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	08/06/2025

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 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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This is a Repeat Deficiency at F609 from 6/24/2025 investigation. Based on interview and record review, the facility failed to report abuse allegations to the State Agency (California Department of Public Health [CDPH]), the ombudsman (an advocate for residents of nursing homes), and local law enforcement for three of seven sampled residents (Residents 5, 6, and 7) when Certified Nursing Assistant (CNA) 5 allegedly was rough with Residents 5, 6 and 7. This repeat deficient practice of delayed notification to CDPH, the ombudsman, and law enforcement resulted in a delay of an onsite inspection and had the potential to result in abuse to all residents in the facility.During a review of the facility's Plan of Correction / In-Service Training titled, Reporting Alleged Violations, dated 6/25/2025 and 6/26/2025, presented by the Director of Staff Development (DSD), the In-Service indicated the Director of Nursing (DON), the Administrator (ADM), Certified Nursing Aide (CNA) 3, and CNA 4 were all educated to report any abuse allegations immediately and for up to two hours to the CDPH, the ombudsman, and law enforcement. Cross Reference F610Findings:a. During a review of Resident 7's admission Record (Face Sheet), the admission Record indicated Resident 7 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including encephalopathy (a medical condition where the brain does not function properly), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and anxiety disorder (mental health condition characterized by excessive and persistent worry, fear, and nervousness about everyday situations). During a review of Resident 7's Minimum Data Set (MDS- a resident assessment tool), dated 7/25/2025, the MDS indicated Resident 7 had moderately impaired cognitive skills (problems with ability to remember, think, and use judgement) for daily decision making. The MDS indicated Resident 7 required supervision with eating, oral hygiene, and personal hygiene. During a review of the facility's Performance Improvement Plan - Abuse Investigation and Reporting dated 7/1/2025, the plan indicated the root cause was communication when an incident happened. The improvement plan indicated the goal was for staff to inform the Administrator and the DON promptly about any incidents, report any abuse allegations immediately to the three government agencies. The improvement plan indicated any grievances would be reported during the daily stand-up meeting for review and would be investigated and reported promptly. The improvement plan indicated to monitor this goal daily and monthly, to track and trend the grievances for possible abuse allegations, and to review the grievance reports. During a concurrent interview and record review on 8/6/2025 at 8:52 a.m., with the Director of Staff Development (DSD), Resident 7's Grievance / Complaint Report Form, dated 7/22/2025 was reviewed. The Grievance Form indicated that on 7/22/2025, Resident 7 reported to Social Services (SS) 1 that CNA 5 was slightly rough when trying to shave him. The DSD stated that on 7/22/2025, SS 1 notified him (SSD) of Resident 7's allegation against CNA 5 and the DSD immediately interviewed CNA 5 who stated, Resident 7 refused to be shaved because he wanted to go to the patio for a smoke break. The DSD stated he did not suspect abuse at the time and believed the incident to be a misunderstanding. The DSD stated shaving should not be an unpleasant experience and should be tailored to the residents' comfort. During an interview on 8/6/2025 at 9:09 a.m., SS 1 stated that on 7/22/2025, Resident 7 approached her in the hallway and informed her that CNA 5 was rough with him when CNA 5 shaved him. SS 1 stated she informed the DSD of the allegation but did not inform the Director of Nursing (DON) nor the Administrator (ADM). SS 1 stated any kind of roughness can be seen as a type of abuse due to shaving's physical nature of using a razor, using their hands to apply the shaving cream, and positioning the resident. SS 1 stated as a mandated reporter (an individual who is legally required to report suspected cases of abuse or neglect to the appropriate authorities), Resident 7's allegation should have been reported to the DON and the ADM and to CDPH, the ombudsman, and law enforcement. During an interview on 8/6/2025 at 10:40 a.m., the DSD stated even though he interviewed CNA 5, who stated the allegation was a misunderstanding, Resident 7's allegation should not have been discredited and should have been reported to the DON, the ADM, CDPH, the ombudsman, and law enforcement to allow investigations to be initiated. The DSD stated he did not implement his In-Service Lesson Plan into his own practice. The DSD stated an investigation was initiated and the allegation was found to be untrue. The DSD stated prior to an investigation, all abuse allegations should be reported to ensure a separate investigation from CDPH was done. During an interview on 8/6/2025 at 12:04 p.m., with the DON, the DON stated she was not made aware of Resident 7's allegation, on 7/22/2025, until 8/5/2025. The DON stated when SS 1

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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. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This is a Repeat Deficiency at F610 from 6/24/2025 investigation. Based on interview and record review, the facility failed to thoroughly investigate an allegation of abuse for one of seven sampled residents (Resident 7), when Resident 7 informed Social Services (SS) 1, on 7/22/2025, that Certified Nursing Assistant (CNA) 5 was rough during facial shaving. This deficient practice resulted in CNA 5 not being suspended pending the investigation of the allegation and placed Resident 7 and all the residents in the facility at risk for further potential abuse.Cross Reference F609Findings:During a review of Resident 7's admission Record (Face Sheet), the admission Record indicated Resident 7 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including encephalopathy (a medical condition where the brain does not function properly), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and anxiety disorder (mental health condition characterized by excessive and persistent worry, fear, and nervousness about everyday situations).During a review of Resident 7's Minimum Data Set (MDS- a resident assessment tool), dated 7/25/2025, the MDS indicated Resident 7 had moderately impaired cognitive skills (problems with ability to remember, think, and use judgement) for daily decision making. The MDS indicated Resident 7 required supervision with eating, oral hygiene, and personal hygiene. During a review of the facility's Performance Improvement Plan - Abuse Investigation and Reporting dated 7/1/2025, the plan indicated the root cause was communication when an incident happened. The improvement plan indicated the goal was for staff to inform the Administrator and the DON promptly about any incidents, report any abuse allegations immediately to the three government agencies. The improvement plan indicated any grievances would be reported during the daily stand-up meeting for review and would be investigated and reported promptly. The improvement plan indicated to monitor this goal daily and monthly, to track and trend the grievances for possible abuse allegations, and to review the grievance reports. During a concurrent interview and record review on 8/6/2025 at 8:52 a.m., with the Director of Staff Development (DSD), Resident 7's Grievance / Complaint Report Form, dated 7/22/2025 was reviewed. The Grievance Form indicated that on 7/22/2025, Resident 7 reported to SS 1 that CNA 5 was slightly rough when trying to shave him. The DSD stated that on 7/22/2025, SS 1 notified him (SSD) of Resident 7's allegation against CNA 5 and the DSD immediately interviewed CNA 5 who stated, Resident 7 refused to be shaved because he wanted to go to the patio for a smoke break. The DSD stated he did not suspect abuse at the time and believed the incident to be a misunderstanding. The DSD stated shaving should not be an unpleasant experience and should be tailored to the residents' comfort. During an interview on 8/6/2025 at 9:09 a.m., SS 1 stated, on 7/22/2025, Resident 7 approached her in the hallway and informed her that CNA 5 was rough with him when CNA 5 shaved him. SS 1 stated she informed the DSD of the allegation but did not inform the Director of Nursing (DON) nor the Administrator (ADM). SS 1 stated any kind of roughness can be seen as a type of abuse due to shaving's physical nature of using a razor, using their hands to apply the shaving cream, and positioning the resident. SS 1 stated as a mandated reporter (an individual who is legally required to report suspected cases of abuse or neglect to the appropriate authorities), Resident 7's allegation should have been reported to the DON and the ADM for a thorough investigation to occur.During an interview on 8/6/2025 at 10:40 a.m., the DSD stated even though he interviewed CNA 5, who stated the allegation was a misunderstanding, Resident 7's allegation should not have been discredited and should have been reported to the DON and the ADM to allow investigations to be initiated. The DSD stated an investigation was initiated but should have been more thorough where other staff members and residents were interviewed, to determine if others were potentially affected by CNA 5. The DSD stated he did not implement his In-Service Lesson Plan into his own practice. The DSD stated that on 7/22/2025, CNA 5 was in-serviced on the proper way of shaving but was not suspended pending an investigation of Resident 7's allegation. The DSD stated CNA 5 should have been suspended on 7/22/2025 to ensure Resident 7's and all the residents' safety. During an interview on 8/6/2025 at 12:04 p.m., the DON stated she was not made aware of Resident 7's allegation, on 7/22/2025, until 8/5/2025. The DON stated when SS 1 and DSD were made aware of Resident 7's allegation, the allegation should have been immediately reported to her and the ADM to initiate a thorough investigation. The DON stated on 7/22/2025, CNA 5 should have been suspended while the investigation was ongoing. The DON stated other residents should have been interviewed to determine if there were other allegations of rough shaving. The DON stated allowing CNA 5 to continue to

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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 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. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of seven sampled resident (Resident 4's) care plan was reviewed and revised with updated interventions to address Resident 4's behavior of pocketing medications. This deficient practice resulted in Resident 4 having medication in his possession without staff knowledge and an increased risk for adverse medication reactions. Cross Reference F755.Findings:During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including paranoid schizophrenia (a subtype of schizophrenia with prominent delusions and hallucinations often involving false beliefs of being watched or targeted), and anxiety disorder (feeling of fear, dread and uneasiness that can be a normal reaction to stress). During a review of Resident 4's care plan titled, Behavior Problem, revised 6/13/2025, the care plan indicated Resident 4 had a behavior problem related to spitting medications and the interventions indicated to administer medications as ordered. Further review of the care plan indicated there were no specific interventions on how to properly administer Resident 4's medications. During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 6/30/2025, the MDS indicated Resident 4 had moderately impaired cognition (problems with memory, thinking, and using judgement), had hallucinations (perceptual experiences in the absence of real external sensory stimuli), and delusions (misconceptions or beliefs that are firmly held, contrary to reality). The MDS indicated Resident 4 required moderate assistance (helper does less than half the effort) with toileting, bathing, and dressing. The MDS indicated Resident 4 received antipsychotic medication (a class of medicines used to treat severe mental disorders and behaviors in which thought, and emotions are so impaired that contact is lost with external reality). During a review of the Physician's Order Summary Report dated 6/24/2025, the Summary Report indicated Resident 4 to receive Klonopin (medication used to treat anxiety) 0.5 milligrams (mg, a unit of measurement), once a day, for anxiety manifested by constant yelling and verbal aggression. The Order Summary Report indicated Resident 4 to receive Risperdal 4 mg, twice a day for paranoid schizophrenia manifested by delusions, disorganized or incoherent speaking, and unusual movement and pacing.During a review of Resident 4's Medication Administration Record (MAR) dated 8/5/2025, the MAR indicated Resident 4's Klonopin and Risperdal were administered at 8 a.m. During a concurrent observation and interview on 8/5/2025 at 2:40 p.m. with Resident 4 in the hallway, Resident 4 approached the State Surveyor and revealed a green pill pressed with zc78 and a yellow pill pressed with 0. 5 in his hand. Resident 4 stated not to tell any of the nurses. Resident 4 stated that on an unknown date, the medications fell to the floor, and he kept them. During a concurrent observation and interview on 8/5/2025 at 3:24 p.m. with Licensed Vocational Nurse (LVN) 3 at LVN 3's medication cart, LVN 3 was approached by the State Surveyor and was handed the green pill pressed with zc78 and a yellow pill pressed with 0.5 received from Resident 4. LVN 3 compared the yellow pill to Resident 4's Klonopin bubble pack (a type of packaging where small items are held in a plastic bubble or dome, which is then sealed to a cardboard backing) and the green pill to Resident 4's Risperdal bubble pack. LVN 3 stated the medications matched Resident 4's prescribed Klonopin and Risperdal. LVN 3 stated Resident 4 had the tendency to pocket medication (placing medication between the cheek and gums of the mouth rather than swallowing) when administered medication. LVN 3 stated since Resident 4 had a dose of Klonopin and Risperdal in his pocket, Resident 4 did not receive the full dose of his medications. During an interview on 8/5/2025 at 3:41 p.m., when asked about Resident 4's Behavior Problem Care Plan, LVN 3 stated the care plan did not have specific interventions on how to properly administer Resident 4's medications. LVN 3 stated the interventions should have indicated to prepare all medications and supplies, observe Resident 4 take all medications into his mouth, drink water, have Resident 4 open his mouth to check underneath his tongue and cheeks, and check Resident 4's hands and pockets. LVN 3 stated care plans were a communication tool to all staff regarding Resident 4's behaviors and instruction on how to properly care for him. During an interview on 8/6/2025 at 11:53 a.m., the Director of Nursing (DON) stated Resident 4's care plans were a tool to communicate actual or potential problems and to refer to how to properly care for him. The DON stated Resident 4's care plan should have been revised to indicate personalized interventions such as observing Resident 4 swallow all his medications, to open his mouth to check for pocketing, and to check his hands and surrounding areas for any medications that could have been spit out. The DON stated by not including personalized interventions

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were administered to meet the needs of each resident and in accordance with professional standards of practice for one of seven sampled residents (Resident 4). Resident 4 was observed with two medications in hand, without staff knowledge. This deficient practice resulted in Resident 4 not receiving the correct dose of medication, and the potential for other residents to receive medications not prescribed to them.Cross Reference F657Findings:During a review of Resident 4's admission Record, the admission record indicated Resident 4 was readmitted to the facility on [DATE] with diagnoses including paranoid schizophrenia (a subtype of schizophrenia with prominent delusions and hallucinations often involving false beliefs of being watched or targeted) and anxiety disorder (feeling of fear, dread and uneasiness that can be a normal reaction to stress). During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 6/30/2025, the MDS indicated Resident 4 had moderately impaired cognition (problems with memory, thinking, and using judgement), had hallucinations (perceptual experiences in the absence of real external sensory stimuli), and delusions (misconceptions or beliefs that are firmly held, contrary to reality). The MDS indicated Resident 4 required moderate assistance (helper does less than half the effort) with toileting, bathing, and dressing. The MDS indicated Resident 4 received antipsychotic medication (a class of medicines used to treat severe mental disorders and behaviors in which thought, and emotions are so impaired that contact is lost with external reality).During a review of the Physician's Order Summary Report dated 6/24/2025, the Summary Report indicated Resident 4 to receive Klonopin (medication used to treat anxiety) 0.5 milligrams (mg, a unit of measurement), once a day, for anxiety manifested by constant yelling and verbal aggression. The Order Summary Report indicated Resident 4 to receive Risperdal 4 mg, twice a day for paranoid schizophrenia manifested by delusions, disorganized or incoherent speaking, and unusual movement and pacing.During a review of Resident 4's Medication Administration Record (MAR) dated 8/5/2025, the MAR indicated Resident 4's Klonopin and Risperdal were administered at 8 a.m. During a concurrent observation and interview on 8/5/2025 at 2:40 p.m. with Resident 4 in the hallway, Resident 4 approached the State Surveyor and revealed a green pill pressed with zc78 and a yellow pill pressed with 0. 5 in his hand. Resident 4 stated not to tell any of the nurses. Resident 4 stated that on an unknown date, the medications fell to the floor, and he kept them. During a concurrent observation and interview on 8/5/2025 at 3:24 p.m. with Licensed Vocational Nurse (LVN) 3 at LVN 3's medication cart, LVN 3 was approached by the State Surveyor and was handed the green pill pressed with zc78 and a yellow pill pressed with 0.5 received from Resident 4. LVN 3 compared the yellow pill to Resident 4's Klonopin bubble pack (a type of packaging where small items are held in a plastic bubble or dome, which is then sealed to a cardboard backing) and the green pill to Resident 4's Risperdal bubble pack. LVN 3 stated the medications matched Resident 4's prescribed Klonopin and Risperdal. LVN 3 stated Resident 4 had the tendency to pocket medication (placing medication between the cheek and gums of the mouth rather than swallowing) when administered medication. LVN 3 stated since Resident 4 had a dose of Klonopin and Risperdal in his pocket, Resident 4 did not receive the full dose of his medications. During an interview on 8/6/2025 at 11:47 a.m., the Director of Nursing (DON) stated the licensed nurses administering medications were responsible for observing Resident 4 swallow each pill before moving on to the next resident. The DON stated ensuring Resident 4 swallowed his medications ensured Resident 4 took the ordered dose. The DON stated taking the full dose was essential to treat the specific behaviors Resident 4 exhibited. The DON stated because Resident 4 had a dose of Klonopin and Risperdal in his pocket, not only was Resident 4 at risk of taking an additional dose on another day, but other residents were also at risk. The DON stated Resident 4 could have given the Klonopin and Risperdal to another resident and they could be at risk of adverse reactions and interactions with their medications. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, revised 4/2019, the P&P indicated Medications are administered in a safe and timely manner, and as prescribed.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) Committee / Quality Assessment and Assurance (QAA) implemented action plans to correct previously identified abuse allegation deficiencies from June 2025. This repeat deficient practice caused an increased risk in the safety and dignity of the residents of the facility. Findings: During a review of the facility's Plan of Correction from a previous abuse deficiency dated June 2025 and the In-Service Training titled, Reporting Alleged Violations, dated 6/25 and 6/26/2025, presented by the Director of Staff Development (DSD), the In-Service indicated the Director of Nursing (DON), the Administrator (ADM), Certified Nursing Aide (CNA) 3, and CNA 4 were all educated to report any abuse allegations immediately and for up to two hours to the CDPH, the ombudsman, and law enforcement. During a review of the facility's Performance Improvement Plan - Abuse Investigation and Reporting dated 7/1/2025, the plan indicated the root cause was communication when an incident happened. The improvement plan indicated the goal was for staff to inform the ADM and the DON promptly about any incidents and report any abuse allegations immediately to the three government agencies. The improvement plan indicated any resident grievances would be reported during the daily stand-up meeting for review and would be investigated and reported promptly. The improvement plan indicated to monitor this goal daily and monthly, to track and trend the grievances for possible abuse allegations, and to review the grievance reports. During a concurrent interview and record review on 8/6/2025 at 8:52 a.m., with the DSD, Resident 7's Grievance / Complaint Report Form, dated 7/22/2025 was reviewed. The Grievance Form indicated that on 7/22/2025, Resident 7 reported to Social Services (SS) 1 that CNA 5 was slightly rough when trying to shave him. The DSD stated that on 7/22/2025, SS 1 notified him (SSD) of Resident 7's allegation against CNA 5 and the DSD immediately interviewed CNA 5 who stated, Resident 7 refused to be shaved because he wanted to go to the patio for a smoke break. The DSD stated he did not suspect abuse at the time and believed the incident to be a misunderstanding. During an interview on 8/6/2025 at 12:01 p.m., the DON stated she and the ADM were not made aware of Resident 5's allegation against CNA 5 regarding being beaten and handled roughly during shaving. During an interview on 8/6/2025 at 12:04 p.m., the DON stated she was not made aware of Resident 7's allegation, on 7/22/2025, until 8/5/2025. The DON stated when SS 1 and DSD were made aware of Resident 7's allegation, the allegation should have been immediately reported to CDPH, the ombudsman, and law enforcement prior to the investigation taking place.