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	08/15/2025

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 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 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 interview and record review, the facility failed to implement the Care Plan for one out of five sampled residents (Resident 2), who had a diagnosis of schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) and exhibited increased in behaviors.This failure had the potential to result in Resident 2 having ongoing behaviors which could lead to altercations that endanger himself, other residents, and staff at the facility.During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 2's diagnoses included schizoaffective disorder.During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool), dated 7/21/2025, the MDS indicated Resident 2 had severe cognitive impairment (problems with the ability to think and reason). Resident 2's MDS indicated Resident 2 required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for Activities of Daily Living (ADLs) such as toileting and personal hygiene.During a review of Resident 2's Care Plan with a focus of Resident 2's potential for behavior problem related to diagnoses of schizoaffective disorder, bipolar type (mental health condition that involves experiencing both symptoms of psychosis (hallucinations [a perception of having seen, heard or touched something that wasn't actual there] and delusions [when a person can't tell what's real from what's imagined]) and mood episodes (such as mania and depression) manifested by mood swings from pleasant to irritable, angry outburst, delusional statements , dated 2/11/2024, the care plan indicated staff interventions included to monitor behavior episodes, document behavior and potential causes. The Care Plan interventions also indicated to notify the physician if it interferes with functioning and to intervene as necessary to protect the rights and safety of others. During a review of Resident 2's Medication Administration Record (MAR), dated 8/2025, the MAR indicated Resident 2 had two episodes of angry outbursts on 8/8/2025, 8/9/2025 and 8/10/2025 during the day shifts. The MAR indicated Resident 2 had episodes of delusional statements on the following dates during the day shifts: 2 episodes on 8/8/2025, 4 episodes on 8/9/2025, 4 episodes on 8/10/2025, 4 episodes on 8/11/25 and 4 episodes on 8/12/2025. The MAR also indicated Resident 2 had episodes of mood swings (from pleasant to irritable) on the following dates during the day shifts:3 episodes on 8/8/2025, 2 episodes on 8/9/2025, 3 episodes on 8/10/2025, 2 episodes on 8/11/2025 and 1 episode on 8/12/2025. During a review of Resident 2's SBAR ([Situation, Background, Assessment, Recommendation] a communication tool used by healthcare workers when there is a change of condition among residents) dated 8/13/2025, the SBAR indicated Resident 2 hit another resident because the resident called him (Resident 2) names. During a concurrent interview and record review on 8/15/2025 at 1:32 p.m., with Licensed Vocational Nurse (LVN) 4, Resident 2's care plan, dated 2/11/2024, MAR dated 08/2025, and progress notes dated 8/8/2025 to 8/12/2025 were reviewed. LVN 4 stated Resident 2 had increased behaviors such as episodes mood swings from 8/8/2025 to 8/12/2025 and an increase of angry outbursts from 8/9/2025 and 8/10/2025. LVN 4 stated there was no documentation to indicate what incidents occurred and what interventions were implemented to address the episodes of behaviors on 8/8/2025-8/12/2025 (prior to the resident-to-resident alteration on 8/13/2025). LVN 4 stated in addition to the number of episodes of the behavior Resident 2 exhibited, staff should have also documented the location, the behavior Resident 2 was exhibiting, and the endorsement to the following shift in the progress notes. During a concurrent interview and record review on 8/15/2025 at 2:24 p.m., with Registered Nurse (RN) 1, Resident 2's Care Plan dated 2/11/2024, and progress notes from 8/8/2025 to 8/12/2025 were reviewed. RN 1 stated if a resident exhibited behaviors, licensed nurses should document non-pharmacological (actions to treat a problem without using medication) and pharmacological (using medicine) interventions used and whether those interventions were effective. RN 1 stated this was important to prevent an incident from occurring because of a resident's increased behavior. RN 1 stated Resident 2's progress notes did not indicate what interventions were done during Resident 2's episodes of increased behaviors from 8/8/2025 to 8/12/2025.During a concurrent interview and record review on 8/15/2025 at 4:34 p.m., with the Director of Nursing (DON), Resident 2's care plan dated 2/11/2024 and progress notes dated 8/8/2025 to 8/12/2025 were reviewed. DON stated, staff should monitor and document when a resident exhibited behaviors and notify the physician if there was an increase in those behaviors. The DON also stated if the specific behaviors or incident were not documented, staff would not be able to target and