STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555715	A. Building B. Wing	06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Gardens Nursing Home	7246 S. Rosemead Blvd. Pico Rivera, CA 90660

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on interview and record review, the facility failed to inform one of three sampled residents' (Resident 1) physician of the resident's Responsible Party's (RP 1) decision to not have a Computed Tomography (CT- a medical imaging procedure to create detailed images of the head) done after Resident 1 was found to have discoloration on his forehead. This deficient practice resulted in Physician 1 being unaware of RP 1's decision which resulted in no further ordered interventions. Findings: During a review of Resident 1's admission Record (Face Sheet), the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included metabolic encephalopathy (condition when the brain's function is impaired due to a chemical imbalance in the body), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and generalized muscle weakness. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 6/9/2025, the MDS indicated Resident 1's cognitive skills (process of thinking) for daily decision making was severely impaired. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) with bathing, upper body dressing, and personal hygiene. During a review of Resident 1's History and Physical (H&P), dated 2/7/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's situation, background, assessment, recommendation (SBAR -a communication tool used by healthcare workers when there is a change of condition among the residents) form, dated 6/4/2025, the SBAR indicated the certified nursing assistant (CNA) reported to the licensed vocational nurse (LVN) of a discoloration on Resident 1's right side of the forehead. The SBAR indicated Physician 1 was notified and Physician 1 ordered to monitor Resident 1 each shift and to ask RP 1 if she wanted a head CT done. The SBAR indicated RP 1 was called three times and a voicemail was left. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/24/2025 at 12:35 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated on 6/4/2025, LVN 2 spoke to RP 1 regarding the head CT. LVN 2 stated RP 1 declined the head CT. LVN 2 stated she did not recall informing Physician 1 about RP 1's decision. LVN 2 stated RP 1's decision should have been relayed to Physician 1 to allow Physician 1 to order further interventions. During an interview on 6/24/2025 at 3:40 p.m. with the Director of Nursing (DON), the DON stated Physician 1 should have been notified of RP 1's declination of Resident 1's head CT. The DON stated informing Physician 1 would provide Physician 1 to recommend other interventions or monitoring for Resident 1. The DON stated without informing Physician 1, the nurses would not receive new orders that could be beneficial to treat and monitor Resident 1's forehead discoloration. During a review of the facility's Policy and Procedure (P&P) titled, Change in a Resident's Condition or Status, revised 2/2021, the P&P indicated the facility will promptly notify the resident's physician of changes in the resident's medical condition and/or status.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an injury of unknown origin to the State Agency (California Department of Public Health [CDPH]), the ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities), and local law enforcement for one of three sampled residents (Resident 1) when Resident 1 was found to have discoloration on the right side of his forehead. This deficient practice of delayed notification to CDPH, the ombudsman, and law enforcement resulted in a delay of an onsite inspection. This deficient practice had the potential to result in further injury to Resident 1. Cross Reference F610. Findings: During a review of Resident 1's admission Record (Face Sheet), the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included metabolic encephalopathy (condition when the brain's function is impaired due to a chemical imbalance in the body), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and generalized muscle weakness. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 6/9/2025, the MDS indicated Resident 1's cognitive skills (process of thinking) for daily decision making was severely impaired. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) with bathing, upper body dressing, and personal hygiene. During a review of Resident 1's History and Physical (H&P), dated 2/7/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's situation, background, assessment, recommendation (SBAR -a communication tool used by healthcare workers when there is a change of condition among the residents) form, dated 6/4/2025, the SBAR indicated the certified nursing assistant (CNA) reported to the licensed vocational nurse (LVN) of a discoloration on Resident 1's right side of the forehead. During an interview on 6/24/2025 at 12:35 p.m. with (LVN) 2, LVN 2 stated on 6/4/2025, a CNA (unable to recall) informed her of Resident 1's discoloration to the right side of his forehead. LVN 2 stated she did not know the origin of the discoloration. LVN 2 stated she was unable to recall if the Director of Nursing (DON) or the Administrator (ADM) were informed. LVN 2 stated a discoloration on the forehead was considered a type of injury. LVN 2 stated an injury of unknown origin was defined as an injury that could have come from anywhere, but the actual cause was unknown. LVN 2 stated with an injury of unknown origin, there was the concern the injury was inflicted by another person, which would be seen as physical abuse. LVN 2 stated Resident 1's discoloration on his forehead should have been reported to the ADM and the DON to allow them to jump into their roles to investigate and report to the appropriate agencies such as CDPH, the ombudsman, and the police. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/24/2025 at 1:26 p.m. with Registered Nurse (RN) 1, RN 1 stated when an injury of unknown origin occurred, the source of the injury had to be reported. RN 1 stated Resident 1's discoloration on his forehead was considered an injury and due to the nursing staff being unable to determine its cause, the injury was from an unknown origin. RN 1 stated once there was knowledge of the injury, the DON and ADM should have been notified so they could report to the necessary agencies and to initiate an investigation to determine if the resident was abused. During an interview on 6/24/2025 at 3:17 p.m. with the DON, the DON stated injuries of unknown injury had to be reported to the ADM and to CDPH, the police, and the ombudsman to begin the process of investigating the cause and to try to prevent it from occurring again. The DON stated reporting injuries of unknown origin was essential to keep Resident 1 safe. The DON stated the incident was not reported because they did not think of the possibility of another individual hitting Resident 1 on the forehead. During an interview on 6/24/2025 at 4 p.m. with the ADM, the ADM stated the purpose of reporting allegations of abuse and injuries of unknown origin was to investigate the cause and to determine if abuse occurred. The ADM stated injuries of unknown origin were to be reported to the appropriate agencies such as CDPH, the ombudsman, and the police. The ADM stated he did not recall if he was informed of the discoloration on 6/4/2025, however, he did see Resident 1 five days later, on 6/9/2025. The ADM stated when he saw Resident 1 on 6/9/2025, he did not see a bump or any discoloration on Resident 1's forehead, therefore did not report it. During a review of the facility's policy and procedure (P&P) titled, Abuse Investigation and Reporting, revised 7/2017, the P&P indicated, All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record; d. Adult Protective Services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's Attending Physician; and g. the facility Medical Director. An alleged violation of abuse, neglect, exploitation (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two hours if the alleged violation involves abuse or has resulted in serious bodily injury; or b. Twenty-four hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate an injury of unknown origin for one of three sampled residents (Resident 1) when Resident 1 was found to have discoloration on the right side of his forehead. This deficient practice resulted in the facility being unaware of the cause of Resident 1's injury. Cross Reference F609. Findings: During a review of Resident 1's admission Record (Face Sheet), the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included metabolic encephalopathy (condition when the brain's function is impaired due to a chemical imbalance in the body), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and generalized muscle weakness. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 6/9/2025, the MDS indicated Resident 1's cognitive skills (process of thinking) for daily decision making was severely impaired. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) with bathing, upper body dressing, and personal hygiene. During a review of Resident 1's History and Physical (H&P), dated 2/7/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's situation, background, assessment, recommendation (SBAR -a communication tool used by healthcare workers when there is a change of condition among the residents) form, dated 6/4/2025, the SBAR indicated the certified nursing assistant (CNA) reported to the licensed vocational nurse (LVN) of discoloration on Resident 1's right side of the forehead. During an interview on 6/24/2025 at 12:35 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated on 6/4/2025 , a CNA (unable to recall) informed her of Resident 1's discoloration to the right side of his forehead. LVN 2 stated she did not know the origin of the discoloration. LVN 2 stated she was unable to recall if the Director of Nursing (DON) or the Administrator (ADM) were informed. LVN 2 stated a discoloration on the forehead was considered a type of injury. LVN 2 stated Resident 1's discoloration on his forehead should have been reported to the ADM and the DON to allow them to jump into their roles to investigate the cause of the injury. During an interview on 6/24/2025 at 1:26 p.m. with Registered Nurse (RN) 1, RN 1 stated when an injury of unknown origin occurred, the source of the injury had to be reported to the DON and the ADM. RN 1 stated the DON and the ADM were responsible for initiating an investigation to determine if the resident was abused or to determine other causes of the discoloration on Resident 1's forehead. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/24/2025 at 3:17 p.m. with the DON, the DON stated a discoloration on the forehead was an example of an injury that required an investigation. The DON stated upon interviewing the nurses who cared for Resident 1, the cause of the discoloration was unknown. The DON stated she interviewed the nurses and asked whether the resident fell or had episodes of combativeness. The DON stated she did not investigate whether Resident 1 was hit by another resident or staff member. The DON stated by not conducting a thorough investigation in all possibilities, Resident 1 and other residents were at risk for further potential abuse. During an interview on 6/24/2025 at 4 p.m. with the ADM, the ADM stated the purpose of reporting allegations of abuse and injuries of unknown origin was to investigate the cause and to determine if abuse occurred. The ADM stated he did not recall if he was informed of the discoloration on 6/4/2025, however, he did see Resident 1 five days later, on 6/9/2025. The ADM stated when he saw Resident 1 on 6/9/2025, he did not see a bump or any discoloration on Resident 1's forehead and did not believe the discoloration on Resident 1's forehead was from abuse. The ADM stated he did not conduct a formal investigation regarding Resident 1's forehead discoloration and only asked the nurses if Resident 1 fell or if any of the nurses witnessed any other unusual occurrences. During a review of the facility's policy and procedure (P&P) titled, Abuse Investigation and Reporting, revised 7/2017, the P&P indicated all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) would be thoroughly investigated by the facility management.

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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 one of three sampled residents (Resident 1) was free of accidents and hazards after falling on 4/10/2025 by failing to: 1. Complete Resident 1's 72-Hour Neurological Check (Neuro Check- series of tests over a 72-hour period to assess for changes in neurological function). 2. Complete Resident 1's post-fall Fall Risk Assessment. 3. Compete the documentation for the Interdisciplinary Team (IDT, a group of healthcare professionals with various areas of expertise who work together towards the goals of the residents) meeting on 4/11/2025. These deficient practices had the potential to result in Resident 1 sustaining undetected neurological changes which could have resulted in delay in treatment. These deficient practices also had the potential to result in the risks and root cause of Resident 1's fall to be unaddressed which increases the potential for reoccurrence of further falls and injury. Findings: During a review of Resident 1's admission Record (Face Sheet), the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included metabolic encephalopathy (condition when the brain's function is impaired due to a chemical imbalance in the body), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and generalized muscle weakness. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 6/9/2025, the MDS indicated Resident 1's cognitive skills (process of thinking) for daily decision making was severely impaired. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) with bathing, upper body dressing, and personal hygiene. During a review of Resident 1's History and Physical (H&P), dated 2/7/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Fall Risk Assessment, dated 4/9/2025, the Fall Risk Assessment indicated Resident 1 was a high risk for falls. During a review of Resident 1's situation, background, assessment, recommendation (SBAR -a communication tool used by healthcare workers when there is a change of condition among the residents) form, dated 4/10/2025, the SBAR indicated on 4/10/2025 Resident 1 stood up from his wheelchair, attempted to walk and fell to the ground. 1. During a review of Resident 1's Care Plan titled, Actual Fall, revised 4/10/2025, the Care Plan indicated staff interventions to conduct neuro-checks. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/24/2025 at 2:18 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 1's 72 Hour Neuro-Check List, dated 4/10/2025 through 4/13/2025, was reviewed. LVN 1 stated Resident 1's 72 Hour Neuro Check List was not completed because there were empty entries on the following dates and times: 4/10/2025 at 6 p.m., 4/10/2025 at 8 p.m., 4/10/2025 at 10 p.m., 4/12/2025 at 6 a.m. , 4/12/2025 at 2 p.m., 4/13/2025 at 6 a.m., and 4/13/2025 at 2 p.m. LVN 1 stated the purpose of neuro checks after a fall was to quickly identify any changes in Resident 1's level of consciousness (degree of an individual's awareness and responsiveness), vital signs, pupil size, and hand grip strength. LVN 1 stated conducting the assessments at the indicated time frequencies would show Resident 1's baseline (initial measurement) and any trends in decline. LVN 1 stated missed neuro check assessments put Resident 1 at risk of sustaining an undetected neurological change and would cause a delay in interventions and treatment. During an interview on 6/24/2025 at 3:23 p.m., with the Director of Nursing (DON), the DON stated neuro checks were essential to assess Resident 1's mental status and to intervene immediately at the first sign of a decline. The DON stated when the licensed nurses did not complete Resident 1's neuro check after he fell, Resident 1 was at risk of having a change of condition that was not immediately detected which could have delayed the necessary interventions. During a review of the facility's Policy and Procedure (P&P) titled, Neurological Assessment (Routine), undated, the P&P indicated, Routine neurological assessment is conducted to evaluate the resident for small changes over time that may be indicative of a neurological injury. 2. During an interview on 6/24/2025 at 2:13 p.m., with LVN 1, LVN 1 stated after a fall, the licensed nurse was responsible for completing a fall-risk assessment. LVN 1 stated Resident 1 had a fall-risk assessment completed on 4/9/2025, but did not have one completed after he fell on 4/10/2025. LVN 1 stated the purpose of the fall-risk assessment was to identify the potential risks and hazards that would increase Resident 1's risk for falls. LVN 1 stated the fall-risk assessment would allow the Interdisciplinary Team (IDT, a group of healthcare professionals with various areas of expertise who work together towards the goals of the residents) to determine the appropriate interventions to prevent further falls and potential injuries. LVN 1 stated without a post-fall fall-risk assessment, Resident 1 was at risk of not having the appropriate interventions in place and could have another fall that results in an injury. During an interview on 6/24/2025 at 3:20 p.m., with the DON, the DON stated a fall-risk assessment was conducted after a fall to assist in creating a patient-centered plan of care and to address any risk factors the resident had. The DON stated Resident 1 did not have a fall-risk assessment done after his fall on 4/10/2025 which unnecessarily increased his risk for falls because of the lack of evaluation of Resident 1's risk factors. During a review of the facility's P&P titled, Falls, revised 3/2018, the P&P indicated, The staff and practitioner will review each resident's risk factors for falling and document in the medical record. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During a concurrent interview and record review on 6/24/2025 at 3:25 p.m., with the DON, Resident 1's IDT Progress Note, dated 4/11/205, was reviewed. The DON stated Resident 1's IDT progress note indicated the staff participants but did not indicate post-fall recommendations after Resident 1's fall on 4/10/2025. The DON stated the purpose of the IDT meeting after a fall was to determine the cause of the fall and to discuss the appropriate interventions to prevent further falls. The DON stated without the documentation of the IDT meeting in Resident 1's electronic health record (eHR); the discussed plan of care would not be implemented. During a review of the facility's P&P titled, Falls, revised 3/2018, the P&P indicated, Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling.