

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  03/16/2026
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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to report an injury of unknown origin to the California Department of Public Health (CDPH) for one of three sampled residents (Resident 3). This deficient practice resulted in delayed investigation by CDPH and had the potential to place residents safety at risk. Findings: During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE]. Resident 3's diagnoses included dementia (a progressive state of decline in mental abilities), hypertension (HTN- high blood pressure), and hyperlipidemia (high levels of fats in the blood). During a review of Resident 3's History and Physical (H&amp;P) dated 11/1/2025, the H&amp;P indicated Resident 3 did not have the capacity to understand or make medical decisions. During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool), dated 2/2/2026, the MDS indicated Resident 3 had moderate cognitive (ability to think and understand) impairment. The MDS indicated Resident 3 required set up or clean-up assistance from staff for eating, toileting and personal hygiene. During a review of Resident 3's Situation Background Assessment Recommendation Communication (SBAR- communication form used to share resident change in condition information with provider) dated 3/6/2026, the SBAR indicated on 3/6/2026, Resident 3 was noted with weakness while walking in the dining hall for lunch, and required assistance with getting back to her room. Resident 3's SBAR form indicated Resident 3 complained of eight out of ten left hip and left leg pain. The SBAR indicated Resident 3's physician was notified and ordered a X-Ray (imaging test that uses radiation to take pictures of the inside of the body) of the hip. During a review of Resident 3's SBAR Communication form dated 3/6/2026, the SBAR indicated Resident 3 complained of left hip pain but was unable to give a complete description of what happened to cause pain. Resident 3's SBAR indicated while Resident 3's X-Ray was being completed, Resident 3 stated she had a fall but was unable to give a detailed description of how the fall occurred. During a review of Resident 3's Interdisciplinary Team (IDT, group of different disciplines working together towards a common goal of a resident) Progress Note dated 3/9/2026, the IDT Progress Note indicated X-Ray findings of the left hip indicated acute complete femoral neck fracture with partial displacement (a break in the uppermost part of the femur, just below the ball of the hip joint). Resident 3's IDT Progress Note indicated Resident 3's physician was made aware and ordered to send Resident 3 to the General Acute Care Hospital (GACH) for further evaluation and treatment. During an interview on 3/16/2026 at 11:04 a.m. with Registered Nurse (RN) 1, RN 1 stated on 3/6/2026, Resident 3 was alert and oriented to name only and was unable to explain how her fall occurred. RN 1 stated the details of Resident 3's fall, such as when or where fall occurred, were unknown. During a concurrent interview and record review on 3/16/2026 at 2:42 p.m. with the Director of Nursing (DON), the facility's policy and procedure (P&amp;P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated 9/2022 was reviewed. The P&amp;P indicated, if resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The P&amp;P indicated, the administrator or the individual making the (continued on next page)</p>

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>allegation immediately reports his or her suspicion to the following persons or agencies, the state licensing/certification agency responsible for surveying/licensing the facility. The DON stated Resident 3's fall was unwitnessed and the details were unknown. The DON stated Resident 3 was unable to explain details surrounding her fall. The DON stated reporting injuries of unknown origin was important to ensure a thorough investigation of the incident takes place and appropriate interventions were implemented to prevent recurrence. The DON stated failure to report an injury of unknown origin delayed investigation by CDPH and placed residents safety at risk.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure fall risk assessments accurately reflected residents' status and was updated following a fall for one of three sampled residents (Resident 3). These deficient practices had the potential to place Resident 3 at an increased risk for a fall. Findings: During a review of Resident 3's admission Record, the admission record indicated Resident 3 was admitted to the facility on [DATE]. Resident 3's diagnoses included dementia (a progressive state of decline in mental abilities), hypertension (HTN- high blood pressure) and hyperlipidemia (high levels of fats in the blood). During a review of Resident 3's History and Physical (H&amp;P) dated 11/1/2025, the H&amp;P indicated Resident 3 did not have the capacity to understand or make medical decisions. During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool), dated 2/2/2026, the MDS indicated Resident 3 had moderate cognitive (ability to think and understand) impairment. The MDS indicated Resident 3 required set up or clean-up assistance from staff for eating, toileting and personal hygiene. a. During a concurrent interview and record review on 3/16/2026 at 11:04 a.m. with Registered Nurse (RN) 1, Resident 3's Fall Risk Assessment dated 2/2/2026 was reviewed. The Fall Risk Assessment indicated Resident 3's mental status was alert and oriented times (x) 3 (medical term confirming resident is awake, knows their identity, location and time). RN 1 stated Resident 3 was alert and oriented to her name only and had periods of confusion. RN 1 stated the mental status section of Resident 3's Fall Risk Assessment should have indicated intermittent confusion instead of alert and oriented x3. RN 1 stated accurate Fall Risk Assessment's were important to ensure staff knew the appropriate interventions and preventative measures to implement for fall prevention. RN 1 stated inaccurate Fall Risk Assessment's placed residents at an increased risk for falls. During a concurrent interview and record review on 3/16/2026 at 2:42 p.m. with the Director of Nursing (DON), Resident 3's Fall Risk Assessment dated 2/2/2026 was reviewed. The Fall Risk Assessment indicated Resident 3's mental status was alert and oriented x3. Resident 3's Physician Progress notes dated 2/15/2026, indicated Resident 3 had periods of confusion. The DON stated the Fall Risk Assessment should reflect residents mental status, and should have indicated Resident 3 had intermittent confusion. The DON stated Fall Risk Assessment accuracy was important because it not only indicated the level of risk, but determined which interventions nursing staff were to implement. During a review of the facility's policy and procedure (P&amp;P) titled, Fall Risk Assessment dated 2001, the P&amp;P indicated the staff, with the support of the attending physician, will evaluate functional and psychological factors that may increase fall risk, including ambulation, mobility, gait, balance, excessive motor activity, activities of daily living capabilities, activity tolerance, continence and cognition. b. During a concurrent interview and record review on 3/16/2026 at 11:04 a.m. with Registered Nurse (RN) 1, Resident 3's Situation Background Assessment Recommendation Communication (SBAR- communication form used to share resident change in condition information with provider) dated 3/6/2026 was reviewed. The SBAR Communication form indicated on 3/6/2026, Resident 3 had a fall and was unable to give a detailed description of how the fall occurred. RN 1 stated nurses were responsible for completing an updated fall risk assessment after a fall. RN 1 stated an updated Fall Risk Assessment was not completed after Resident 3 fell. RN 1 stated updated Fall Risk Assessment's were important because nursing staff needed to reassess the resident to determine what preventative measures needed to be implemented to ensure safe ambulation (walking). RN 1 stated failure to update Resident 3's Fall Risk Assessment's placed the resident at an increased risk for falls. During a concurrent interview and record review on 3/16/2026 at 2:42 p.m. with the Director of Nursing (DON), Resident 3's Fall Risk Assessment's dated 2/2/2026 were reviewed. The Fall Risk Assessment was not updated after Resident 3's fall on 3/6/2026. The DON stated nursing staff should have updated Resident 3's Fall Risk Assessment to ensure appropriate interventions were being implemented for fall prevention and resident safety. The DON stated the facility did not have a specific policy for required documentation for residents after a fall.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to follow the care plan and monitor for paranoid delusions (fixed, irrational beliefs that others are plotting against or trying to harm you, without evidence) for one of three sampled residents (Resident 1). This deficient practice had the potential to result in unmonitored paranoid delusions and unaddressed aggressive behaviors. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included major depressive disorder (mental health condition characterized by intense sadness and loss of interest in activities), hypertension (HTN-high blood pressure), and chronic kidney disease (CKD- kidney damage resulting in loss of ability to filter waste and fluid from blood). During a review of Resident 1's History and Physical (H&amp;P) dated 1/20/2026, the H&amp;P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 1/25/2026, the MDS indicated Resident 1 had moderate cognitive (ability to think and understand) impairment. The MDS indicated Resident 1 required moderate assistance from staff for toileting and supervision from staff for eating and personal hygiene. During an interview on 3/16/2026 at 10:05 a.m. with Resident 1, Resident 1 stated on 3/2/2026, while eating dinner in the dining hall, he read Resident 2's lips and saw Resident 2 was talking about him while on the phone. Resident 1 stated he walked up to Resident 2 and punched him in the face. During a concurrent interview and record review on 3/16/2026 at 11:04 a.m. with Registered Nurse (RN) 1, Resident 1's medical records and care plan dated 3/12/2026 were reviewed. The medical records did not indicate there was a physician order for the behavior monitoring of Resident 1's paranoid delusions. The care plan indicated Resident 1 had episodes of paranoid behavior as evidenced by the resident claiming the mafia was trying to kill him. RN 1 stated the care plan included an intervention to monitor Resident 1's episodes of paranoid delusions every shift. RN 1 stated staff documented monitoring behaviors in the task section of the Medication Administration Record (MAR). RN 1 stated behavior monitoring tasks were created when an order was made to monitor for specific behaviors. RN 1 stated monitoring Resident 1's paranoid delusions was important to ensure effectiveness of medication regimen and to determine the need of physician reassessment. RN 1 stated not following care plan interventions placed Resident 1 at risk of unmonitored paranoid delusions and unaddressed behaviors. During an interview on 3/16/2026 at 2:42 p.m. with the Director of Nursing (DON), the DON stated following the care plan was important to prevent unaddressed aggressive behaviors and to keep residents and staff safe. The DON stated monitoring Resident 1's paranoid delusions allowed the care team to evaluate the effectiveness of the residents current plan of care, as well as the need for physician reassessment or medication adjustment. During a review of the facility's policy and procedure (P&amp;P) titled Care Plans, Comprehensive Person-Centered dated 2/2022, the P&amp;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&amp;P indicated, Services provided for or arranged by the facility and outlined in the comprehensive care plan are: provided by qualified persons.</p>		