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	04/02/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a comprehensive care plan was revised for one of four sampled residents (Resident 3), following a second episode of aggression.This deficient practice had the potential to place Resident 3 at risk for further episodes of physical and verbal aggression toward staff and residents. Findings:a. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and hypertension (high blood pressure).During a review of Resident 3's Minimum Data Set ([MDS], a resident assessment tool), dated 3/6/2026, the MDS indicated Resident 3's cognitive skills (ability to think and reason) for daily decision making were intact. The MDS indicated Resident 3 required moderate assistance (helper does less than half the effort) for toileting, showering, and dressing.During a review of Resident 3's situation, background, assessment, recommendation (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents), dated 3/10/2026, the SBAR indicated Resident 3 was verbally aggressive towards staff.During a review of Resident 3's SBAR dated 3/17/2026, the SBAR indicated Resident 3 was verbally aggressive towards staff, and threw furniture and his food tray.During a review of Resident 3's SBAR Note, dated 3/23/2026, the note indicated staff witnessed Resident 3 hit another resident (Resident 4) in the face.b. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 4's diagnoses included schizoaffective disorder, diabetes (poor blood sugar control), and depression (an overwhelming feeling of sadness).During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 4 required supervision for oral hygiene, toileting, and showering.During a concurrent interview and record review on 4/2/2026 at 12:46 p.m. with Registered Nurse (RN) 1, Resident 3's SBARs, dated 3/10/2026, 3/17/2026, and 3/23/2026, and Resident 3's care plans and Interdisciplinary Team (IDT, group of different disciplines working together towards a common goal of a resident) Meeting Notes, dated 3/2026, were reviewed. The care plans did not indicate revisions were made after Resident 3 was verbally aggressive on 3/10/2026. There were no IDT Meetings documented from 2/27/2026 through 3/17/2026 to evaluate or revise the resident's care and behavioral interventions. RN 1 stated the facility's practice was to conduct IDT Meetings to formally evaluate or reevaluate the resident's care and medication regimen in collaboration with the psychiatrist. RN 1 stated an IDT meeting should have been conducted to reevaluate the care for Resident 3 prior to the resident's altercation on 3/23/2026 due to prior documented aggressive behaviors. RN 1 stated this would have allowed for a timely revision of Resident 3's aggression care plan. RN 1 stated Resident 3's care plan should have been revised on 3/10/2026 following continued aggressive behavior to allow for implementation of additional interventions to prevent further (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	episodes. RN 1 stated without alternative interventions, Resident 3 was at risk for continued aggression toward staff and escalation to altercations with other residents.During an interview on 4/2/2026 at 4:03 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she authored Resident 3's SBAR dated 3/10/2026. LVN 1 stated she did not revise Resident 3's care plan. LVN 1 stated the care plan should be revised after continued episodes of aggressive behavior for appropriate interventions to prevent reoccurrence or escalation.During a review of the facility's Policy and Procedure (P&P) titled, Comprehensive, Person-Centered Safety and Supervision of Residents, revised 3/2022, the P&P indicated the facility was to ensure assessments of residents were ongoing and care plans are revised as information about the residents and the residents' conditions change. The P&P indicated the interdisciplinary team reviewed and updated the care plan when there was a significant change in the resident's condition and when the desired outcome was not met.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate and complete documentation of monitoring of a resident's aggressive behaviors following readmission from a 5150 hold (a 72-hour hold for a resident experiencing a mental health crisis and evaluated to be a danger to others, themselves, or gravely disabled) at the general acute care hospital (GACH) and a physical altercation for one out of five sampled residents (Resident 1).This deficient practice had the potential to place Resident 1 and other residents at risk for physical harm caused by Resident 1.Findings:a. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included major depressive disorder (overwhelming feeling of sadness), hypertension (high blood pressure), and abnormalities of gait and mobility.During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 3/14/2026, the MDS indicated Resident 1's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) for toileting, showering and dressing.During a review of Resident 1's situation, background, assessment, recommendation (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents), dated 3/2/2026, the SBAR indicated on 3/2/2026, Resident 1 punched another resident in the face, resulting in a transfer to the general acute care hospital (GACH).During a review of Resident 1's care plan titled, Psychotropic Medications (medications that manage mental health conditions), initiated on 1/21/2026, and revised on 3/16/2026, the care plan indicated to monitor and record the occurrence of target behaviors, including aggression towards others, and document per facility protocol.During a review of Resident 1's SBAR, dated 3/19/2026, the SBAR indicated on 3/19/2026, staff witnessed Resident 1 strike Resident 2's face, resulting in a transfer to the GACH.b. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE]. Resident 2's diagnoses included diabetes, anxiety (an overwhelming feeling of uneasiness), and hypertension. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 2 required moderate assistance for toileting, showering and dressing.During a concurrent interview and record review on 4/2/2026 at 12:16 p.m. with Registered Nurse (RN) 1, Resident 1's Nursing Progress Notes, dated 3/10/2026 through 3/18/2026, and Resident 1's Medication Administration and Monitoring Record, dated 3/2026, were reviewed. The progress notes indicated Resident 1 was readmitted on [DATE] following hospitalizations under a 5150 hold (a 72-hour psychiatric hold for a resident experiencing a mental health crisis and evaluated to be a danger to others, themselves, or gravely disabled) for a prior altercation with a resident. The Medication Administration and Monitoring Record did not indicate Resident 1's aggressive behaviors were monitored from 3/13/2026 to 3/18/2026, prior to his altercation with Resident 2. RN 1 stated that it was important to monitor and document Resident 1's aggressive behaviors to ensure the safety of the resident and others.During an interview on 4/2/2026 at 3:34 p.m. with the Director of Nursing (DON), the DON stated the expectation of the licensed nurses was to document Resident 1's condition every shift. The DON stated Resident 1's recent readmission to the facility and physical altercation, placed Resident 1 at increased risk for further aggressive behavior, requiring ongoing supervision and monitoring for changes in behavior. The DON stated the lack of monitoring and documentation increased the risk for Resident 1 to engage in another physical altercation. During a review of the facility's Policy and Procedure (P&P) titled, Safety and Supervision of Residents, revised 2/2021, the P&P indicated the facility was to ensure individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. The P&P indicated the facility was to (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	implement interventions to reduce accident risks and hazards which included the following ensuring interventions were implemented and documented.