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	02/18/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five residents (Resident 1), received treatment and care in accordance with professional standards of practice. The facility failed to: 1). Ensure Resident 1's Medical Doctor (MD) was notified of the resident's refusal to eat breakfast and lunch, during the resident's change of condition (COC) on 12/18/2025.2). Carry out (follow) MD's urinalysis ([UA] a common diagnostic test that examines the urine to detect disorders) order on 12/18/2025.3). Monitor Resident 1 for dehydration (having lost a large amount of water from the body [dizziness on sitting/standing, change in mental status, decreased urine output, concentrated urine, poor skin turgor, dry, cracked lips, dry mucous membranes, sunken eyes, constipation, fever, infection, electrolyte imbalance]) as indicated in the resident's care plan titled, Resident has decreased or unable to eat/drink adequate amounts of food or fluid intake related to (r/t) resident refusing breakfast and lunch. Resident allowing food to fall out of mouth.4). Notify Resident 1's MD when there was a delay in transferring to a General Acute Care Hospital (GACH) on 12/22/2025. These failures had the potential to affect the care and services Resident 1 needs and the potential to delay care, resulting in complications and hospitalization.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 1's diagnoses included Metabolic Encephalopathy (a change in how the brain works due to an underlying condition) and dysphagia (difficulty swallowing), oropharyngeal phase (the second stage of swallowing, where food or liquid is moved from the back of the mouth, through the throat, and into the esophagus [a muscular tube in the chest that connects the throat to the stomach] while closing off the airway to prevent choking). During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool) dated 12/23/2025, the MDS indicated Resident 1 had severe (extreme) cognitive impairment (problems with the ability to think, remember, and solve problems). The MDS indicated Resident 1 was dependent (helper does all the effort) with Activities of Daily Living (ADLs) such as toileting and personal hygiene. The MDS indicated Resident 1 was dependent with staff in rolling from a lying on back position to her left and right side, from sitting to lying position, lying to sitting on side of bed and sitting to standing position. During a review of Resident 1's clinical records, the following were identified: 1). On 12/18/2025, Resident 1 had a Change of Condition (COC), indicating Resident 1 was not eating breakfast and lunch, and was allowing food to fall out of mouth. The COC indicated, a family member (FM 1) stated, This was a pattern when Resident 1 gets urinary tract infection, and requested a UA to be done. The COC indicated Resident 1's urine was yellow and had no foul odor. Resident 1's MD ordered UA. The COC did not indicate that MD was informed of Resident 1's refusal to eat breakfast and lunch and food falling out of the resident's mouth. During a review of Resident 1's Progress Notes dated 12/18/2025, the progress notes did not indicate Resident 1's MD was informed of Resident 1's refusal to eat breakfast and lunch and food falling out of the (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: 555715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2026

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's mouth. 2). On 12/18/2025, Resident 1's care plan titled, Resident has decreased or unable to eat/drink adequate amounts of food or liquid intake r/t Resident refusing breakfast and lunch. Resident allowing food to fall out of mouth, was created. One of the interventions indicated to assess the resident for dehydration.During a review of Resident 1's clinical records from 12/18/2025, the clinical records had no indication Resident 1 was monitored for dehydration. 3). During a review of Resident 1's progress notes dated 12/19/2025 at 1:48 p.m., the progress notes indicated a urine specimen was collected from Resident 1.During a review of Resident 1's lab reports, dated 12/22/2025, the lab report did not indicate a UA result. 4). On 12/22/2025 at 1:45 p.m., Resident 1 had a COC indicating Resident 1 had poor meal intake and was pocketing food and had abnormal lab results (unspecified). Resident 1's MD ordered to transfer Resident 1 to GACH for evaluation. During a review of Resident 1's progress notes, dated 12/22/2025 at 2:07 p.m., the progress notes indicated GACH had no available bed. At 6:08 p.m., the progress notes indicated the GACH emergency department (ED) notified the facility that GACH could not take (admit) Resident 1 due to saturated admissions (high number of admissions). The progress notes did not indicate Resident 1's MD was notified that Resident 1 was still waiting bed availability to be transferred to GACH. During a review of Resident 1's progress notes dated 12/23/2025 at 4:08 a.m., the progress notes indicated Resident 1 was still waiting to be transferred to hospital. The progress notes did not indicate resident's MD was notified of the delayed transfer to GACH. During a concurrent interview and record review on 2/18/2026 at 12:22 p.m., with Licensed Vocational Nurse (LVN) 1, the following were reviewed:Resident 1's COC, dated 12/18/2025Progress notes, dated 12/19/2025, 12/22/2025, and 12/23/2025Resident 1's COC, dated 12/21/2025.LVN 1 stated the COC indicated Resident 1 was not eating much, which could cause Resident 1 to deteriorate, become weak/ lack of energy, and dehydrated. LVN 1 stated there was no documented evidence that the license staff informed Resident 1's MD about the COC on 12/18/2025 (resident refusing breakfast and lunch and allowing food to fall out of mouth). LVN 1 stated Resident 1's MD should have been informed when the GACH was full and was unable to take (admit) the resident in ED for evaluation. LVN stated the staff should have obtained other orders from MD to ensure Resident 1's needs were met. LVN 1 stated Resident 1's condition could have gotten worse due to the delayed transfer. During an interview on 2/18/2026 at 1:40 p.m., with LVN 1, LVN 1 stated they were not sure if they have documents to indicate staff were assessing Resident 1 for dehydration. During a concurrent interview and record review on 2/18/2026 at 2:08 p.m. with the Director of Nursing (DON), the following were reviewed:Resident 1's COC, dated 12/18/2025Resident 1's labs, dated 12/22/2025Resident 1's care plan titled, Resident has decreased or unable to eat/drink adequate amounts of food or liquid intake related to (r/t) Resident refusing breakfast and lunch. Resident allowing food to fall out of mouth, dated 12/18/2025,Resident 1's progress notes dated from 12/18/2025 to 12/22/2025.The DON stated Resident 1's COC dated 12/18/2025 indicated an order for UA, however, there was no result found in Resident 1's clinical record. The DON stated there was a possibility the specimen was not collected. The DON stated Resident 1's progress notes had no indication Resident 1 was assessed for dehydration on 12/18/2025 as indicated in Resident 1's care plan titled, Resident has decreased or unable to eat/drink adequate amounts of food or liquid intake r/t Resident refusing breakfast and lunch. Resident allowing food to fall out of mouth, which indicated an intervention to assess for dehydration. The DON stated when Resident 1's transfer to GACH was delayed on 12/22/2025, the staff should have informed Resident 1's MD and obtained new orders or recommendation. If residents were not transferred timely, there could be a delay in and cause other problems to occur. During an interview on 2/20/2026 at 11:27 a.m. with the DON, the DON stated the facility-contracted laboratory told the DON stated there was no (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	urine specimen collected on 12/18/2025. During a review of facility's policy and procedure (P&P) titled, Physician Orders, dated 2/2014, the P&P indicated, the receiving nurse should carry out the order. During a review of facility's P&P titled, Change in a Resident's Condition or Status, dated 2/2021, the P&P indicated the facility should promptly notify the resident's attending physician of changes in the resident's medical condition and/or status) and need to transfer the resident to the hospital/treatment center. During a review of facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated, the comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The P&P indicated, a comprehensive, person-centered care plan is developed and should be implemented for each resident.