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	11/14/2025

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. (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 0580 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 inform Physician 1 and Conservator 1 of an abuse allegation for one of three sampled residents (Resident 5).This deficient practice resulted in a delay in potential medical and psychiatric evaluations and resulted in Conservator 1 being unaware of Resident 5's well-being. Findings:During a review of Resident 5's admission Record (Face Sheet), the Face Sheet indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included nontraumatic chronic subdural hemorrhage (a slow collection of blood on the surface of the brain that develops over time, without being caused by a severe head injury), schizophrenia (a mental illness that is characterized by disturbances in thought), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 5's Minimum Data Set (a resident assessment tool), dated 9/14/2025, the MDS indicated Resident 5's cognitive skills (process of thinking) for daily decision making were moderately impaired. The MDS indicated Resident 5 required supervision with oral hygiene, toileting, bathing, dressing, and personal hygiene.During a review of Resident 5's History and Physical (H&P), dated 9/9/2025, the H&P indicated Resident 5 did not have the mental capacity to understand and make decisions.During a review of Resident 5's Progress Note, dated 9/9/2025 at 10:46 p.m., authored by LVN 11, indicated on 9/9/2025, Resident 5 falsely accused a certified nursing assistant of hitting him. The Progress Note indicated that LVN 11 assessed Resident 5's arm for any bruises, scratches, and discoloration, but found none.During an interview on 9/24/2025 at 1:03 p.m., with LVN 11, LVN 11 stated, on 9/9/2025, Resident 5 refused Certified Nursing Assistant (CNA) 11's request to change him and CNA 11 requested LVN 11 to speak to Resident 5. LVN 11 stated she approached Resident 5 in the dining room to ask him when it would be a good time for the staff to change him. LVN 11 stated Resident 5 replied, I do not want to go, they hit me when they do anything. LVN 11 stated Resident 5 did not specify who they were but also complained there were scratches and bruises on his arm. LVN 11 stated she assessed Resident 5's arms and did not find any scratches or bruises. LVN 11 stated Resident 5 did not have any injury to his arms, and she went to Resident 5's room and observed CNA 11 change Resident 5's underwear and nightgown without being hit by any people in the room. LVN 11 stated she did not believe Resident 5's allegation was true. LVN 11 stated she documented the incident in Resident 5's Progress Notes but did not notify Physician 1 and Conservator 1. LVN 11 stated she determined Resident 5's allegation was not considered a change in condition due to Resident 5's behavior of fabricating stories in the past and felt his allegation was not true. During an interview on 9/25/2025 at 8:12 a.m., with the Director of Nursing (DON), the DON stated once a licensed nurse was made aware of an abuse allegation, they were responsible for notifying the resident's physician and their responsible party. The DON stated Physician 1 should have been notified of Resident 5's abuse allegation, including the fact that Resident 5 thought there were scratches and bruises on his arm. The DON stated notifying Physician 1 would have allowed Physician 1 to order for any medical or psychiatric evaluations and/or medications. The DON stated if Resident 5 were confused, a medical diagnosis such as an infection could have explained the sudden onset. The DON stated, without notifying Physician 1, the necessary evaluation and treatment were delayed. The DON stated in addition to notifying Physician 1, Conservator 1should have been notified to ensure he was aware of what was going on with Resident 1. The DON stated Conservator 1 was responsible for making any medical decisions for Resident 1 and may advocate for other assessments and/or treatments.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, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status.During a review of the facility's Performance Improvement Plan- Abuse Investigation and Reporting, initiated 7/1/2025, the Improvement Plan indicated the goal was for staff to inform the Administrator and the DON promptly about any incidents and report any abuse allegations immediately to the three government agencies. The Improvement Plan indicated the licensed nurse would initiate the Situation, Background, Assessment, Recommendation (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents) and notify the primary physician and the resident and/or their responsible party.

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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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an abuse allegation 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 5).This deficient practice resulted in a delayed notification to CDPH, the ombudsman, and law enforcement and also resulted in a delay of an onsite inspection This deficient practice had the potential to result in potential abuse to all residents in the facility.Findings:During a review of Resident 5's admission Record (Face Sheet), the Face Sheet indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included nontraumatic chronic subdural hemorrhage (a slow collection of blood on the surface of the brain that develops over time, without being caused by a severe head injury), schizophrenia (a mental illness that is characterized by disturbances in thought), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 5's Minimum Data Set (a resident assessment tool), dated 9/14/2025, the MDS indicated Resident 5's cognitive skills (process of thinking) for daily decision making were moderately impaired. The MDS indicated Resident 5 required supervision with oral hygiene, toileting, bathing, dressing, and personal hygiene.During a review of Resident 5's History and Physical (H&P), dated 9/9/2025, the H&P indicated Resident 5 did not have the mental capacity to understand and make decisions.During a review of Resident 5's Progress Note, dated 9/9/2025 at 10:46 p.m., authored by LVN 11, indicated on 9/9/2025, Resident 5 falsely accused a certified nursing assistant of hitting him. The Progress Note indicated that LVN 11 assessed Resident 5's arm for any bruises, scratches, and discoloration, but found none.During a review of the facility's In-Service Training titled, Abuse Reporting/Investigation/Prevent/Correct Alleged and Management of Residents with Behaviors, dated 8/16/2025, presented by the Quality Assurance (QA) Nurse, the In-Service indicated LVN 11 received training to report any abuse allegations immediately and up to two hours to the CDPH, the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities), and local law enforcement. During an interview on 9/24/2025 at 1:03 p. m., with LVN 11, LVN 11 stated, on 9/9/2025, Resident 5 refused Certified Nursing Assistant (CNA) 11's request to change him and CNA 11 requested LVN 11 to speak to Resident 5. LVN 11 stated she approached Resident 5 in the dining room to ask him when it would be a good time for the staff to change him. LVN 11 stated Resident 5 replied, I do not want to go, they hit me when they do anything. LVN 11 stated Resident 5 did not specify who they were but also complained there were scratches and bruises on his arm. LVN 11 stated she assessed Resident 5's arms and did not find any scratches or bruises. LVN 11 stated the facility's policy indicated any abuse allegations had to be reported to the Administrator (ADM), who was the abuse coordinator, State Agency, the ombudsman, and local law enforcement within two hours. LVN 11 stated she did not report Resident 5's abuse allegation because he did not have any injury to his arms. LVN 11 stated she went to Resident 5's room and observed CNA 11 change the resident's underwear and nightgown without being hit. LVN 11 stated she did not believe Resident 5's allegation was true.During an interview on 9/24/2025 at 2:46 p.m., with the Director of Staff Development (DSD), the DSD stated LVN 11 was in-serviced on reporting all abuse allegations to the ADM, CDPH, the ombudsman, and law enforcement to ensure a proper investigation was initiated. The DSD stated all abuse allegations had to be reported regardless of if the individual does not believe the allegation to be true.During an interview on 9/25/2025 at 8:05 a.m., with the Director of Nursing (DON), the DON stated she was unaware of Resident 5's abuse allegation on 9/9/2025. The DON stated per the facility's policy and recent in-services, LVN 11 should have reported the abuse allegation to the ADM who would then initiate an investigation. The DON stated Resident 5 did not specify who hit him, therefore, the alleged perpetrator could have been a staff member or another resident. The DON stated Resident 5's abuse allegation did not have many specifics and without the proper reporting and investigation, Resident 5 and other residents were at risk for further abuse.During an interview on 9/25/2025 at 8:58 a.m., with the ADM, the ADM stated he was the abuse coordinator in the facility, and he was responsible for investigating all abuse allegations brought to his attention. The ADM stated all staff members were responsible for notifying him of all abuse allegations and were instructed to notify CDPH, the ombudsman, and law enforcement to ensure all reports were completed within the two-hour window. The ADM stated once Resident 5 informed LVN 11 of being hit, LVN 11 had the responsibility of reporting, not

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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. (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 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 develop a person-centered care plan for one of three sampled residents' (Resident 5) after Resident 5 informed Licensed Vocational Nurse (LVN) 11 of an abuse allegation.This deficient practice had the potential to negatively affect Resident 5's physical, mental, and psychosocial well-being, delay the delivery of necessary care and services.Findings:During a review of Resident 5's admission Record (Face Sheet), the Face Sheet indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included nontraumatic chronic subdural hemorrhage (a slow collection of blood on the surface of the brain that develops over time, without being caused by a severe head injury), schizophrenia (a mental illness that is characterized by disturbances in thought), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 5's Minimum Data Set (a resident assessment tool), dated 9/14/2025, the MDS indicated Resident 5's cognitive skills (process of thinking) for daily decision making were moderately impaired. The MDS indicated Resident 5 required supervision with oral hygiene, toileting, bathing, dressing, and personal hygiene.During a review of Resident 5's History and Physical (H&P), dated 9/9/2025, the H&P indicated Resident 5 did not have the mental capacity to understand and make decisions.During a review of Resident 5's Progress Note, dated 9/9/2025 at 10:46 p.m., authored by LVN 11, indicated on 9/9/2025, Resident 5 falsely accused a certified nursing assistant of hitting him. The Progress Note indicated that LVN 11 assessed Resident 5's arm for any bruises, scratches, and discoloration, but found none.During a review of Resident 5's Care Plans, dated 4/17/2025 through 9/11/2025, the Care Plans did not indicated there was a Care Plan that addressed Resident 5's abuse allegation on 9/9/2025.During an interview on 9/24/2025 at 1:03 p.m., with LVN 11, LVN 11 stated, on 9/9/2025, Resident 5 refused Certified Nursing Assistant (CNA) 11's request to change him and CNA 11 requested LVN 11 to speak to Resident 5. LVN 11 stated she approached Resident 5 in the dining room to ask him when it would be a good time for the staff to change him. LVN 11 stated Resident 5 replied, I do not want to go, they hit me when they do anything. LVN 11 stated Resident 5 did not specify who they were but also complained there were scratches and bruises on his arm. LVN 11 stated she assessed Resident 5's arms and did not find any scratches or bruises. LVN 11 stated Resident 5 did not have any injury to his arms, and she went to Resident 5's room and observed CNA 11 change Resident 5's underwear and nightgown without being hit by any people in the room. LVN 11 stated she did not believe Resident 5's allegation was true. LVN 11 stated she documented the incident in Resident 5's Progress Notes. LVN 11 stated she did not develop or update Resident 5's care plan because she determined Resident 5's allegation was not considered a change in condition due to Resident 5's behavior of fabricating stories in the past and felt his allegation was not true.During an interview on 9/25/2025 at 8:29 a.m., with the Director of Nursing (DON), the DON stated care plans were used as a guideline on how to care for each individual resident and provided an appropriate approach to each problem. The DON stated care plans were used as a communication tool to inform all staff assigned to the residents of the problems, the goals, and the interventions to be done. The DON stated after an abuse allegation was made, the licensed nurse was responsible for developing a care plan that addressed the allegation and to include immediate interventions implemented and other pertinent interventions for the continuation of care. The DON stated Resident 5 did not have a care plan developed after informing LVN 11 of his abuse allegation on 9/9/2025. The DON stated there were no guidelines on how to approach Resident 5's situation. The DON without the necessary care plan addressing Resident 5's abuse allegation, Resident 5 was at risk for a delay in delivery of necessary care and services and was at risk for further potential abuse.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 care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.