Resident 48 had returned from a Cardiologist appointment on 11/19/2025 with an order from the Cardiologist's office that indicated Resident 48 was to have a neurology appointment. RN 1 stated the neurology consultation was not ordered [by the facility] until 12/16/2025. RN 1 stated it was the policy of the facility to place orders in the resident's (in general) medical record right away to ensure continuity of care (sharing accurate information between all caregivers so the patient gets safe, coordinated treatment without gaps) and to maintain the resident's health. During an interview on 12/19/2025 at 9:10 AM with the Director of Nursing (DON), the DON stated Resident 48's neurology consult order should have been ordered on 11/19/2025. The DON stated the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	importance of placing the order in a timely manner was to ensure Resident 48's safety and to prevent delayed treatment. During a review of the facility's policy and procedure (P&P) titled, Request for Diagnostic Services, dated 4/2007, the P&P indicated orders for diagnostic services will be promptly carried out as [indicated] by the physician's order. During a review of the facility's undated P&P titled, Referrals, Social Services, the P&P indicated social services will collaborate with the nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician. b. During a review of Resident 51's AR, the AR indicated Resident 51 was admitted to the facility on [DATE] with multiple diagnoses including type 2 diabetes mellitus (DM II - adult onset disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high blood sugar), alcohol abuse, uncomplicated, and essential (primary) hypertension (HTN - high blood pressure). During a review of Resident 51's H&P, dated 12/10/2025, the H&P indicated Resident 51 had the capacity to understand and make decisions. During a review of Resident 51's MDS, dated [DATE], the MDS indicated Resident 51's cognitive skills for daily decision making were intact. The MDS indicated, Resident 51 required from substantial/maximal assistance (helper does more than half the effort) to set up or clean-up assistance (helper sets up or cleans up; resident completes activity). During a review of Resident 51's Change in Condition Evaluation (COC), dated 12/12/2025, timed at 10:39 PM, the COC indicated, Resident 51 had nausea/vomiting and Nurse Practitioner (NP) 2 ordered Zofran (Ondansetron – a medication used to prevent nausea and vomiting) four (4) mg (milligrams – unit of measurement) prn (as needed) every six (6) hours. During a review of Resident 51's Order Summary Report (OSR), active orders as of 12/16/2025, the OSR did not indicate a physician's order for Pepto Bismol Ultra and for Resident 51 to take own medication from home. During a concurrent observation and interview with Licensed Vocational Nurse (LVN) 3 on 12/16/2025 at 11:32 AM, Resident 51 was not in Resident 51's room. There was a 4 fluid ounce (Fl. Oz. – a unit of liquid volume) bottle of Pepto Bismol Ultra Liquid with three quarters of remaining medication contents on top of Resident 51's bedside table. The medicine measuring cup was over the bottle's cap and there were multiple drinks on the table. LVN 3 stated the Pepto Bismol Ultra Liquid medication should not have been at Resident 51's bedside table due to [self-administration of medications] needed assessments and physician orders and Resident 51 could be taking the Pepto Bismol Ultra Liquid. During an interview on 12/17/2025 at 7:48 AM with Resident 51, Resident 51 stated Resident 51 took one shot of the Pepto Bismol Ultra Liquid medication that was brought [to the facility] by Resident 51's son on 12/13/2025. Resident 51 stated, Resident 51 had reported to the staff (unnamed) that Resident 51 had heartburns and nausea, and the Ondansetron medication was effective. Resident 51 stated, Resident 51 took the Pepto Bismol Ultra Liquid medication because Resident 51 still had residual from my heartburn. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/18/2025 at 2:35 PM with RN 1, RN 1 stated, it was important not to leave Resident 51's Pepto Bismol Ultra Liquid medication (or any medications), brought from home, at Resident 51's bedside so staff could control how often Resident 51 took the medication. RN 1 stated, residents are forgetful, and Resident 51's roommate could potentially take the medication not knowing what the medication was for, for safety. RN 1 stated, Resident 51 needed to have an order for [self-administration of] Pepto Bismol liquid medication and [the medication] had to be consented (to take own medication). During a review of the facility's undated P&P, titled, Medications Brought to the Facility by the Resident/Family, the P&P indicated, the facility should ordinarily not permit residents and families to bring medications into the facility. The P&P indicated, if a medication was not otherwise available and/or it was determined to be essential to the resident's life, health, safety, or well-being to be able to take a medication brought in from outside, the director of nursing services and nursing staff, with support of the attending physician and consultant pharmacist, should check to ensure that the medications have been ordered by the resident's attending physician, and documented on the physician's order sheet. During a review of the P&P, titled, Medication and Treatment Orders, date revised 7/2016, the P&P indicated, medications should be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to properly store discontinued controlled medications (DCM, drugs strictly regulated by government law due to their high potential for abuse, addiction or dependence) for two of two sampled residents (Resident 87 and Resident 89) as indicated in the facility's policy and procedures (P&P) titled, Controlled Substance, and Controlled Medication Storage. This deficient practice had the potential to result in diversion (illegally taking prescription drugs from their intended use, taking the drug from the healthcare setting for personal abuse) or medication errors involving Resident 87 and 89's DCMs.Findings: a. During a review of Resident 87's admission Record (AR), the AR indicated Resident 87 was admitted to the facility on [DATE] with diagnosis that included insomnia (inability to sleep) and hypertension (high blood pressure). During a review of Resident 87's Physician Orders (PO), the PO indicated hydrocodone - acetaminophen (a controlled medication used to treat pain) 10-325 milligram (mg, unit of measurement) given every three hours, as needed (PRN), this PO was discontinued on 12/5/2025. The PO, dated 11/29/2025, indicated to transfer Resident 87 to the general acute care hospital (GACH). b. During a review of Resident 89's AR, the AR indicated Resident 89 was admitted to the facility on [DATE] with diagnosis that included Type 2 Diabetes Mellitus (DM, a condition that results in elevated blood sugar) and Atrial fibrillation (AF, irregular heartbeats). During a review of Resident 89's PO, dated 10/21/2025, it indicated Hydrocodone-Acetaminophen 10-325 mg to be given every four hours for moderate to severe pain as needed was ordered for the resident. This PO was discontinued 12/11/2025 due to Resident 89's transfer to the GACH. During a review of Resident 89's PO, dated 11/14/2025, the PO indicated alprazolam (a controlled medication, used to treat anxiety and panic disorders) 0.25 mg given every six hours PRN for Resident 89's anxiety. During a review of Resident 89's Order Listing Report (OLR), dated 11/18/2025, the OLS indicated alprazolam 0.25 mg was completed (discontinued). During a review of Resident 89's PO, dated 12/7/2025, the PO indicated for Resident 89 to be transferred the GACH for desaturation (low oxygen). During an observation and concurrent interview with the Director of Nursing (DON) on 12/16/2025 at 2:10 PM, the DON stated the facility process was, when there were DCMs, the licensed nurse (LN) delivered the un-used DCMs (along with the narcotic count sheet [a rigorous process in healthcare facilities where a physical inventory of all controlled drugs are taken and documented on a specific log sheet]) to the DON. Followed by the DON and the LN confirming accuracy, and the DON storing the DCMs inside a double locked cabinet located inside the DON's office for safekeeping. The DON stated the cabinet designated to hold DCMs was empty. The DON stated there were no DCMs in the facility since 11/26/2025. During an interview and concurrent record review, on 12/17/2025 at 9:56 AM, with the DON, a list of discharged residents since 11/26/2025 were reviewed with the DON. The DON stated Resident 84 and Resident 89's DCMs were found inside medication carts, along with other active medications. The DON stated nursing staff should have given Resident 84 and 89's DCMs within 72 hours [of resident discharge]. The DON stated if a resident was discharged , DCMs should be given to the DON right away. The DON stated it was important to dispose of DCMs to avoid possible medication errors (given to another resident) or diversion of DCMs. The DON stated based on nursing best practice the DON taught the nursing team to hand over DCMs to the DON within 72 hours. During an interview with Licensed Vocational Nurse (LVN) 1, on 12/17/2025 at 2:21 PM, LVN 1 stated DCMs were only given to the DON usually on the same day or within 48 hours [after discontinuation of the medication or resident discharge]. LVN 1 stated it [this method] was safer because DCMs can be administered to other residents or used incorrectly. During a review of the facility's P&P titled Controlled Medication Storage, dated 8/2014, the P&P indicated controlled medications remaining in the facility after the order has been discontinued are retained in the facility in a securely double locked area with restricted access until (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	destroyed by the facility's director of nursing . and a pharmacist. During a review of the facility's P&P titled, Controlled Substance, dated 11/2022, the P&P indicated controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. The P&P indicated disposal methods are used to prevent diversion and/or accidental exposure to controlled or hazardous substances. The P&P indicated controlled substances remaining in the facility after the order has been discontinued or the residents have been discharged are securely locked in an area with restricted access until destroyed. The P&P indicated accountability record for discontinued controlled substances are kept with the unused supply until it is destroyed or disposed of as required by applicable law or regulation. During a review of the facility's Inservice Meeting Minutes, Disposal of Narcotics [controlled medications], dated 10/22/2025 - 10/29/2025, co-presented by the DON, the minutes' s summary of discussion indicated after discontinuation, all narcotics must be counted and turned into the DON or Assistant DON.

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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. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary conditions were maintained in one of one kitchen (Kitchen 1) when the following was observed: 1. A large bag of round brown frozen meat was observed unlabeled and undated in the facility's walk-in freezer. 2. A brown green build up was observed on two of the four corners of the dishwasher.3. The water collection area of the dishwasher had brown, tan gunk buildup in the water and the gunk rimmed the waterline.4. The stove top was observed with an accumulation of layered sticky to touch grease spots and food particles.5. The area behind the stove was dusty, sticky to touch, and colored layer of buildup. These deficient practices had the potential to result in foodborne illnesses (sickness from eating or drinking contaminated food or beverages) to the residents consuming the food prepared in Kitchen 1.Findings:During an initial tour of Kitchen 1 on 12/16/2025 at 8:58 AM, with the Dietary Supervisor (DS), a bag of round brown in color meat was unlabeled and undated with no expiration date.During an interview, on 12/16/2025 at 9:10 AM, with the DS, the DS stated the bag of meat balls did not have a label or a date to indicate the type of food in the bag or the expiration of the food. The DS stated it was important for food to be labeled to know when it was opened and to know when the food had to be used by to prevent the residents (in general) from getting sick. During a follow-up tour of Kitchen 1, on 12/19/2025 at 11:20 AM, with the DS, the following was observed:-The water collection area of the dishwasher had brown, tan gunk buildup in the water and the gunk rimmed the waterline.-The stove top was observed with an accumulation of layered sticky to touch grease spots and food particles.-The area behind the stove was dusty, sticky to touch, and colored layer of buildup. During an interview with the DS on 12/19/2025 at 11:29 AM, the DS stated the kitchen staff cleaned daily, but I don't know, I told them [kitchen staff] to clean everything, they will clean it now. The DS stated Kitchen 1's equipment should be cleaned all the time because it is bad for the food and the food could get the patients sick.During an interview with the Director of Nursing (DON), on 12/19/2025 at 11:38 AM, the DON stated Kitchen 1 had to remain clean. The DON stated Kitchen 1's equipment should be cleaned after each use and cleaned where there was buildup. The DON stated the stove should be cleaned after every use and as needed. The DON stated there should be no buildup of grease on or behind the stove. The DON stated it was important to have a clean and sanitary kitchen so the food was prepared clean to prevent residents from getting sick. During a review of the facility's policy and procedures (P&P) titled, Food Receiving and Storage, revised 11/2022, the P&P indicated food shall received and stored in a manner that complies with safe food handling practices. The P&P indicated refrigerated food is labeled, dated, and monitored so they are used by their use-by-date, frozen or discarded.During a review of the facility's P&P titled, Sanitization, revised 11/2022, the P&P indicated the food service area is maintained in a clean and sanity manner. The P&P all kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects. The P&P all utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions . that may affect their use or proper cleaning.

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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** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 31), was treated with dignity when on 12/16/2025, Licensed Vocational Nurse 3 (LVN 3) failed to knock on Resident 31's door prior to entering Resident 31's room.This deficient practice resulted in Resident 31 feeling bothered and had the potential to result in Resident 31 feeling invaded to Resident 31's privacy and feeling humiliated, embarrassed, and ashamed.Findings:During a review of Resident 31's admission Record (AR), the AR indicated, Resident 31 was admitted to the facility on [DATE] with multiple diagnoses including paraplegia (loss of movement and/or sensation, to some degree, of the legs), unspecified, major depressive disorder (a mental health condition characterized by persistent feelings of sadness, loss of interest, and other symptoms that significantly interfere with daily life), single episode, unspecified, and colostomy (a surgery to create an opening for the large intestine that lets stools pass through the belly) status.During a review of Resident 31's History and Physical Examination (H&P), dated 12/14/2025, the H&P indicated Resident 31 had the capacity to understand and make decisions.During a review of Resident 31's Minimum Data Set (MDS - a resident assessment tool) dated 12/14/2025, the MDS indicated Resident 31's cognitive skills (ability to think and process information) for daily decision making were intact. The MDS indicated Resident 31 was dependent (helper does all the effort) and/or required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with activities of daily living.During a concurrent observation and interview with LVN 3 on 12/16/2025 at 10:03 AM, Resident 31 was lying in bed. LVN 3 entered Resident 31's room without knocking (or announcing self) on the door. LVN 3 stated, LVN 3 knocked earlier but LVN 3 left the room to get Resident 31's Morphine (medication used to treat severe pain). LVN 3 stated, knocking on the door before entering a resident's (in general) room was important for resident's privacy and dignity.During an interview on 12/18/2025 at 8:40 AM with Resident 31, Resident 31 was lying in bed and using his cellphone while having breakfast. Resident 31 stated, some staff knocked on Resident 31's door prior to entering Resident 31's room and some of them [staff] don't. Resident 31 stated, Resident 31 did not want staff to get in trouble but staff not knocking on the door prior to entering Resident 31's room bothered Resident 31 a little bit, and it would be nice if they knock[ed] first.During an interview 12/18/2025 at 2:35 PM with Registered Nurse Supervisor (RN) 1, RN 1 stated, knocking on a resident's door and announcing yourself, prior to entering the resident's room was important for courtesy and politeness [purposes].During a review of the facility's policy and procedure (P&P), titled, Dignity, date revised 2/2021, the P&P indicated residents were treated with dignity and respect at all times. The P&P indicated the residents' private space and property were respected at all times. The P&P indicated, staff were expected to knock and request permission before entering residents' rooms.During a review of the facility's P&P, titled, Resident Rights, date revised 2/2021, the P&P indicated, employees should treat all residents with kindness, respect, and dignity.

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

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on interview and record review, the facility failed to do a background check for one of three sampled certified nursing assistant (CNA 2).This failure had the potential to risk the residents' personal safety, mistreatment and misappropriation of personal funds.Findings:During a review of Certified Nursing Assistant (CNA) 2's employee file, it indicated CNA 2 was hired on 2/18/2025. CNA 2's employee file did indicate a background check was completed.During an interview on 12/19/2025 at 9:19 am with Director of Staff Development (DSD), DSD stated there was no background check done on CNA 2. DSD stated background checks should always be done to make sure the patients are safe and that they are qualified to work for the facility.During an interview on 12/19/2025 at 11:30 am with the DSD, DSD stated she was unable to find paperwork for CNA 2's background check that included criminal conviction investigation and sex offender checks. DSD stated CNA 2 was hired when there was no Director of Staff Development in the facility.During a review of the facility's policy and procedure (P&P) titled, Background Screening Investigations, undated, the P&P indicated the facility is to conduct background screening checks, reference checks and criminal conviction investigations on all applicants who will have direct access to residents.

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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. Based on interview and record review the facility failed to develop a comprehensive care plan (CP), for one of one sampled residents (Resident 4), that addressed diabetes mellitus (a chronic [persistent or long-lasting] disease characterized by high blood sugar levels due to insufficient insulin [a hormone which regulates the amount of sugar in the blood] production) and anticoagulant (a medication that helps prevent blood clots) use.This failure had the potential to result in unmet individualized medical needs for Resident 4 and the potential to affect the resident's physical and psychosocial well-being.Findings:During a review of Resident 4's admission Record (AR), the AR indicated the facility originally admitted Resident 4 on 9/3/2025 with diagnoses including hemiplegia and hemiparesis (paralysis or weakness on one side of the body) following cerebral infarction (a medical condition where blood flow to the brain is disrupted, causing brain tissue damage) affecting the left non-dominant side (the side of the body that is used less) and type 2 diabetes mellitus with hyperglycemia (high blood sugar levels).During a review of Resident 4's History and Physical (H&P), dated 11/2/2025, the H&P indicated Resident 4 did not have the capacity to understand and make decisions.During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 12/8/2025, the MDS indicated Resident 4's cognitive (the ability to think and process information) skills for daily decision making were intact.During a review of Resident 4's Order Summary Report (OSR), dated active as of 12/18/2025, the OSR indicated heparin sodium (an anticoagulant) 5000 units (a unit of measurement) was ordered for Resident 4, start date of 11/3/2025.During a concurrent interview and record review on 12/18/2025 at 1:20 PM with Registered Nurse Supervisor (RN) 1, Resident 4's CPs were reviewed. RN 1 stated CPs addressing diabetes mellitus and anticoagulant therapy were not developed for Resident 4. RN 1 stated it was important to develop comprehensive CPs to ensure appropriate monitoring of Resident 4's medical conditions and to maintain Resident 4's safety and continuity of care (sharing accurate information between all caregivers so the patient gets safe, coordinated treatment without gaps). During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised March 2022, the P&P's policy statement indicated a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial (relates to how a person's mental health and social environment [relationships, community] affect each other) and functional needs was developed and implemented for each resident. The P&P's policy interpretation and implementation indicated the comprehensive, person-centered care plan should be developed no more than 21 days after admission.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise one of one sampled resident's (Resident 8's) fall risk care plan after Resident 8 had a fall on 11/26/2025. This failure placed Resident 8 at risk for future and recurrent falls.Findings: During a review of Resident 8's admission Record (AR), the AR indicated Resident 8 was admitted on [DATE] with diagnoses that included end-stage renal disease (ESRD-irreversible kidney failure), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and blindness in the left eye. During a review of Resident 8's History & Physical (H&P), dated 7/27/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 8's Minimum Data Set (MDS - a resident assessment tool), dated 10/2/2025, the MDS indicated Resident 8 had moderately impaired cognition (ability to think) and was dependent (helper does all the effort and the resident does none of the effort to complete the activity) on facility staff (in general) to complete most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). The MDS also indicated Resident 8 was dependent on facility staff (in general) to move around in bed and for transfers. During a review of Resident 8's Fall Risk Care Plan (CP), initiated on 4/2/2022, the CP indicated Resident 8 was at risk for falling out of bed with a goal to remain free from injury and or falls. The CP Interventions initiated on 4/2/2022 indicated to check Resident 8 frequently and reposition Resident 8 in bed, to encourage Resident 8 to use the call light and to keep the call light within Resident 8's reach, to apply bilateral grab bars in bed to prevent sliding and rolling off the bed. The CP also indicated Resident 8 slipped through the lift sling and slid down the shower chair on 11/26/2025 but there were no new interventions added, or revisions made on the CP on 11/26/2025. During a review of Resident 8's Change in Condition Evaluation (CIC/SBAR - situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 11/26/2025, the CIC indicated Resident 8 fell the morning of 11/26/2025 while being transferred by a nursing assistant in a Hoyer lift (a mechanical device used to lift and/or transfer a person from place to place). During a concurrent interview and record review on 12/18/2025 at 12:19 PM with Registered Nurse Supervisor 1 (RN 1), Resident 8's Fall Risk Care Plan (CP), initiated on 4/2/2022, was reviewed. RN 1 stated Resident 8's CP for falls indicated there was no revision to the CP. RN 1 stated the CP's purpose was to guide the licensed nurses and nursing assistants in providing care to the resident and allowed them to know what monitoring was needed for the resident. RN 1 stated, the CP should have been updated after Resident 8's fall on 11/26/2025. During an interview on 12/19/2025 at 9:20 AM with the Director of Nursing (DON), the DON stated CPs were updated when a resident had any change of condition and must be updated after a fall by the nurse who documented the resident's change in condition. The DON stated revising the CP was important to ensure fall interventions were in place, to prevent further falls, to minimize injuries, and to guarantee residents were receiving the best care from staff. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, last revised 7/2017, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The P&P indicated, events, incidents or accidents involving the resident and progress toward or changes in the care plan goals and objectives should be documented in the medical record. 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, a significant change of condition was a major decline or improvement in the resident's status that required interdisciplinary review and/or revision to the care (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 3/2022, the P&P indicated, a comprehensive, person-centered CP that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident. The P&P indicated, assessments of residents were ongoing and CPs were revised as information about the residents and the residents' conditions change.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide one of one sampled resident (Resident 60) with their chosen individual activity when their television was not working.This failure had the potential to affect the resident's psychosocial well-being, mental health and self-satisfaction.Findings:During a review of Resident 60's admission Record, it indicated Resident 60 was admitted on [DATE] with diagnoses that included but not limited to: fracture (crack or break) of right femur, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), generalized anxiety disorder (a mental health condition marked by persistent, excessive, and hard to control worry about everyday things), and abnormalities of gait and mobility.During a review of Resident 60's Minimum Data Set (MDS - a comprehensive assessment and screening tool) dated 11/16/2025, the MDS indicated Resident 60 has normal thinking and memory. Resident 60 requires a helper for less than half the effort for dressing, hygiene, bed mobility, sit to stand, and walking ten feet.During a review of Resident 60's History and Physical (H&P) dated 11/18/2025, the H&P indicated Resident 60 has the capacity to understand and make decisions.During a review of Resident 60's Activity Participation Review (APR) dated 11/20/2025, the APR indicated Resident 60 is independent with her activity involvement and enjoys watching television.During a review of the facility's Maintenance Request Log (MRL), the MRL indicated Resident 60 requested for her television to be repaired on 11/18/2025, 11/20/2025, and 11/21/2025. Each request was signed off as corrected on the same date.During a concurrent observation and interview on 12/16/2025 at 9:40 am with Resident 60, in Resident 60's room, Resident 60 showed that many of the basic television channels did not have a picture. Resident 60 stated the channels that work do not interest her, and she has been asking the facility staff to repair the television. Resident 60 stated the Maintenance Supervisor (MS) had told her he would replace the television but has not.During an interview on 12/18/2025 at 11:30 am with Certified Nursing Assistant (CNA) 1, CNA 1 stated that residents often complain of the televisions not working. CNA 1 stated Resident 60 complained this morning about her television needing to be changed. CNA 1 placed a request in the MRL.During an interview on 12/18/2025 at 2:15 pm with MS in Resident 60's room, MS stated that Resident 60's television is missing channels and needs repair. MS stated he received multiple complaints from Resident 60, he could not provide a work order for the cable company. MS stated the repair will be completed promptly, emphasizing the importance of functioning televisions for residents' happiness and engagement.During a review of the facility's policy and procedure (P&P) titled, Activity Evaluation, the P&P indicated individual activities promote physical, mental and psychosocial well-being of residents.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure pressure ulcer/injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) measures for one of two sampled residents (Resident 9) were provided as ordered by the physician when Resident 9's low air loss mattress (LALM - a specialty bed that alternates pressure to help heal and prevent pressure injuries) was set to static (not moving, changing, or active) and Resident 9's heel protectors were not on. These failures had the potential to worsen and prevent the healing for Resident 9's pressure ulcer/injury and had the potential for Resident 9 to develop further skin injury.Findings: During a review of Resident 9's admission Record (AR), the admission Record indicated Resident 9 was admitted to the facility on [DATE] with diagnoses that included encounter for a gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), pressure ulcer/injury (PU) stage 3 (full-thickness loss of skin. Dead and black tissue may be visible), dementia (a progressive state of decline in mental abilities), and a right-hand contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion). During a review of Resident 9's History & Physical (H&P), dated 9/21/2025, the H&P indicated the resident had contracted legs and did not have the capacity to understand and make decisions. During a review of Resident 9's Minimum Data Set assessment (MDS - a resident assessment tool), dated 12/15/2025, the MDS indicated Resident 9 had severely impaired cognition (ability to think) and was dependent (helper does all the effort and the resident does none of the effort to complete the activity or the assistance of two or more helpers was required for the resident to complete the activity) on staff (in general) to roll left and right in bed or move from sitting to lying or vice versa in bed. The MDS indicated Resident 9 was at risk of developing PUs and a skin and ulcer/injury treatment used was a pressure reducing device for the bed. During a review of Resident 9's Order Summary Report (OS), the OS indicated Resident 9 had an active physician order for a Low Air Loss Mattress, every shift for skin management, ordered on 5/25/2025 and may have foot boots, every shift, ordered on 6/22/2025. During a review of Resident 9's Care Plan (CP), revised 6/23/2025, the CP indicated Resident 9 was at risk for PU development related to history of wounds/ulcers and had a right plantar foot deep tissue injury with interventions to float the resident's heels and a LALM. During a review of Resident 9's IDT Wound Management Update (IDT), dated 12/9/2025, the IDT indicated Resident 9 had an open wound to the right plantar foot, classified by the wound specialist as a pressure ulcer, stage 3. The IDT indicated strict pressure offloading (pressure removal), strict offloading of the right foot, and a Prevalon boot (medical boot used for bed-bound or limited mobility patients to prevent/relieve heel pressure injuries by elevating the heel off the bed) was placed to the right foot while Resident 9 was in bed. During a review of Resident 9's Surgical Consult, dated 12/11/2025, the consult indicated Resident 9 had a PU on the right plantar foot that was not healed and measured 1.2 centimeters (cm - unit of measure) in length by 0.6 cm in width by 0.3 cm in depth. The consult further recommended continuing offloading, turning, and continuing the pressure reducing mattress for Resident 9. During an observation on 12/16/2025 at 9:10 AM in Resident 9's room, Resident 9 was in bed with the LALM on the static mode (a setting that creates a firm surface). During a concurrent observation and interview on 12/16/2025 at 9:48 AM with Licensed Vocational Nurse 1 (LVN 1) in Resident 9's room, Resident 9 was in bed and his LALM setting was on static and foot boots were off. LVN 1 stated, Resident 9 needed a LALM setting instead of LALM being in static mode because of a wound on his foot and should have been wearing a foot boot. During a concurrent observation and interview on 12/16/2025 at 9:52 AM with Treatment Nurse 1 (TN 1) in Resident 9's room, Resident 9 was in bed with the LALM without foot boots and the LALM static setting was on. TN 1 confirmed the bed was set to static and the foot boots were not applied to Resident 9. TN 1 stated, Resident 9 currently had a stage three PU on his right plantar foot and should (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	always be wearing a foot boot for pressure relief. TN 1 stated the LALM was needed due to Resident 9's contractures, immobility, history of recurrent wounds, and was used as a method to counteract the pressure Resident 9 placed on Resident 9's foot. TN 1 further stated, the LALM should not remain on static, as it made the mattress harder, leading to further skin breakdown. During a review of Resident 9's Braden Scale for Predicting Pressure Sore Risk (assessment tool used to assess a resident's risk of developing a pressure ulcer), dated 12/17/2025, the Braden Scale indicated Resident 9 was bedfast (confined to bed) with a very limited ability to change and control body position (made occasional slight changes in body or extremity position but unable to make a frequent or significant changes independently) and was classified at high risk for developing PUs. During an interview on 12/19/2025 at 9:23 AM with the Director of Nursing (DON), DON stated, a LALM was typically used for residents with stage 3 or 4 PUs used to aid in wound healing and prevention. DON stated, Resident 9 was bedbound, had a history of wounds, and was at high-risk for skin breakdown. DON stated, Resident 9's LALM on static may have delayed wound healing or caused wound regression (returned to previous condition). DON stated, Resident 9's foot boots were used to offload the pressure on Resident 9's heels, to aid in Resident 9's wound healing, and eliminate pressure on the wound. DON stated, Resident 9's foot boots should be worn when the resident was in bed to prevent further skin breakdown. During a review of Virgo Medical & Rehab Supply: How to Use the LALM, undated, the guide indicated under operation, the static setting was used to inflate all the mattress cells and when firm enough, the static button should be turned off to allow the mattress to begin the alternating pressure cycle (cycled every six to eight minutes). During a review of Drive: Med-Aire Alternating Pressure Mattress Replacement System with Low Air Loss User Manual Item #14027, dated 2012, the LAL mattress manual indicated the Med-Aire 8, 14027 System was specifically designed for the prevention and treatment of pressure injuries while optimizing patient comfort and should be operated as instructed. The manual indicated, the static control button was used to shift between alternating and static mode and when in static mode, the static indicator would turn on and the mattress would become a firm surface. During a review of the facility's policy and procedure (P&P) titled, Support Surface Guidelines, revised 2/2024, the P&P indicated, the purpose of the procedure was to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk of skin breakdown. The P&P indicated, redistributing support surfaces were to promote comfort for all bed- or chairbound residents, promote circulation and provide pressure relief or reduction. The P&P indicated, individuals at risk for developing pressure ulcers should be placed on redistribution support surface, such as foam, static air, alternating air, gel, or air-loss device, when lying in bed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a post-fall review (assessment done by the facility to identify underlying medical conditions, environmental factors, and other fall risk factors to create/revise interventions to prevent falls) for one of one sampled resident (Resident 8) was completed after Resident 8 fell on [DATE]. This failure had the potential to place Resident 8 at an increased risk of further falls.Findings: During a review of Resident 8's admission Record (AR), the AR indicated Resident 8 was admitted on [DATE] with diagnoses that included end-stage renal disease (ESRD-irreversible kidney failure), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and blindness in the left eye. During a review of Resident 8's History & Physical (H&P), dated 7/27/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 8's Minimum Data Set (MDS - a resident assessment tool), dated 10/2/2025, the MDS indicated Resident 8 had moderately impaired cognition (ability to think) and was dependent (helper does all the effort and the resident does none of the effort to complete the activity) on facility staff (in general) to complete most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). The MDS also indicated Resident 8 was dependent on facility staff (in general) to move around in bed and for transfers. During a review of Resident 8's Fall Risk Care Plan (CP), initiated on 4/2/2022, the CP indicated Resident 8 was at risk for falling out of bed with a goal to remain free from injury and or falls. The CP Interventions initiated on 4/2/2022 indicated to check Resident 8 frequently and reposition Resident 8 in bed, to encourage Resident 8 to use the call light and to keep the call light within Resident 8's reach, to apply bilateral grab bars in bed to prevent sliding and rolling off the bed. The CP also indicated Resident 8 slipped through the lift sling and slid down the shower chair on 11/26/2025 but there were no new interventions added, or revisions made on the CP on 11/26/2025. During a review of Resident 8's Change in Condition Evaluation (CIC/SBAR - situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 11/26/2025, the CIC indicated Resident 8 fell the morning of 11/26/2025 while being transferred by a nursing assistant in a Hoyer lift (a mechanical device used to lift and/or transfer a person from place to place). During a concurrent interview and record review on 12/17/2025 at 2:05 PM with Registered Nurse Supervisor 1 (RN 1), Resident 8's medical record was reviewed. Resident 8's medical record indicated a post-fall review was not completed. RN 1 stated a post-fall review should have been completed within 24 hours to document a more thorough assessment of the incident, the surroundings, and any details that could have prevented the fall. RN 1 stated a post-fall review was important for the safety and care of the resident. During an interview on 12/19/2025 at 9:15 AM with the Director of Nursing (DON), the DON stated the necessary post-fall documentation after a witnessed or unwitnessed resident fall consisted of a CIC, a pain assessment, a fall risk assessment, and a post-fall review. The DON stated complete post-fall documentation assured interventions were in place to prevent falls, prevent further falls, minimized injuries, and allowed residents to receive the best care from staff. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, last revised 7/2017, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The P&P indicated, events, incidents or accidents involving the resident should be documented in the medical record. The P&P indicated, documentation in the medical record would be objective, complete, and accurate. During a review of the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, last (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revised 3/2018, the P&P indicated that based on previous evaluations and current data, the staff would identify interventions related to the resident's specific risks and causes in an attempt to prevent the resident from falling and to minimize complications from falling. During a review of the facility's policy and procedure (P&P) titled, Fall Risk Assessment, undated, the P&P indicated, the nursing staff in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, would seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information. The P&P indicated assessment data would be used to identify underlying medical conditions that may increase the risk of injury from falls, staff would seek to identify environmental factors that may contribute to falling and identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 7) who received enteral feeding (liquid form of nutrients given to people who cannot eat or drink by mouth safely) through a gastrostomy tube (G-tube, a tube inserted through the wall of the abdomen directly into the stomach, can be used to give nutrition and/or drugs) had a properly labeled enteral feeding bag. This failure had the potential to result in Resident 7 receiving an expired or inappropriate amount of enteral feeding/nutrition and experiencing nausea, vomiting, abdominal bloating, or other complications.Findings: During a review of Resident 7's admission Record (AR), the AR indicated Resident 7 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) dysphagia (difficulty swallowing), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 7's History & Physical (H&P), dated [DATE], the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 7's Minimum Data Set assessment, dated [DATE], the MDS indicated Resident 7's cognition (ability to think) was severely impaired. The MDS indicated Resident 7 was dependent on staff (in general) for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 7's Order Summary Report (OS), the OS indicated Resident 7 had an active physician order, dated [DATE], for an enteral feeding of DiabeticSource AC 1.2 via G-tube for a total of 1,000 milliliters (ml - unit of measure)/1200 Kilocalories (Kcal - unit of energy) at 50 ml/hour for 20 hours or until dose met. During a review of Resident 7's Care Plan (CP), revised on [DATE], the CP indicated Resident 7 required a tube feeding (enteral feeding) related to dysphagia and the CP goal was for Resident 7 to remain free of side effects or complications related to tube feeding through the review date. During an observation on [DATE] at 10:51 AM, Resident 7 had DiabeticSource AC infusing via G-tube and the enteral feeding bag was not labeled with a time when the enteral feeding bag was hung and the initials of the nurse who administered the feeding. During a concurrent observation and interview on [DATE] at 10:57 AM with Licensed Vocational Nurse 1 (LVN 1) in Resident 7's room, LVN 1 observed Resident 7's enteral feeding bag. LVN 1 stated the enteral feeding bag was missing the time when the enteral feeding bag was hung and should have been labeled because the enteral feeding formula was only good for 48 hours (hrs.) once the bag was opened. LVN 1 stated the enteral feeding bag should have been labeled by the licensed nurse who hung the bag for resident safety and to prevent the administration of an expired feeding to Resident 7. During an interview on [DATE] at 9:38 AM with the Director of Nursing (DON), the DON stated an enteral feeding bag should be labeled with the date and time of administration by the licensed nurse hanging the bag. The DON stated it was important to label the enteral feeding bag with the date and time of administration because the feeding was only good for 48 hrs. The DON stated that without the date and time labeled on the enteral feeding bag, the licensed nurses would not know when the feeding bag was hung and could result in giving Resident 7 expired enteral feeding formula which could lead to gastrointestinal issues (problems affecting the digestive tract such as diarrhea, nausea, vomiting) for the resident. The DON stated, properly labeling enteral feeding bags was necessary as a safety and infection control measure for the residents. During a review of the facility's policy and procedure (P&P) titled, Enteral Feedings-Safety Precautions, last revised 11/2018, the P&P indicated the purpose of the P&P was to ensure the safe administration of enteral nutrition and the facility would remain current in and follow accepted best practices in enteral nutrition. The P&P indicated on the formula label, document initials, date and time the formula was hung, and initial that the label was checked against the order.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 23), received proper respiratory (relating to breathing) care when, on 12/16/2025 and 12/18/2025, Resident 23 did not receive 4 liters per minute (L/min, unit of measurement) of oxygen (02, a colorless, odorless, tasteless gas essential for living) therapy as indicated in the physician's order dated 11/30/2025.This deficient practice had the potential to result in desaturation (a drop in the oxygen level in the blood), respiratory distress, and a physical decline to Resident 23.Findings:During a review of Resident 23's admission Record (AR), the AR indicated Resident 23 was originally admitted to the facility 3/29/2024 and readmitted the resident on 11/4/2025 with multiple diagnoses including chronic (long standing) obstructive pulmonary disease (COPD - a lung disease causing difficulty in breathing), unspecified, acute (sudden) respiratory failure (when the lungs can't release enough oxygen into your blood) with hypoxia (low levels of 02 in the body tissues), and end stage renal disease (irreversible kidney failure).During a review of Resident 23's Minimum Data Set (MDS - a resident assessment tool), dated 11/9/2025, the MDS indicated Resident 23's cognitive skills for daily decision making were intact. The MDS indicated Resident 23 was dependent (helper does all of the effort) and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with activities of daily living (ADLs). The MDS indicated Resident 23 was receiving special treatments such as 02 therapy and dialysis (a treatment to cleanse blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed).During a review of Resident 23's Care Plan (CP), initiated 11/8/2025, the CP's focus indicated Risk for Ineffective Airway Clearance related to Acute Respiratory failure with hypoxia, the CP's interventions indicated to administer 02 as ordered by the physician: 02 at 2 liters via nasal cannula (NC, lightweight flexible plastic tube with two prongs that sit in the nostrils to deliver supplemental oxygen) continuously. During a review of Resident 23's Order Summary Report (OSR), active orders as of 12/16/2025, the OSR indicated an order, dated 11/30/2025, for 02 at 4 L/min via NC continuously every shift for COPD. During a review of Resident 23's OSR, active orders as of 12/18/2025, the OSR indicated an order, dated 11/30/2025, for 02 at 4 L/min via NC continuously every shift for COPD.During a review of Resident 23's Change in Condition Evaluation (COC), dated 12/18/2025, timed at 2:13 PM, the COC indicated Resident 23 had pain (uncontrolled) and desaturation. The COC indicated, on 12/18/2025 at 2:10 PM, Resident 23 complained of generalized pain and Resident 23's 02 (saturation) was eighty seven percent (87%) via NC running at 2L/min. The COC indicated, the facility called 911 (emergency number in the U.S.A. to get help when there is a life-threatening or in-progress emergency) and Resident 23 left the facility and was transferred to the General Acute Care Hospital's emergency room (GACH ER) at 2:32 PM.During a review of Resident 23's Medication Administration Record (MAR), dated 12/1/2025 - 12/31/2025, the MAR indicated, to monitor 02 saturation every shift and notify the physician if Resident 23's 02 (saturation) was less than (<) 93%. The MAR indicated Resident 23's 02 saturation was 87% on 12/18/2025 during the day shift. During a concurrent observation and interview on 12/16/2025 at 11:52 AM with Resident 23, Resident 23 was returned back to Resident 23's bed by transporter from dialysis on 2 1/2 L/min 02 via N/C. Resident 23 stated, Resident 23 was on 02 and received 2 - 4 L/min.During a concurrent observation and interview on 12/16/2025 at 4:15 PM with Registered Nurse Supervisor 2 (RN 2), Resident 23 was awake, alert, lying in bed, and receiving 2 1/2 L/min of O2 via NC. RN 2 stated Resident 23's 02 flow rate was 2 1/2 to 2 and a quarter L/min.During a concurrent interview and record review on 12/16/2025 at 4:18 PM with RN 2, Resident 23's active orders as of 12/16/2025 and 12/18/2025 for the 02 were reviewed. The order for O2, dated 11/30/2025, indicated 4 L/min via NC continuously every shift for COPD. RN 2 stated the facility was not following the physician's order and Resident 23's 02 flow rate should be set at 4L/min. RN 2 stated, the RN (in general) was supposed to check residents (in general) when residents returned to (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility. RN 2 stated, checking the residents after residents returned to the facility was important especially something could happen during transport was to ensure residents were stable. RN 2 stated, Resident 23's wrong 02 flow rate could cause hypoxia.During a concurrent observation and interview on 12/18/2025 at 2:25 PM with Licensed Vocational Nurse (LVN) 4, Resident 23 was sitting up at the edge of Resident 23's bed with a face mask, hunched over, head down, and both hands holding on to the edge of the bed. There were multiple paramedics at the bedside interviewing and assessing Resident 23. LVN 4 stated, Resident 23 complained of generalized pain and LVN 4 medicated Resident 23. LVN 4 stated, LVN 4 checked Resident 23 after being medicated and the 02 saturation was 88% while Resident 23 received 2L/min via NC. LVN 4 stated Resident 23 continued to have pain and was taken by the paramedics via gurney at 2:23 PM.During a concurrent interview and record review on 12/18/2025 at 2:35 PM with RN 1, Resident 23's order for 02 was reviewed. RN 1 stated the order for 02 indicated 4 L/min via NC continuously. RN 1 stated, staff were not following Resident 23's O2 physician's order. RN 1 stated, RNs (in general) were supposed to assess residents and verify physician orders [to ensure] the correct amount of 02 was delivered, his (Resident 23) order was 4L/min, when residents returned [readmitted] to the facility. RN 1 stated, ensuring delivery of the correct amount of 02 was important to prevent desaturation, [in] this case, he [Resident 23] desated [desaturation], they [staff] were not following the doctor's orders.During a review of the facility's policy and procedures (P&P), titled, Medication and Treatment Orders, date revised 7/2016, the P&P indicated, medications should be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state.During a review of the facility's P&P, titled Oxygen Administration, date revised 2/2024, the P&P indicated, the purpose of the P&P was to provide guidelines for safe oxygen administration. The P&P indicated, to verify that there was a physician's order for oxygen administration, review the physician's orders and adjust the oxygen delivery device so that it was comfortable for the resident and the proper flow of oxygen was being administered.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow infection (the invasion and growth of germs in the body) prevention and control practices for 1 of 5 sampled residents (Residents 10) by failing to ensure Resident 10's restroom which was in full view of Resident 10 remained clean and orderly.This failure could potentially result in health hazards such as cross contamination (bacteria or microorganisms are unintentionally transferred from one surface/object to another and can result in a harmful effect) and compromise Resident 10's physical well-being.Findings:During a review of Resident 10's admission Record (AR), the AR indicated, Resident 10 was originally admitted to the facility on [DATE] and readmitted the resident on 11/4/2025 with multiple diagnoses including acute (sudden) respiratory failure (when the lungs can't release enough oxygen into your blood), extended spectrum beta lactamase (ESBL - enzymes produced by some bacteria that may make them resistant to some antibiotics) resistance, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), unspecified.During a review of Resident 10's Minimum Data Set (MDS - a resident assessment tool), dated 10/12/2025, the MDS indicated Resident 10's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 10 was dependent (helper does all of the effort) to setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with ADLs.During a review of Resident 10's History and Physical Examination (H&P), dated 11/9/2025, the H&P indicated, Resident 10 had the capacity to understand and make decisions. During a concurrent observation and interview on 12/16/2025 at 10:29 AM with the Infection Preventionist Nurse (IPN), Resident 10's room had a EBP (Enhanced Barrier Precautions - an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs] in nursing homes) signage on the room's door. Resident 10 was awake, alert, and lying in bed complaining of a headache. Inside Resident 10's restroom, there were two wheelchairs (one labeled with Resident 10's name and the other labeled with Resident 10's roommate's name), a black colored oscillating portable tower fan, a gray colored bucket on the floor next to the toilet which had a commode chair on top of the toilet, 2 urinals and paper towel trash in the sink. The IPN stated, resident care equipment should not be stored inside resident's (in general) restrooms. The IPN stated, the wheelchairs should be kept at the bedside, the bucket should be [kept] in the commode chair, and the restroom [sink] should be clean for infection control [purposes]. The IPN stated Resident 10's roommate was transferred out to the hospital, but the IPN did not remember the date of transfer.During an interview on 12/18/2025 at 2:35 PM with Registered Nurse Supervisor (RN) 1, RN 1 stated, resident care equipment should not be stored inside resident's restroom, we have a parking area for the resident's wheelchairs in the back, for health, safety and infection control [purposes]. During an interview on 12/19/2025 at 10:37 AM with the Restorative Nurse Assistant (RNA), the RNA stated, resident wheelchairs were kept at the resident's bedside close to the residents. The RNA stated there was a room to store commodes, and urinals should not be kept in the sink. The RNA stated, equipment supplies should not be stored inside the restroom because sometimes the resident want to use the restroom, it's in the way. The RNA stated resident care equipment were disinfected and put in proper storage for infection control [purposes].During a review of the facility's policy and procedures (P&P) titled, Homelike Environment, date revised 2/2021, the P&P indicated, residents were provided with a safe, clean, comfortable and homelike environment. The P&P indicated, the facility staff and management minimized, to the extent possible, the characteristics of the facility that reflected a depersonalized, institutional setting that included a clean, sanitary and orderly environment.During a review of the facility's P&P titled, Infection Control, date revised 4/2025, the P&P indicated, the facility's P&P were intended to facilitate maintaining a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public to help prevent and manage transmission of diseases and infection.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the antibiotic stewardship program (promotes the appropriate use of antibiotics [ABX, a medicine that inhibits growth of infection]) for one of three sampled residents (Resident 31). Resident 31s' physician (Medical Doctor [MD] 1) was not informed Resident 31 did not meet Loebs (a tool used to help prescribers decide if to start the use of ABX aiming to reduce unnecessary use of ABX) or the McGreer's criteria (infection surveillance checklist used to determine the appropriate ABX) for ABX use. This deficient practice had the potential to result in unnecessary ABX treatment and lead to ABX resistance (germs, mostly bacteria, that have become strong enough to resist many common ABX, making infections harder to cure) to Resident 31.Findings:During a review of Resident 31's admission Record (AR), the AR indicated Resident 31 was admitted to the facility on [DATE] with diagnosis that included arthritis (joint pain and swelling) due to other bacteria, and osteomyelitis (inflammation or infection of bone tissue).During a review of Resident 31's Infection Screening Evaluation (ISE), dated 12/9/2025, the ISE indicated the Loebs or the McGreer's criteria were not triggered for ABX use. The ISE indicated manual trigger for ABX use was not checked off on the ISE form.During a review of Resident 31's Antibiotic Time Out (ATO), dated 12/12/2025, completed by the Infection Preventionist Nurse (IPN), the ATO indicated, Antibiotic review performed with [MD 1]. Due to severity of [the] resident condition, ATB [ABX] not appropriate at this time. Ordered to continue at this time.During a review of Resident 31's History and Physical (H&P), dated 12/14/2025, the H&P indicated Resident 31 had the capacity to understand and make decisions.During a review of Resident 31's Order Summary Report (OSR), dated active as of 12/17/2025, the OSR indicated a physician's order for daptomycin-sodium chloride (type of ABX) 700 milligrams (mg, unit of measurement) to be given daily via intravenously (IV, through the vein) to Resident 31, dated 12/9/2025.During a review of Resident 31's IV Medication Administration Record (IVMAR), dated 12/2025, the IVMAR indicted Resident 31 was administered 700 mg of daptomycin-sodium chloride daily from 12/10/2025 to 12/19/2025.During a interview and concurrent record review with the IPN, on 12/17/2025 at 3:30 PM, Resident 31's Infection Screening Evaluation, dated 12/9/2025, and the ATO, dated 12/12/2025, were reviewed with the IPN. The IPN stated Resident 31 did not meet Loebs criteria or McGreer's criteria for antibiotic use. The IPN stated the Antibiotic Time Out form had a typo not and the IPN meant to document appropriate at this time. The IPN stated the IPN did not inform MD 1 Resident 31 did not meet the Loebs or McGreer's criteria for MD 1 to make an informed decision regarding the continued use of ABX for Resident 31. The IPN stated the IPN should have informed MD 1 for MD 1 to determine if Resident 31 benefitted from the use of ABX because ABXs had a lot of side effects (unintended or unwanted effects that can result from medication administration) such as diarrhea, abdominal cramps, and [unnecessary use of ABX] may lead to ABX resistance.During a review of the facility's policy and procedure (P&P) titled Antibiotic Stewardship - Review and Surveillance of Antibiotic use and Outcomes, revised 12/2016, the P&P indicated ABX usage and outcome data will be collected and documented using a facility-approved ABX surveillance tracking form. The data will be used to guide decisions for improvement of individual resident ABX prescribing practices and facility wide ABX stewardship. The IP [IPN] will review ABX utilization as part of the ABX stewardship program and identify specific situations that are not consistent with the appropriate use of ABX. The P&P indicated at the conclusion of the review, the provider will be notified of the review findings.