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	12/30/2025

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a care plan addressing a resident's diagnosis of sleep apnea (blocked airways) and use of a Bilevel Positive Airway Pressure ([BiPAP] a breathing therapy used to help a person with breathing difficulties) for one out of three sampled residents (Resident 2). These deficient practices had the potential to place Resident 2 at risk for device related injury, respiratory distress, and not receiving the necessary care and services. Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension (HTN- high blood pressure). During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 11/7/2025, the MDS indicated Resident 2's cognition (ability to think and process information) was intact. The MDS indicated Resident 2 required moderate (helper does less than half the effort) assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 2's Order Summary Report, dated 12/30/2025, the order summary report indicated on 11/21/2025, Resident 2's attending physician prescribed the use of a BiPAP machine at bedtime for treatment of sleep apnea. During a concurrent observation and interview on 12/30/2025 at 8:00 a.m., in Resident 2's room, observed Resident 2's BiPAP machine on the nightstand next to the resident's bed. Resident 2 stated he used the BiPAP machine every night for sleep apnea. During a concurrent interview and record review on 12/30/2025 at 11:15 a.m., with the Assistant Director of Nursing (ADON), Resident 2's clinical health records including the document titled Psychiatric Evaluation and Mental Status Examination, dated 11/21/2025, Order Summary Report dated 12/30/2025, and the resident's active care plans, were reviewed. Resident 2's psychiatric evaluation included a diagnosis of sleep apnea. The order summary report indicated an active physician order dated 11/21/2025, for the use of the BiPAP machine nightly at bedtime to treat the resident's sleep apnea. Upon review of Resident 2's care plans, the ADON stated there was no care plan created or initiated to address Resident 2's sleep apnea. The ADON stated there was no care plan initiated for Resident 2's use of BiPAP. The ADON stated care planning serves as a communication tool among staff to ensure consistent implementation of goals and interventions, including monitoring of BiPAP use, resident education, and evaluation of tolerance. The ADON stated that without a care plan the staff would not know how to provide necessary care and services. The ADON stated this had the potential to place Resident 2 at risk for inconsistent use of the BiPAP machine and related complications, such as respiratory distress or injuries. During a review of the facility's policy and procedures (P&P) titled Care Plans, Comprehensive Person-Centered, revised 3/2022, the P&P indicated the facility would develop and implement a comprehensive person-centered care plan which includes measurable objectives and timelines to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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
	555715	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Gardens Nursing Home	7246 S. Rosemead Blvd. Pico Rivera, CA 90660

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the safe storage of medications for one of three sampled residents (Resident 2). This deficient practice had the potential to place Resident 2 at risk for unsafe medication administration, misuse of medications and overdose. Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension (HTN- high blood pressure). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 11/7/2025, the MDS indicated Resident 2's cognition (ability to think and process information) was intact. The MDS indicated Resident 2 required moderate (helper does less than half the effort) assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent observation and interview on 12/30/2025 at 8:00 a.m., in Resident 2's room, with Resident 2, observed four prescription medications inside the nightstand next to Resident 2's bed, within reach and not secured. The medication bottles were not labeled for self-administration and were not stored in a locked medication card or secured drawer. Resident 2 stated, I take the medications every day whenever I want. The medication bottles included the following:a. Atorvastatin (medication used to lower high cholesterol) 40 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount), one tablet daily.b. Torsemide (medication used to treat fluid retention) 20 mg, two tablets daily c. Fenofibrate (medication used to treat high cholesterol)160 mg, 1 tablet daily.d. Lisinopril (medication used to treat high blood pressure) 2.5 mg, one tablet daily. During interview on 12/30/2025 at 1:20 p.m., with the Assistant Director of Nursing (ADON), the ADON stated the facility did not permit residents to keep medications at their bedside. The ADON stated the facility did not allow self-administration of medications unless there was a completed self-administration assessment, and a documented physician order. The ADON stated Resident 2 was assessed for self-administration of medication and was determined as not appropriate to self-administer medications. The ADON stated residents were not supposed to have medications in their rooms or take them on their own. The ADON stated that was not part of the facility policy or standard practice. The ADON stated the presence of multiple medications at Resident 2's bedside, and the resident's unsupervised administration, was unacceptable, unsafe, and should have been addressed by the nursing staff. The ADON stated unsecured access to antihypertensive and diuretics, such as lisinopril, and torsemide, placed Resident 2's at risk for overdose, dangerous drops in blood pressure or dehydration, adverse medications interactions or complications. During a review of the facility's policy and procedure (P&P) titled Medication Labeling and Storage, revised 2023, the P&P indicated the facility would store all medications and biologicals in locked compartments. The P&P indicated only authorized personnel would have access to keys. During a review of the facility's P&P titled Administering Medications', revised 4/2019, the P&P indicated medications would be administered in a safe and timely manner. The P&P indicated only persons licensed or permitted by the state to prepare, administer and document the administering of medications.