

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER Colonial Gardens Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a safe, home-like environment for one of three sampled residents (Resident 2) by failing to replace the broken window in Resident 2's room in a timely manner. This failure had the potential to result in Resident 2 feeling uncomfortable due to cold air coming inside the window and negatively affecting Resident 2's well-being. Findings: During an observation on 11/18/2025 at 8:40 a.m. in Resident 2's room, Resident 2's window was observed with a wooden panel and an opening or gap in the upper half of the window. Cold air was felt coming inside the room through the opening. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 2's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness of one entire side of the body), Atrial fibrillation (irregular and often very rapid heart rhythm) and schizoaffective disorder (a mental illness that can affect thoughts, mood and behavior). During a review of Resident 2's History and Physical (H&P) dated 10/25/2025, the H&P indicated Resident 2 had the capacity to express needs but was unable to make medical decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 10/29/2025, the MDS indicated Resident 2 had severe cognitive (ability to think and reason) impairment. The MDS indicated Resident 2 was dependent on staff with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer and mobility. During an interview on 11/18/2025 at 8:57 a.m., with the Maintenance Supervisor (MS), the MS stated Maintenance rounds were done to the facility rooms every day to check for things that needed to be fixed. The MS stated the window in Resident 2's room was broken on 11/14/2025 (4 days prior). The MS stated that the Maintenance assistant (MA) removed the frame from the window and covered the window with a piece of wood. The MS stated the window frame was ready to be installed on 11/14/2025 and the MA should have put the window frame on 11/14/2025 or 11/15/2025. The MS stated he did not know why the window had not been installed. The MS stated it was the facility's responsibility to keep the facility in working order for residents' safety and provide a home-like environment. The MS also stated there was cold air coming inside Resident 2's room which placed the resident at risk of feeling cold. During an interview on 11/18/2025 at 9:45 a.m., with MA, the MA stated the window frame of Resident 2's room was ready on 11/14/2025 and he had a plan to install it on 11/17/2025 but was not done because he was busy with other tasks (unspecified). The MA also stated Maintenance staff were onsite at the facility on the weekends in emergency cases, and Resident 2's window could have been done on the weekend. The MA stated the facility was Resident 2's home and should be in working conditions for resident 2's safety. The MA stated the window should have been repaired as soon as it was ready to protect Resident 2 from getting cold. During an interview on 11/18/2025 at 12:54 p.m., with the Director of Nursing (DON), the DON stated the piece of wood on Resident 2's window was for temporary protection until the Maintenance could install a new window for the resident. The DON stated changing the window frame as soon as it was received, was considered a priority, and it needed to be fixed right away for the Residents' safety. The DON also stated cold air could come inside Resident 2's room through the gap and could make the resident feel uncomfortable. The DON stated the MA should have replaced Resident 2's window as soon as it was ready, regardless of the weekend. The DON stated the facility was residents' homes and should be kept clean, safe and in working conditions for the residents. During a review of the facility's Policies and Procedures (P&P) titled, Maintenance Services dated 2001, the P&P indicated the maintenance department is responsible for always maintaining the building grounds and equipment in a safe and operable manner. The P&P indicated functions of maintenance personnel included maintaining the building is in good repair, free from hazards and establishing priorities in providing repair services. During a review of the facility's P&P titled, Homelike Environment dated 2001, the P&P indicated Residents are provided with a safe, clean, comfortable and homelike environment.</p>		