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	12/04/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (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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F 0726 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 ensure Certified Nurse Assistant (CNA 1) had the competencies and skill sets necessary to immediately provide Basic Life Support ([BLS] medical care for residents experiencing cardiac arrest [when the heart stops beating] or respiratory distress [difficulty in breathing]) for one of three sampled residents (Resident 3), who had a full code status (when a medical personnel does everything possible to save a person's life in a medical emergency), was observed unresponsive in bed. This deficient practice had the potential for delayed provision of BLS for Resident 3 and other residents at risk of not receiving timely life saving measures. Findings:During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 3's diagnoses included hypertension (high blood pressure) and heart failure (heart cannot pump enough blood and oxygen to meet the body's needs).During a review of Resident 3's History and Physical (H&P) dated [DATE], H&P indicated Resident 3 had the capacity to make medical decisions and was a full code status (when medical personnel does everything possible to save a person's life in a medical emergency). During a review of Resident 3's Minimum Data Set ([MDS] a resident assessment tool) dated [DATE], the MDS indicated Resident 3 usually understood and was understood by others. The MDS indicated Resident 3 required supervision for eating, and upper dressing. The MDS indicated Resident 3 was dependent (helper does all the effort Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) for eating, oral hygiene and toileting hygiene. During a review of Resident 3's Progress Note dated [DATE] at 4:40 a.m., the Note indicated CNA 1 was checking on Resident 3's diaper and found Resident 3 unresponsive. The Notes indicated CNA 1 called Registered Nurse (RN 1) and RN 1 immediately assessed Resident 3 who was unresponsive, not breathing and pulseless. The Notes indicated RN 1 initiated Cardiopulmonary Resuscitation ([CPR] - an emergency procedure to restart a person's heart a person's heart and breathing after one or both suddenly stop. The note indicated the paramedics arrived at the facility at 4:10 a.m., after 911 was called and Resident 3 expired at 4:39 a.m. During a phone interview on [DATE] at 11:37 a.m., with CNA 1, CNA 1 stated on [DATE] at around 4:00 a.m., he went to Resident 3's room and noticed Resident 3 was not moving and walked out of the room to inform RN 1. CNA 1 stated RN 1 ran to the room and started CPR on Resident 1, while a Licensed Vocational Nurse (LVN) called 911, because RN 1 was shouting [from the room] to call 911. CNA 1 stated he had BLS training two months prior and during his BLS training, he was taught to initiate CPR as soon as he found someone unresponsive. CNA 1 stated, he left Resident 1 and did not check for Resident 1's pulse and breathing nor start CPR because at the facility, he was supposed to call the licensed nurse first. CNA 1 was unable to verbalize the process prior to initiating CPR. During a phone interview on [DATE] at 11:53 a.m., with RN 1, RN 1 stated on [DATE] at around 4:00 a.m., CNA 1 walked to the nurses' station 1 to notify her that Resident 3 was not responsive. RN 1 stated, she ran to Resident 3's room with an RN in training to assess Resident 3. RN 1 stated she found Resident 3 unresponsive, not breathing and without a pulse. RN 1 stated she initiated CPR immediately and yelled to call 911 as the RN in training was assisting her. RN stated all patient care personnel such as CNAs, LVNs and RNs were trained to provide BLS, and should immediately check for alertness, breathing, pulse and initiate CPR. RN 1 stated CNA 1 should not have left Resident 1 and started CPR immediately. During a review of the facility's Policies and Procedures (P&P) titled, Emergency Procedure-Cardiopulmonary Resuscitation and Basic Life Support dated 2021, the P&P indicated personnel have completed training on the initiation of CPR and BLS, including defibrillation, for victims of sudden cardiac arrest. The P&P indicated if an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally, staff members who are trained in CPR/BLS shall initiate CPR. The P&P indicated staff are trained to follow current America Heart Association (AHA) Guidelines and recommendations for the sequence of resuscitation, including, recognition of cardiac arrest, initiation of resuscitation and opening the airway.