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	05/22/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to ensure choices were honored for one of three residents (Resident 74) when the resident was not permitted to take requested smoke breaks. This failure interfered with Resident 74's right to make choices about his routine and preferences. Findings: During a review of Resident 74's Admission Record, the admission record indicated Resident 74 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses which included chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), alcohol abuse, hypertension (HTN - high blood pressure), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest in life). During a review of Resident 74's History and Physical (H&P), dated 1/14/2025, the H&P indicated Resident 74 had the capacity to make medical decisions. During a review of Resident 74's Minimum Data Set (MDS - a resident assessment tool), dated 1/16/2025, the MDS indicated Resident 74's cognition (ability to think, remember, and reason) was moderately impaired. The MDS indicated Resident 74 required supervision (helper provides verbal cues and/or touching/steadying as resident completes the activity) for eating, toileting, oral and personal hygiene. The MDS indicated Resident 74 felt it was very important that he participated in his favorite activities. During a review of Resident 74's care plan titled, Preferences, initiated on 5/8/2025, the care plan indicated Resident 74 enjoyed watching television, reading, smoke breaks, patio times and other activities of choice. The care plan indicated staff would respect Resident 74's preferences and rights. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555715	A. Building B. Wing	05/22/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/19/2025 at 11:01 a.m. with Resident 74, Resident 74 stated he preferred to smoke more than twice a day. Resident 74 stated the facility has two scheduled smoke breaks, but he preferred to smoke at least one more time later in the evening before dinner. Resident 74 stated he asked nursing staff for an additional smoke break on several occasions, but his request was ignored. During an interview on 3/21/2025 at 2:42 p.m., Resident 74 stated he had a smoke break at 1 p.m., but wanted to smoke again at around 4 p.m. Resident 74 stated he would ask the Activities Department if he could take an additional smoke break at 4 p.m. Resident 74 stated he did not want to ask the nursing staff because they would just blow him off. During a concurrent observation and interview on 3/21/2025 at 4:25 p.m., with Resident 74, observed Resident 74 in his room, sitting up in his bed. Resident 74 stated he asked the Activities Department if he could take a smoke break at 4 p.m. Resident 74 stated Activities Assistant (AA) 1 informed him that she would ask the Social Services Director (SSD) if it was okay to take a smoke break at that time. Resident 74 stated no one from the nursing staff or the Activities Department followed up with him regarding his request for a smoke break at 4 p.m. Resident 74 stated, This is what they do all the time. During an interview on 3/21/2025 at 4:35 p.m., with Certified Nursing Assistant (CNA) 3, CNA 3 stated she was assigned to Resident 74, but was unaware of Resident 74's request for a smoke break at 4 p.m. CNA 3 stated smoke breaks were scheduled at 9 a.m. and 1 p.m. every day. CNA 3 stated additional smoke breaks would have to be approved by the SSD. CNA 3 stated the residents who smoke need at least one more smoke break in the evening. CNA 3 stated the residents get more anxious (feeling of unease) when they are not allowed to smoke. CNA 3 stated for some residents, smoking is all they have to look forward to and it helps calm them. CNA 3 stated the facility used to allow one more scheduled smoke break in the evening, which relaxed the residents and made them much calmer before bedtime. During an interview on 5/22/2025 at 9:03 a.m., with AA 1, AA 1 stated residents who request additional smoke breaks are directed to the nursing stations. AA 1 stated she informed Resident 74 to ask his nurse if he wanted an additional smoke break. AA 1 stated Resident 74 had a right to smoke at times other than the scheduled smoke breaks at 9 a.m. and 1 p.m. AA 1 stated when Resident 74 asked for an additional smoke break, she should have communicated this to the charge nurse. AA1 stated this would have ensured the nursing staff were aware Resident 74 requested an additional smoke break at 4 p.m. AA 1 stated it is not a good feeling when a resident feels they are being ignored, and their choices are not met. During an interview on 5/22/2025 at 11:27 a.m., with the Director of Nursing (DON), the DON stated all residents can be accommodated to smoke at other times to honor their preferences. The DON stated the facility can always make arrangements for residents to smoke. The DON stated Resident 74 could become frustrated if not allowed to take requested smoking breaks because smoking was part of the resident's routine in his previous life. The DON stated that as long as Resident 74 was safe, the facility must respect and honor Resident 74's choices and preferences. (continued on next page)

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	05/22/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Dignity, revised February 2021, the P&P indicated each resident would be cared for in a manner that promotes and enhances his or her level of satisfaction with life, and feelings of self-worth and self-esteem. The P&P also indicated, The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs. The P&P indicated residents are supported in exercising their rights and encouraged to attend the activities of their choice.

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	05/22/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on interview and record review, the facility failed to obtain informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) from the residents prior to treatment of psychotropic (medications that affect brain activities associated with mental processed and behavior) medications for two of six sampled residents (Residents 40, and 64) by failing to: 1. Obtain informed consent from Resident 40, for the use of Quetiapine Fumarate (an antipsychotic medication [a medication that effects the mind, emotion, and behavior]). 2. Ensure Resident 64's informed consent for Depakote (an anticonvulsant medication used to treat behavioral disorders), Risperdal (an antipsychotic medication), and Seroquel (an antipsychotic medication) were complete. The deficient practice of failing to obtain informed consent prior to initiating treatment with psychotropic medications could have prevented Residents 40 and 64 from exercising their right to decline treatment with psychotropic medications, and increased the risk of adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) leading to impairment or decline in their mental or physical condition or functional or psychosocial status. Findings: a. During a review of Resident 40's Admission Record, the Admission Record indicated Resident 40 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia (a progressive state of decline in mental abilities), and anxiety (a feeling fear, and worry). During a review of Resident 40's Minimum Data Set (MDS - a resident assessment tool), dated 5/7/2025, the MDS indicated Resident 40's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 40 required moderate assistance (helper does less than half the effort) 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). The MDS indicated Resident 40 received antipsychotic medication. During a review of Resident 40's Order Summary Report, dated 3/28/2025, the Order Summary Report indicated to administer Quetiapine Fumarate 50 milligrams ([mg]- metric unit of measurement, used for medication dosage and/or amount) by mouth two times a day for dementia with psychotic (loss of contact with reality) features manifested by disorganized thoughts. During a review of Resident 40's informed consent documentation and clinical record, the records indicated there was no documentation that Resident 40 received education regarding the risks and benefits of Quetiapine Fumarate prior to initiation on 3/28/2025. (continued on next page)

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	05/22/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/2025 at 3:25 p.m., with the Director of Nursing (DON), the DON she was not able to provide documented evidence the licensed staff obtained informed consent from Resident 40 prior to the use of Quetiapine Fumarate. The DON stated the facility failed to obtain informed consent prior to initiation of therapy. The DON stated there was a risk that Resident 40 would not be able to exercise their right to opt out of treatment with Quetiapine Fumarate if the informed consent was not done. The DON stated this increased the risk that Resident 40 could have experienced adverse effects related to treatment with Quetiapine Fumarate. b. During a review of Resident 64's Admission Record, the Admission Record indicated Resident 64 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia with behavioral disturbance (change in a person's mood, thoughts, and actions). During a review of Resident 64's MDS, dated [DATE], the MDS indicated Resident 64's cognition was moderately impaired. The MDS indicated Resident 64 was dependent on staff for ADLs. The MDS indicated Resident 64 received antipsychotic medications. During a review of Resident 64's Orders, dated 5/1/2025, the Orders indicated to administer: 1. Depakote 125 mg, two capsules by mouth at bedtime, for dementia with behavior disturbance manifested by (m/b) mood swings. 2. Risperdal 1 milliliter ([ml]- a unit of measurement), 1 ml by mouth two times a day for psychosis m/b agitation, resting care. 3. Seroquel 25 mg, one tablet two times a day for psychosis m/b screaming, yelling, resting care. During a review of Resident 64's Medication Administration Record ([MAR], a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 4/1/2025 through 5/31/2025, the MAR indicated: 1. Resident 64 received the first dose of Depakote on 4/19/2025 at 8:00 p.m. 2. Resident 64 received the first dose of Risperdal on 4/19/2025 at 8:00 p.m. 3. Resident 64 received the first dose of Seroquel on 4/19/2025 at 5:00 p.m. During a concurrent interview and record review on 5/21/2025 at 3:20 p.m., with Registered Nurse (RN) 2, Resident 64's Informed Consents for Use of Psychotropic Medication, undated, were reviewed. RN 2 stated the attending physician signature was indicated on the Informed Consents for Resident 64's use of Depakote, Risperdal, and Seroquel, however, the Informed Consents did not indicate from whom the informed consents were obtained from nor the date. RN 2 stated she could not recall why the Informed Consents were not completed. RN 2 stated it was a possibility that the informed consents were misplaced or not presented to the resident at the time of the resident's readmission to the facility. RN 2 stated the Informed Consents for Depakote, Risperdal, and Seroquel were not completed, which indicated informed consent was not obtained from Resident 64 prior to their administration to Resident 64. (continued on next page)

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	05/22/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/2025 at 11:30 am., with the DON, the DON stated due to Resident 64's uncompleted Informed Consent forms for Depakote, Risperdal, and Seroquel, Resident 64 was not given the opportunity to make an informed decision to proceed with the ordered treatment. The DON stated Resident 64 should have been given that opportunity as it was his right to make an informed decision regarding his care and treatment. During a review of the facility's policy and procedure (P&P) titled Verification of Informed Consent for Psychotherapeutic Medications, revised 5/2024, the P&P indicated Each resident has the right to be free from psychotherapeutic drugs and, to provide informed consent before treatment with psychotherapeutic drugs.

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	05/22/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to ensure a call light device was within reach for one of eight sampled residents (Resident 47). This deficient practice resulted in Resident 47 being unable to summon staff for assistance in a timely manner and had the potential to compromise Resident 47's safety and care. Cross Reference F919 Findings: During a concurrent observation and interview on 5/19/2025 at 10:07 a.m., with Resident 47, Resident 47 was observed in his room, lying in bed awake and alert. Resident 47's call light was observed hanging from a hook on the wall out of reach. Resident 47 stated that he was cold and asked if he could be covered with his blanket. Resident 47 stated he could not reach his call light, and the call light had not worked for months. During a review of Resident 47's Admission Record, the Admission Record indicated Resident 47 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses which included bilateral (on both sides) osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of the hip, difficulty walking, lack of coordination, asthma (a chronic disease of the airways that makes breathing difficult), dysphagia (difficulty swallowing), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 47's History and Physical (H&P), dated 3/19/2025, the H&P indicated Resident 47 was able to express his needs. During a review of Resident 47's Minimum Data Set (MDS - a resident assessment tool), dated 3/28/2025, the MDS indicated Resident 47's cognition (ability to think, remember, and reason) was severely impaired. The MDS indicated Resident 47 required supervision (helper provides verbal cues and/or touching/steadying as resident completes the activity) with toileting, bathing, oral and personal hygiene. The MDS indicated Resident 47 required a walker to assist with mobility. During a review of Resident 47's care plan titled, Activities of Daily Living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) self-care and mobility deficit, initiated on 4/9/2025, the care plan indicated Resident 47 had impaired cognition, incontinence (lacking control of bowel or bladder) and required assistance with ADLs. The care plan interventions indicated to encourage Resident 47 to use the bell to call for assistance. During a review of Resident 47's care plan titled, Limited physical mobility (the ability to move freely) related to difficulty walking and lack of coordination, initiated on 3/21/2025, the care plan indicated Resident 47 would remain free of complications related to immobility (state of not being able to move around) and ADL needs would be met safely. The care plan interventions indicated to place the call light within reach. (continued on next page)

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	05/22/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/19/2025 at 10:21 a.m., with Certified Nursing Assistant (CNA) 4, CNA 4 observed Resident 47's call light device hanging from a hook on the wall. CNA 4 then clipped the call light on the resident's sheet within his reach. CNA 4 stated Resident 47 could not reach the call light device when it was hanging from the wall. CNA 4 stated the call light should have been within reach in case the resident needed assistance. CNA 4 stated it was her responsibility to ensure the call light device was within the resident's reach. During an interview on 5/22/2025 at 11:33 a.m. with the Director of Nursing (DON), the DON stated the nursing staff should check to ensure call lights are working properly and within reach of the residents every change of shift. The DON stated not having a call light device within reach could delay care and services for the residents especially in the event of an emergency. During a review of the facility's policy and procedures (P&P) titled, Call System, Residents, dated 2001, the P&P indicated calls for assistance are answered as soon as possible, but no later than 5 minutes. Urgent requests for assistance are addressed immediately.

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	05/22/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on interview and record review, the facility failed to ensure the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) and one of two residents (Resident 98) was provided a notice of discharge prior to the resident's discharge on 2/21/2025. This deficient practice increased the risk of potential harm to Resident 98 and breach of the resident's rights. Findings: During a review of Resident 98's Admission Record, the Admission Record indicated Resident 98 was admitted to the facility on [DATE]. Resident 98's diagnoses included generalized muscle weakness, dementia (a progressive state of decline in mental abilities), and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 98's Minimum Data Set (MDS- a resident assessment tool), dated 12/26/2024, the MDS indicated Resident 98 had mild cognitive impairment (ability to think and reason). The MDS indicated Resident 98 required setup assistance with eating. The MDS indicated Resident 98 required supervision with oral hygiene and chair/ bed-to-chair transferring. The MDS indicated Resident 98 required moderate assistance (helper did less than half the effort) with toileting hygiene and showering/ bathing self. During a review of Resident 98's Order Recap Report, dated 2/21/2025, the report indicated to discharge Resident 98 to lower level of care. During a concurrent interview and record review on 5/21/2025 at 3:28 p.m. with Medical Records Director (MR 1), Resident 98's closed records were reviewed. The record indicated there was no notice of discharge for 2/21/2025. MR 1 stated there was no notice of discharge to the Ombudsman in Resident 98's closed record. During an interview on 5/21/2025 at 4:20 p.m. with the Director of Nursing (DON), the DON stated the licensed nurse assigned to the resident's care was responsible for completing the notice of discharge. The DON stated the licensed nurse should inform Resident 98 and his family the reason of discharge. The DON stated the notice of discharge should be kept in Resident 98's record. The DON stated the licensed nurse needed to fax the notice of discharge to the Ombudsman because the facility needed to inform the Ombudsman. The DON stated the notice of discharge needed to be completed and faxed to the Ombudsman upon discharge. The DON stated it would be unclear where the resident went without the notice of discharge. The DON stated the notice of discharge would include the discharge date , the responsible party, and the discharge location. The DON stated if the notice of discharge was not in Resident 98's closed record meant the notice of discharge was not done. (continued on next page)

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	05/22/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled Transfer or discharge, facility-initiated, dated 10/2022, the P&P indicated, The resident and representative are notified in writing of the following information: a. The specific reason for the transfer or discharge, including the basis under; b. The effective date of the transfer or discharge; c. The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is being transferred or discharged ; d. An explanation of the resident's rights to appeal the transfer or discharge to the state, including: (1) The name, address, email and telephone number of the entity which receives such appeal hearing requests; (2) Information about how to obtain an appeal form; and (3) How to get assistance in completing and submitting the appeal hearing request; e. The Notice of Facility Bed-Hold and policies; f. The name, address, and telephone number of the Office of the State Long-term Care Ombudsman; The name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with intellectual and developmental (or related) disabilities (as applies); h. The name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with a mental disorder or related disabilities (as applies); and i. The name, address, and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices. The P&P further indicated, A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative.

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	05/22/2025

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52411 Based on interview and record review, the facility failed to complete the Minimum Data Set (MDS - a federally mandated resident assessment tool) for significant change in status within the required time frame for one of six sample residents (Resident 40). This failure had the potential to negatively affect Resident 40 receiving the necessary care services that would have been required due to their significant change in status. Findings: During a review of Resident 40's Admission Record dated 11/1/2024 the Admission Record indicated the facility initially admitted Resident 40 on 11/1/2024, and readmitted Resident 40 on 3/28/2025 with diagnoses that included dementia (a progressive state of decline in mental abilities) metabolic encephalopathy (a condition that affects the brain due to problems with the body's metabolism), diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). Resident 40 also had a gastrostomy feeding tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Residents 40's MDS, dated [DATE], the MDS indicated Resident 40 was on a therapeutic diet, eating by mouth. Upon Resident 40's readmission on 3/28/2025, an MDS change of condition was not available for review to address Resident 40's [NAME] gastrostomy feeding tube as of their readmitted [DATE]. During a review of Residents 40's next available MDS, dated [DATE], the MDS indicated Resident 40's cognition (thought process) was moderately impaired, and Resident 40 required moderate assistance (helper does less than half the effort) 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). No other MDS assessments were available for review between 2/7/2025 and 5/7/2025. During a concurrent interview and record review on 5/20/2025, at 3:48 p.m. with the MDS Nurse (MDSN), Resident 40's MDS dated [DATE], was reviewed. The MDSN stated there was a change of condition recognized upon re-admitting Resident 40, and a change of condition assessment should have been completed within 14 days from the re-admitted [DATE]. The MDSN stated it was important to complete a resident assessment to provide proper care and ensure care plans are completed. The MDSN stated Resident 40's MDS was not completed within 14 days of readmission on 3/28/2025. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status revised 2/2021, the P&P indicated a significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions. A comprehensive assessment of the resident's condition will be conducted as required by current OBRA regulations governing resident assessments and as outlined in the MDS RAI Instructional Manual.

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	05/22/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on interview and record review, the facility failed to accurately complete the minimum data set (MDS - a comprehensive resident assessment tool) assessment Section I (active diagnoses) by failing to include a diagnosis of depression (a mental disorder characterized by depressed mood, poor appetite, difficulty sleeping, and lack of interest in normal enjoyable activities) per information in the medical record for one of six sampled residents (Resident 54). The deficient practice of failing to accurately assess active diagnoses and complete MDS Section I increased the risk that Resident 54 may not have received care planning and treatment according to his needs possibly leading to a decline in his overall health and well-being. Findings: During a review of Resident 54's Admission Record, the Admission Record indicated Resident 54 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included depression (a mental disorder characterized by depressed mood, poor appetite, difficulty sleeping, and lack of interest in normal enjoyable activities). During a review of Resident 54's MDS, dated [DATE], the MDS indicated Resident 54's cognition (process of thinking) was severely impaired. The MDS indicated Resident 54 was dependent on staff for activities of daily living (ADLs - routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves). The MDS indicated Resident 54 received antidepressant medication. The MDS indicated Resident 54 did not have depression as an active diagnosis. During a review of Resident 54's Orders, dated 5/1/2025, the Orders indicated the resident was prescribed Trazadone (a medication used to treat depression) 50 milligrams ([mg]- a unit of measurement), one tablet by mouth at bedtime for depression manifested by self-isolation from others on 3/19/2025. During a concurrent interview and record review on 5/22/2025 at 8:10 a.m., with the MDS Nurse (MDSN), Resident 54's MDS section I, dated 4/7/2025, was reviewed. The MDSN stated Resident 54's MDS was inaccurate as it did not include depression as one of the resident's active diagnoses. The MDSN stated Resident 54 had a diagnosis of depression based on documentation in his medical record, but the MDS assessment indicated that he did not have depression. The MDSN stated there was a risk that Resident 54's needs would not be adequately addressed through a care plan if the MDS assessment was inaccurate which could lead to a decline in his physical, mental, or psychosocial status. During a review of the facility's policy and procedure (P&P) titled Certifying Accuracy of the Resident Assessment, revised 11/2019, the P&P indicated any health care professional completing the Minimum Data Set (MDS) must sign and certify the accuracy of the resident assessment.

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	05/22/2025

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** 49900 Based on interview and record review, the facility failed to ensure the following for three of 12 sampled residents (Resident 17, 54, and 61): 1. Develop and implement a care plan for Resident 17's diagnosis of vitamin D deficiency (low levels of vitamin D in the body), and the administration of oyster shell calcium (a dietary supplement), Trazodone (a medication used to treat depression [mental health disorder]), and Buspirone (a medication used to treat anxiety [a feeling fear, and worry]). 2. Develop and implement a care plan addressing Resident 54's diagnosis of depression. 3. Implement Resident 61's care plan addressing the resident's oxygen therapy and diagnosis of chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing). These deficient practices placed Residents 17, 54, and 61 at risk of not receiving care and resident-centered interventions to meet and address their needs and had the potential to result in oxygen toxicity (lung damage from too much extra oxygen) and respiratory distress (difficulty breathing) for Resident 61. Finding: 1a. During a review of Resident 17's Admission Record, the Admission Record indicated Resident 17 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses which included anxiety, depression, atrial fibrillation (heart rhythm disorder where the heart beats irregularly and rapidly), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 17's History and Physical (H&P), dated 3/25/2025, the H&P indicated Resident 17 did not have the capacity to make healthcare decisions. During a review of Resident 17's Minimum Data Set (MDS - a resident assessment tool), dated 3/24/2025, the MDS indicated Resident 17's cognition (process of thinking) was severely impaired. The MDS indicated Resident 17 was dependent (helper does all the effort) on staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 17 received antidepressant (used to treat depression) and antianxiety (used to treat anxiety) medications. During a review of Resident 17's Order Summary Report, as of 5/1/2025, the report indicated an active order, dated 3/22/2025, to administer oyster shell calcium 500 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) tablet by mouth two times a day for vitamin D deficiency. (continued on next page)

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	05/22/2025

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	During a concurrent interview and record review on 5/21/2025 at 9:32 a.m. with the MDS Nurse (MDSN), Resident 17's care plans were reviewed. There were no care plans addressing Resident 17's vitamin D deficiency diagnosis nor the administration of oyster shell calcium. The MDSN stated the facility should have a care plan addressing Resident 17's vitamin D deficiency diagnosis and the administration oyster shell calcium. The MDSN stated she was responsible for ensuring residents' care plans were completed. The MDSN stated the purpose of care plans was to address residents' needs and to personalize care for residents. The MDSN stated the care plans were developed based on residents' diagnosis and residents' medications should be included in the intervention of the care plans. The MDSN stated she reviewed residents' orders to make sure there were care plans addressing the prescribed medications quarterly. The MDSN stated the nursing department was responsible for developing the care plan for residents when receiving new medication orders. The MDSN stated residents were at risk for side effects and staff needed to know the appropriate interventions to address the side effects and medical diagnoses. The MDSN stated the facility would not be able to provide necessary and appropriate care for residents without care plans. During an interview on 5/21/2025 at 10:51 a.m. with the Director of Nursing (DON), the DON stated the licensed nurse who received the order of oyster shell calcium should initiate the care plan. The DON stated the care plan was to address what was needed for the specific diagnosis and the administration of supplements. The DON stated the risk of not having a comprehensive person-centered care plan failed to meet the specific needs for the residents. b. During a concurrent interview and record review on 5/21/2025 at 1:35 p.m., with the MDSN, Resident 17's Order Summary Report, dated 5/1/2025, and Resident 17's Care Plans, dated 2024 to 2025, were reviewed. The Order Summary Report indicated Resident 17 was ordered Trazadone 50 mg, one tablet by mouth one time a day for depression manifested by (m/b) inability to sleep, Busbar 15 mg, one tablet by mouth two times a day for restlessness (behaviors such as agitation, inability to sit still) by constantly trying to get up unassisted, and Buspar 20 mg, one tablet by mouth at bedtime, for anxiety m/b physical restlessness by constantly trying to get up unassisted. The MDSN stated there were no care plans to address Resident 17's behaviors of inability to sleep and constantly trying to get up unassisted. The MDSN stated there were no care plans to address Resident 17's orders for trazadone and buspar. The MDSN stated it was important to ensure all of Resident 17's behaviors were care planned to ensure care was appropriately rendered for Resident 17. The MDSN stated it was important to ensure care plans were in place for each psychotropic (medication that affect a person's mind, emotion, and behavior, used to treat or manage mental health conditions) in order to monitor usage and side effects of the medications. The MDSN stated Resident 17 was at risk for mismanaged care and unmet short- and long-term goals for each psychotropic medication and behavior. 48343 2. During a review of Resident 54's Admission Record, the Admission Record indicated Resident 54 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included depression, Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), and diabetes mellitus ([DM] -a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 54's Orders, dated 3/19/2025, the Orders indicated to administer trazodone 50 mg, one tablet by mouth at bedtime for depression manifested by self-isolation from others. (continued on next page)

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	05/22/2025

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	During a review of Resident 54's MDS, dated [DATE], the MDS indicated Resident 54's cognition was severely impaired. The MDS indicated Resident 54 was dependent on staff for ADLs. The MDS indicated Resident 54 received antidepressant medication. During a concurrent interview and record review on 5/22/2025 at 8:10 a.m., with MDSN, Resident 54's Care Plans, dated 4/22/2025, were reviewed. The MDSN stated there were no care plans that addressed Resident 54's depression. The MDSN stated care planning serves as a communication tool among facility staff who provide care for the residents. The MDSN stated care plans should have been developed with interventions to monitor specific depression behaviors that Resident 54 required monitoring. The MDSN stated that without a care plan, the facility staff would not be able to provide quality care and services for their needs. During an interview on 5/22/2025 at 11:10 a.m., with the DON, the DON stated care plans were developed to ensure each resident received care and services, based on their individual needs. The DON stated without care plans to guide the staff, the residents may not receive the care and services they need. 47858 3. During a review of Resident 61's Admission Record, the Admission Record indicated Resident 61 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included pulmonary embolism (PE- a serious condition that occurs when a blood clot blocks blood flow to part of one or both lungs), COPD, dementia (a progressive state of decline in mental abilities), and pleural effusion (a condition characterized by the buildup of excess fluid between the layers of tissue that line the lungs and the chest cavity). During a review of Resident 61's MDS, dated [DATE], the MDS indicated Resident 61's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 61 required substantial or maximal assistance (helper does more than half of the effort) for bathing, toileting, performing personal hygiene, sitting to standing, and transferring from the bed to a chair. The MDS indicated Resident 61 had an active diagnosis of PE. During a review of Resident 61's H&P, dated 12/25/2024, the H&P indicated Resident 61 had fluctuating capacity to understand and make decisions. During a review of Resident 61's Care Plan titled, Resident Has Diagnosis of COPD, dated 3/6/2025, the Care Plan indicated interventions were to provide oxygen as ordered. During a review of Resident 61's Care Plan titled, The Resident Has Oxygen Therapy, dated 3/27/2025, the care plan indicated interventions were to explain the importance of keeping oxygen at the prescribed setting and to stress that more oxygen may not be best for a diagnosis of COPD. During an observation on 5/19/2025 at 9:39 a.m., in Resident 61's room, Resident 61 laid flat on his bed with his nasal cannula positioned in his nose. The oxygen concentrator (a medical device that provides supplemental oxygen by concentrating oxygen from ambient air) flow rate (amount of oxygen delivered to a patient) was set to 4.5 liters per minute (LPM). (continued on next page)

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	05/22/2025

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	During a concurrent interview and observation on 5/19/2025 at 2:55 p.m. with Certified Nursing Assistant (CNA) 2, Resident 61 laid flat on his bed with his nasal cannula positioned in his nose. The oxygen concentrator flow rate was set to 4.5 LPM. CNA 2 stated Resident 61 had been on continuous oxygen throughout the day. CNA 2 stated she had known Resident 61 to have continuous oxygen for greater than one month. During a concurrent interview and record review on 5/20/2025 at 10:15 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 61's Physician Orders dated 4/29/2025 were reviewed. Resident 61's Physician Orders indicated to administer 2 LPM of oxygen as needed. LVN 1 stated Resident 61 was usually on continuous oxygen, which did not align with the physician orders. LVN 1 stated she was Resident 61's assigned nurse on 5/19/2025 and 5/20/2025. LVN 1 stated she recalled Resident 61 was administered continuous oxygen. LVN 1 stated Resident 61 should not have been placed on 4.5 LPM continuously because it did not follow the physician's order and because it placed Resident 61 at risk for oxygen toxicity and carbon dioxide (CO2-gaseous by product of the body) retention (when the lungs cannot eliminate enough CO2 through breathing). During a concurrent interview and record review on 5/21/2025 at 3:30 p.m. with the DON, Resident 61's Care Plan, titled Resident Has Diagnosis of COPD, dated 3/6/2025, was reviewed. The care plan interventions indicated to provide oxygen as ordered. The DON stated residents diagnosed with COPD were contraindicated to receive high concentrations of oxygen because the resident may not be able to tolerate the oxygen therapy, causing him or her to retain more carbon dioxide which could lead to respiratory distress. The DON stated if Resident 61 required an increased amount of oxygen and continuous oxygen to be administered, the licensed nursing staff would have been expected to notify the physician and change the order. The DON stated Resident 61's physician order for two LPM as needed was not followed if Resident 61 was administered 4.5 LPM of oxygen continuously. The DON stated Resident 61's care plan were not followed which placed the resident at risk for oxygen toxicity. During a review of the facility's policy and procedures (P&P) titled Care Plans, Comprehensive Person -Centered, revised 12/2016, the P&P indicated, A comprehensive, person- centered care plan that includes measurable objectives and timeframes to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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	05/22/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 52411 Based on observation, interview and record review, the facility failed to provide safe enteral nutrition (the delivery of liquid nutrients through a feeding tube directly into the gastrointestinal tract) for one of six sampled residents (Resident 40), when Resident 40's head of bed was not maintained in an elevated 30 to 45 degrees (refers to an angle of position) position while receiving enteral nutrition by gastrostomy tube (GT - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). This failure had the potential for resident harm and or death, as the provision of enteral feedings without elevating Resident 40's resting position increased the risk for vomiting and aspiration pneumonia, which may be caused when liquid nutrition and/or other stomach contents enter a person's airway and/or lungs. Findings: During a review of Resident 40's Admission Record. dated 11/1/2024, and readmitted Resident 40 on 3/28/2025, with diagnoses that included gastrostomy status, dementia (a progressive state of decline in mental abilities), and gastro-esophageal reflux disease (GERD - a common condition in which the stomach contents move up into the esophagus). During a review of Resident 40's, Order Summary Report, dated 3/28/2025 the document indicated Enteral feed order every shift - Elevated head of bed 30-45 degrees during feeding and one hour after feeding. During a review of Residents 40's Minimum Data Set (MDS - a resident assessment tool) dated 5/7/2025, the MDS indicated Resident 40's cognition (thought process) was moderate impaired. The MDS indicated Resident 40 required moderate assistance (helper does less than half the effort) 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 an observation on 5/19/2025 at 9:11 a.m. Resident 40's room was receiving GT feeding of Jevity 1.2 at 70 cc/hour (rate of cubic centimeters per hour) with the head of the bed at approximately 20 degrees head elevation (resident was only slightly elevated from laying in flat position). During a concurrent observation and interview on 5/19/2025 at 2:48 p.m. with Licensed Vocations Nurse 3 (LVN 3) in Resident 40's room while LVN 3 was performing resident rounds, LVN 3 did not adjust the head of the bed for Resident 40 while the GT feeding was being administered. LVN 3 stated she did notice Resident 40's bed was flat, and when the feeding for Resident 40 was re-started at 2:00 p.m. the previous LVN should have told her that the bed was lowered. LVN 3 stated the bed positioning for Resident 40 was not acceptable. During an interview 05/22/25 11:13 a.m. with the Director of Nursing (DON), the DON stated that all residents receiving tube feedings should have the head of the bed elevated to 45 degrees to prevent complications, such as aspiration (when liquid or foreign objects enter the airway and lungs). (continued on next page)

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	05/22/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Enteral Tube Feeding via Continuous Pump revised 11/2018, the P&P indicated Position the head of the bed at 30?-45 degrees for feeding, unless medically contraindicated.

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	05/22/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on observation, interview, and record review, the facility failed to ensure respiratory care was provided according to physician's orders and professional standards of practice for one of three residents reviewed for oxygen therapy (Resident 61) when the following occurred: 1. Staff administered continuous oxygen at a rate of 4.5 liters per minute (LPM- a unit of measurement), exceeding the prescribed rate of two liters per minute as needed. 2. Resident 61 was observed unmonitored in the facility patio with increased respirations without his supplemental oxygen. 3. Staff failed to ensure the amount of oxygen administered to Resident 61 was documented from 4/29/2025 to 5/20/2025. These failures had the potential to place Resident 61 at risk for oxygen toxicity (lung damage from too much extra oxygen) and respiratory distress, and compromise Resident 61's safety. Findings: During a review of Resident 61's Admission Record, the Admission Record indicated Resident 61 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included pulmonary embolism (PE-a serious condition that occurs when a blood clot blocks blood flow to part of one or both lungs), chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), dementia (a progressive state of decline in mental abilities), and pleural effusion (a condition characterized by the buildup of excess fluid between the layers of tissue that line the lungs and the chest cavity). During a review of Resident 61's Minimum Data Set ([MDS], a resident assessment tool), dated 3/30/2025, the MDS indicated Resident 61's cognitive skills (ability to think and reason) for daily decision making were severely impaired. The MDS indicated Resident 61 required substantial or maximal assistance (helper does more than half of the effort) for bathing, toileting, performing personal hygiene, sitting to standing, and transferring from the bed to a chair. The MDS indicated Resident 61 had an active diagnosis of PE. During a review of Resident 61's History and Physical (H&P), dated 12/25/2024, the H&P indicated Resident 61 had fluctuating capacity to understand and make decisions. During a review of Resident 61's Care Plan, titled, The Resident Has Oxygen Therapy, dated 3/27/2025, the care plan indicated staff's interventions were to explain the importance of keeping oxygen at the prescribed setting and to stress more oxygen may not be best for a diagnosis of COPD. During a review of Resident 61's Care Plan, titled, Resident Has Diagnosis of COPD, dated 3/6/2025, the care plan indicated the staff's interventions were to provide oxygen as ordered. (continued on next page)

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	05/22/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. During an observation on 5/19/2025 at 9:39 a.m., in Resident 61's room, Resident 61 laid flat on his bed with his nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) positioned in his nose, and his oxygen concentrator (a medical device that provides supplemental oxygen by concentrating oxygen from ambient air) flow rate (amount of oxygen delivered to a patient) was set to 4.5 liters per minute (LPM- a unit of measurement). During a concurrent interview and observation on 5/19/2025 at 2:55 p.m. with Certified Nursing Assistant (CNA) 2, Resident 61 laid flat on his bed with his nasal cannula positioned in his nose, and his oxygen concentrator flow rate was set to 4.5 LPM. CNA 2 stated Resident 61 had been on continuous oxygen throughout the day. CNA 2 stated she had known Resident 61 to have continuous oxygen for greater than one month. During a concurrent interview and record review on 5/20/2025 at 10:15 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 61's Physician Orders, dated 5/2025, Nursing Progress Notes, dated 3/2025 to 5/2025, were reviewed. Resident 61's Physician Orders indicated Resident 61 was ordered for the administration of 2 LPM of oxygen as needed on 4/29/2025. LVN 1 stated Resident 61 was usually on continuous oxygen, which did not align with the physician orders. LVN 1 stated she was Resident 61's assigned nurse on 5/19/2025 and 5/20/2025, and recalled Resident 61 was administered continuous oxygen. LVN 1 stated Resident 61 should not have been placed on oxygen at 4.5 LPM continuously because it did not follow the physician's order and placed Resident 61 at risk for oxygen toxicity and carbon dioxide (CO_2- gaseous by product of the body) retention (when the lungs cannot eliminate enough CO_2 through breathing). During an interview on 5/22/2025 at 8:52 a.m. with RN (Registered Nurse) 2, RN 2 stated she was the licensed nurse who inputted Resident 61's order for the administration of oxygen at 2 LPM as needed on 4/29/2025 into Resident 61's electronic medical record (EMR). RN 2 stated the licensed nursing staff did not follow the physician's order if Resident 61 was left on 4.5 LPM of oxygen throughout the day on 5/19/2025. RN 2 stated there was a significant difference between 2 LPM and 4.5 LPM of supplemental oxygen and she would have expected the licensed nursing staff to notify the physician if Resident 61's oxygen demand increased and if supplemental oxygen needed to be administered continuously. RN 2 stated this placed Resident 61 at risk for increased CO_2 retention that could have resulted in respiratory distress or hospitalization . During an interview on 5/21/2025 at 3:30 p.m. with the Director of Nursing (DON), the DON stated residents diagnosed with COPD were contraindicated to receive high concentrations of oxygen because the resident may not be able to tolerate the oxygen therapy, causing him or her to retain more carbon dioxide, which could lead to respiratory distress. The DON stated if Resident 61 required an increased amount of oxygen and continuous oxygen to be administered, the licensed nursing staff would have been expected to notify the physician to change the order. The DON stated Resident 61's physician order for oxygen at 2 LPM as needed was not followed if Resident 61 was administered 4.5 LPM of oxygen continuously. The DON stated the administration of continuous oxygen placed Resident 61 at risk for oxygen toxicity. 2. During an observation on 5/20/2025 at 10:07 a.m., in the facility patio, CNA 5 was observed speaking with another (unidentified) CNA. CNA 5 and the unidentified CNA were looking at a cellular handheld device. Resident 61 sat in his wheelchair, amongst the other residents, with his eyes closed, and with no supplemental oxygen. Resident 61 was breathing fast and Resident 61's neck muscles tensed with each breath. Resident 61 stated he felt short of breath. (continued on next page)

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	05/22/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/20/2025 at 10:10 a.m. with LVN 1, in the facility patio, Resident 6's respiratory rate was measured at 24 breaths per minute (normal respiratory rate is between 12 to 18 breaths per minute) and his oxygen saturation level (O2 sat- a measurement of how much oxygen the blood is carrying as a percentage) measured 87% (normal O2 sat is 95% to 100%). LVN 1 stated she was not made aware Resident 61's nasal cannula was removed and the resident was moved to the patio. During a concurrent observation and interview on 5/20/2025 at 10:12 a.m. with CNA 1, Resident 61 was without his supplemental oxygen. CNA 1 stated she brought Resident 61 to the patio about 20 minutes prior. CNA 1 stated Resident 61 refused his supplemental oxygen and proceeded to take him to the patio (without his oxygen), as requested. CNA 1 stated she should have informed LVN 1 that Resident 61 refused the supplemental oxygen before she removed Resident 61's nasal cannula and took him to the patio. CNA 1 stated this placed Resident 61 at risk for becoming short of breath in the patio. During a concurrent observation and interview on 5/20/2025 at 10:14 a.m. with LVN 1, in Resident 61's room, LVN 1 placed Resident 61 on 4.5 LPM of oxygen. LVN 1 stated oxygen at 4.5 LPM was not ordered by the physician and Resident 61's physician order was for 2 LPM of oxygen as needed. During an interview on 5/20/2025 at 10:27 a.m. with LVN 1, LVN 1 stated she expected CNA 1 to notify her when Resident 61 refused the administration of oxygen and when CNA 1 placed Resident 61 in the facility patio without his supplemental oxygen. LVN 1 stated this placed Resident 61 at significant risk for exhibiting unmonitored respiratory distress for an unknown length of time. During an interview on 5/21/2025 at 3:30 p.m. with the DON, the DON stated she expected CNA 1 to immediately notify LVN 1 once Resident 61 refused his supplemental oxygen. The DON stated this notification would have allowed LVN 1 to explain the risks and benefits to Resident 61, notify the physician, implement a care plan, and monitor Resident 61 for shortness of breath. CNA 1's lack of communication with LVN 1 regarding Resident 61's refusal of supplemental oxygen therapy and placement of Resident 61 (without his supplemental oxygen) in the facility's patio placed Resident 61 at risk for an episode of desaturation (when blood levels of oxygen are low), respiratory distress, and a medical emergency. 3. During a concurrent interview and record review on 5/20/2025 at 10:15 a.m. with LVN 1, Resident 61's Physician Orders, dated 5/2025, Nursing Progress Notes, dated 3/2025 to 5/2025, were reviewed. Resident 61's Physician Orders indicated Resident 61 was ordered for the administration of 2 LPM of oxygen as needed on 4/29/2025. Resident 61's Nursing Progress Notes indicated Resident 61's flow meter readings (LPM) were not documented each shift. LVN 1 stated she did not know what the flow rate was set to on 5/19/2025. LVN 1 stated she forgot to check and document Resident 61's flow rate settings the entire shift. LVN 1 stated the normal process was to check the residents' flow rate settings and ensure it aligned with the physician's orders during hand off report at the beginning of each shift. LVN 1 stated Resident 61 should not have been placed on 4.5 LPM continuously because it did not follow the physician's order and placed Resident 61 at risk for oxygen toxicity and CO2 retention. During an interview on 5/21/2025 at 3:30 p.m. with the DON, the DON stated she expected the licensed nursing staff to document the LPM of oxygen administered to Resident 61 each shift especially if Resident 61's oxygen was administered continuously. The DON stated the lack of LPM documentation and physician notification for Resident 61's increased and continuous need for supplemental oxygen placed Resident 61 at risk for delay in treatment and services to manage his COPD diagnosis. (continued on next page)

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	05/22/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P), titled, Oxygen Administration, dated 2001, the P&P indicated the facility staff were to ensure the following: 1. Proper flow of oxygen was administered. 2. The rate of oxygen flow was documented in the resident's medical record. 3. The resident's refusal of the procedure was documented in the resident's medical record. 4. The supervisor was notified if the resident refused the procedure. 5. Other information was reported in accordance with the facility policy and professional standards of practice.

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	05/22/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on observation, interview, and record review, the facility failed to ensure the safe medications administrations for two of six residents (Resident 17 and Resident 76) when the following occurred: 1. 40 out of 40 doses of oyster shell calcium (a dietary supplement) 500 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) were not administered to Resident 17 from 5/1/2025 to 5/20/2025. 2 a. Two out of 38 doses of tramadol HCl (a strong painkiller from a group of medicines called opiates, or narcotics) 50mg for Resident 76 on North Station, North Medication Cart on 5/21/2025 were not accurately accounted for and documented. b. Two out of 19 doses of lorazepam (a controlled medication [had a high potential for abuse] could be used to aid in the management of agitation) 1mg for Resident 76 on North Station, North Medication Cart on 5/21/2025 were not accurately accounted for and documented. c. One out of 11 doses of hydrocodone-acetaminophen (a strong painkiller from a group of medicines called opiates, or narcotics) 5-325mg for Resident 76 on North Station, North Medication Cart on 5/21/2025 was not accurately accounted for and documented. These deficient practices had the potential to result in Resident 17 not receiving enough calcium that could negatively affect Resident 17's overall health condition. These deficient practices also increased the risk for unsafe medication administration with the potential for diversion (situation when a medication was taken for use by someone other than whom it was prescribed) and medication errors due to lack of documentation, possibly resulting in serious health complications that could lead to hospitalization or death for Resident 76. Findings: 1. During a medication pass observation on 5/20/2025 at 8:22 a.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 did not administer oyster shell calcium 500mg to Resident 17. During a review of Resident 17's Admission Record, the Admission Record indicated Resident 17 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 17's diagnoses included difficulty in walking, metabolic encephalopathy (a condition that affected brain function due to an imbalance in the body's metabolism), and kidney failure. During a review of Resident 17's Minimum Data Set (MDS- a resident assessment tool), dated 3/24/2025, the MDS indicated Resident 17 had severely cognitive impairment (ability to think and reason). The MDS indicated Resident 17 was dependent (helper did all the effort) with eating, oral hygiene, and chair/ bed-to-chair transferring. (continued on next page)

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	05/22/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 17's History and Physical (H&P), dated 3/25/2025, the H&P indicated Resident 17 was unable to make healthcare decisions. During a concurrent interview and record review on 5/20/2025 at 10:45 a.m. with LVN 2, Resident 17's Medication Administration Record (MAR) from 5/1/2025 to 5/20/2025 was reviewed. The order for oyster shell calcium 500 mg was not transcribed onto the MAR. LVN 2 stated Resident 17's MAR did not have the order for oyster shell calcium 500mg order. During a concurrent interview and record review on 5/20/2025 at 10:47 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 17's electronic health record (EHR) was reviewed. The EHR indicated an order to administer oyster shell calcium 500 mg by mouth two times a day for vitamin D deficiency. LVN 2 stated Resident 17's oyster shell calcium 500mg order should be on the MAR. LVN 2 stated she needed to inform Resident 17's physician regarding the missing doses of oyster shell calcium. LVN 2 stated she worked the prior day (5/19/2025) and did not administer the oyster shell calcium to Resident 17 because the MAR did not have the medication listed. LVN 2 stated she reviewed residents' active orders on the EHR weekly, but she had not done so yet for the week. LVN 2 stated the purpose of checking residents' active orders on the EHR was to ensure the MAR was complete and accurate. LVN 2 stated Resident 17 did not get the oyster shell calcium in 5/2025 because the order was not on the MAR. LVN 2 stated it put Resident 17 at risk of mood changes, weakness, and pain in the bones. During an interview on 5/21/2025 at 10:51 a.m. with the Director of Nursing (DON), the DON stated the nurse who received the medication order was responsible for ensuring to add the orders on the residents' MAR. The DON stated the licensed nurses should check the PCC and ensure the paper MAR matched the active orders every shift to ensure accuracy. The DON stated the risk was that residents would not receive medications as ordered. The DON stated that it was a medication error when medication was ordered but not administered. During a review of the facility's policy and procedure (P&P) titled Medication Administration, undated, the P&P indicated Medications are administered in accordance with the written orders of the attending physician. During a review of the facility's P&P titled Physician Orders, dated 2/2014, the P&P indicated The receiving nurse with order/s will carry out the order and print the medication or treatment record/s. During a review of the facility's Charge Nurse Job Description, revised in 10/2020, the Job Description indicated the duties and responsibilities of the charge nurses were to Record verbal and telephone orders from practitioners on order sheets or in electronic health record (HER) per facility policies. The Job Description further indicated that the charge nurse should Audit nursing documentation in the clinical record for appropriate and relevant entries. 2. During a review of Resident 76's Admission Record, the Admission Record indicated Resident 76 was admitted to the facility on [DATE]. Resident 76's diagnoses included schizophrenia (a mental illness that was characterized by disturbances in thought), depression (a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities previously enjoyed), and low back pain. (continued on next page)

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	05/22/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 76's MDS, dated [DATE], the MDS indicated Resident 76 had moderate cognitive impairment. The MDS indicated Resident 76 required supervision with eating and oral hygiene; and moderate assistance (helper did less than half the effort) with toileting hygiene, showering/ bathing self, personal hygiene, and chair/ bed-to-chair transferring. During a review of Resident 76's H&P, dated 2/23/2025, the H&P indicated Resident 76 had the mental capacity to understand and make medical decisions. During a review of Resident 76's Order Summary Report, as of 5/1/2025, the report indicated the following: a. Tramadol HCl 50mg by mouth three times a day for pain. b. Lorazepam 1mg by mouth every 4 hours as needed for restlessness leading to agitation. c. Hydrocodone-acetaminophen 5-325mg by mouth every six hours as needed for pain. During a review on Resident 76's MAR, dated 5/1/2025 to 5/21/2025, the MAR indicated the following: 1. Two doses of Tramadol HCl 50mg were administered as indicated by the nurses' initials documented on the MAR, on 5/21/2025 at 8 a.m. and 12 p.m. 2. Two doses of lorazepam 1mg were administered as indicated by the nurses' initials documented on the MAR, on 5/21/2025 at 8 a.m. and 12 p.m. 3. One dose of hydrocodone-acetaminophen 5-325mg was administered on 5/21/2025 at 10 a.m. as indicated by the nurses' initials documented on the MAR, for the dates and times of 5/21/2025 at 10 a.m. During a concurrent observation, interview, and record review on 5/21/2025 at 2:00 p.m. with LVN 1, Resident 76's Narcotic Count Sheet (NCS) and bubble pack (a card that packaged doses of medication within small, clear, or light-resistant-amber-colored plastic bubbles) of Resident 76's 8 a.m. dose of Tramadol HCl 50mg was reviewed. Resident 76's NCS indicated there were 11 tablets remaining in the bubble pack for the morning dose. The bubble pack was observed containing 10 tablets of Tramadol HCl. LVN 1 stated there was a missing signature on the NCS on 5/21/2025 at 8 a.m. LVN 1 stated she was too busy to sign Resident 76's NCS after administrating the Tramadol HCl 50mg to Resident 76 at 8 a.m. During a concurrent interview and record review on 5/21/2025 at 2:00 p.m. with LVN 1, Resident 76's NCS and bubble pack for the resident's 12 p.m. dose of Tramadol HCl 50mg was reviewed. The NCS indicated there were 13 tablets remaining. The bubble pack was observed containing 12 tablets. LVN 1 stated there was a missing signature on Resident 76's NCS on 5/21/2025. LVN 1 stated she was too busy to sign Resident 76's NCS after administrating the Tramadol to Resident 76 at 12 p.m. During a concurrent interview and record review on 5/21/2025 at 2:00 p.m. with LVN 1, Resident 76's NCS and bubble pack of Resident 76's lorazepam was reviewed. Resident 76's NCS indicated there were 13 tablets remaining. The bubble pack was observed containing 11 tablets. LVN 1 stated there were two missing nurses' signatures on Resident 76's NCS on 5/21/2025 at 8 a.m. and 12 p.m. LVN 1 stated she was too busy to sign the NCS after administrating the lorazepam to Resident 76. (continued on next page)

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	05/22/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/21/2025 at 2:00 p.m. with LVN 1, Resident 76's NCS and bubble pack of Resident 76's hydrocodone-acetaminophen 5-325mg was reviewed. Resident 76's NCS indicated there were 20 tablets remaining. The bubble pack was observed containing 19 pills. LVN 1 stated there was a missing signature on the NCS on 5/21/2025 at 10 a.m. LVN 1 stated she was too busy to sign the NCS after administrating the hydrocodone-acetaminophen to Resident 76 at 10 a.m. LVN 1 stated she should sign the NCS after the medication administration because she needed to verify the medication was given. LVN 3 stated it was a medication error and dangerous. LVN 3 stated the risks of not signing the NCS were discrepancies and medication errors. During an interview on 5/21/2025 at 3:05 p.m. with the DON, the DON stated the nurse should sign the NCS after administering the medication and endorse to the next shift. The DON stated it was important because it was the rule. The DON stated not documenting on the NCS was a medication error and posed a risk for a miscounting of narcotic medications. The DON stated there were possibilities to administer extra doses of the narcotic medication. The DON stated the residents might overdose and the medication potency would increase in the resident's system. During a review of the facility's P&P titled Controlled Drugs, undated, the P&P indicated the nurse must enter the date and time of administration, dose administered, and the signature of the nurse that administered the dose on the NCS immediately after a dose of a narcotic drug was administered.

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	05/22/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on interview and record review, the facility failed to ensure residents were monitored for medication side effects or efficacy of medication for two of 12 sampled residents (Residents 17 and 29), by failing to: 1. Monitor signs and symptoms of bleeding for Resident 17, who was receiving Eliquis (an anticoagulant medication, used to prevent blood clots forming in the blood vessels and the heart). 2. Monitor Resident 17's sleep hours, who was receiving Trazadone (a medication used to treat depression [-a mental health disorder], and insomnia [-a sleep disorder]). 3. Monitor Resident 17's episodes of physical restlessness (behaviors such as agitation, inability to sit still) constantly trying to get up unassisted, who was receiving Buspar (a medication used to treat anxiety [-a feeling fear, and worry]). 4. Monitor signs and symptoms of bleeding for Resident 29, who was receiving Apixaban (an anticoagulant medication). These deficient practices placed Residents 17 and 29 at increased risk for preventable complications associated with anticoagulant use such as internal bleeding or bruising, which could result in death and had the potential to result in Resident 17 receiving unnecessary medications and not receiving the adequate care and treatment necessary for resident's physical, mental and psychosocial well-being. Findings: a. During a review of Resident 17's Admission Record, the Admission Record indicated Resident 17 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses which included anxiety, depression, atrial fibrillation (heart rhythm disorder where the heart beats irregularly and rapidly), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 17's Minimum Data Set (MDS - a resident assessment tool), dated 3/24/2025, the MDS indicated Resident 17's cognition (process of thinking) was severely impaired. The MDS indicated Resident 17 was dependent (helper does all the effort) on staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 17 was receiving an anticoagulant, antidepressant (used to treat depression), and antianxiety medications. During a review of Resident 17's History and Physical (H&P), dated 3/25/2025, the H&P indicated Resident 17 did not have the capacity to make healthcare decisions. During a concurrent interview and record review on 5/21/2025 at 9:05 a.m., with Licensed Vocational Nurse (LVN) 2, Resident 17's Order Summary Report, dated 5/1/2025, was reviewed. The order summary report indicated: (continued on next page)

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	05/22/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Resident 17 was ordered Eliquis 5 mg, two times a day, for atrial fibrillation. This order started on 3/22/2025. 2. Resident 17 had an order to monitor and document signs and symptoms of bleeding and bruising relating to Eliquis and to notify Resident's 17's physician of any signs and symptoms of bleeding were present. This order started on 4/2/2025. 3. Resident 17 was ordered Trazadone 50 mg, one time a day, for depression manifested by (m/b) inability to sleep. This order started on 3/22/2025. 4. Resident 17 had an order to monitor Resident 17's sleep hours every evening and night for use of Trazadone. This order started on 4/11/2025. 5. Resident 17 was ordered Busbar 15 mg, two times a day, and Buspar 20 mg, at bedtime, for anxiety m/b physical restlessness, constantly trying to get up unassisted. This order started on 3/22/2025. 6. Resident 17 had an order to monitor and document the number of episodes of physical restlessness, constantly trying to get up unassisted. This order started on 4/11/2025. During a concurrent interview and record review on 5/21/2025 at 9:15 a.m., with Licensed Vocational Nurse (LVN) 2, Resident 17's Medication Administration (MAR) from 5/1/2025 to 5/31/2025, was reviewed. LVN 2 stated there was no monitoring documented on Resident 17's MAR from 5//1/2025 to 5/21/2025. LVN 2 stated it was the Registered Nurses (RN) responsibility to transcribe (rewrite) physician orders onto the MAR for nursing staff to implement and follow the orders. LVN 2 stated Resident 17's monitoring orders from 5/1/2025 to 5/31/2025 were not transcribed onto Resident 17's MAR; therefore, Resident 17 was not monitored for potential side effects, changes in behavior, or sleep hours. LVN 2 stated this failure could place Resident 17 at risk for undetected side effects, ineffective treatment, and potential deterioration in health status. During an interview on 5/21/2025 at 2:22 p.m., with RN 2, RN 2 stated she was responsible for ensuring physician orders were transcribed onto Resident 17's MAR. RN 2 stated she missed the physician's monitoring orders and did not initiate any required monitoring for Resident 17 for the month of 5/2025. RN 2 stated this delay resulted in the orders not being made available to the nursing staff responsible for monitoring. RN 2 stated this failure to transcribe and implement physician orders placed Resident 17 at risk of suffering undetected internal bleeding, missed or delayed treatment, and a lack of behavioral monitoring such as increased agitation (feeling of unease), which could result in avoidable hospitalization s if not addressed immediately. 48131 b. During a review of Resident 29's Admission Record, the Admission Record indicated Resident 29 was initially admitted on [DATE] and readmitted on [DATE] with the following diagnoses which included metabolic encephalopathy (a change in how the brain works due to an underlying condition), atrial fibrillation (an irregular, often rapid heart rate that can cause poor blood flow, leading to blood clots, stroke, or heart failure), difficulty walking, lack of coordination, type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). (continued on next page)

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	05/22/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 29's History and Physical (H&P), dated 3/10/2025, the H&P indicated Resident 29 could make needs known but could not make medical decisions. During a review of Resident 29's MDS, dated [DATE], the MDS indicated Resident 29's cognition was severely impaired. The MDS indicated Resident 29 required moderate assistance (helper does less than half the effort) for toileting and required some help (resident needed partial assistance from another person to complete) for self-care and indoor mobility (the ability to move freely). The MDS indicated Resident 29 required a walker to assist with mobility. The MDS indicated Resident 29 was receiving an anticoagulant. During a review of Resident 29's Order Summary Report, dated 2/5/2025, the Order Summary Report indicated to start Apixaban Oral Tablet, 2.5 mg two times a day for atrial fibrillation. During a review of Resident 29's care plan titled The resident is on anticoagulant therapy Apixaban related to atrial fibrillation, initiated on 2/21/2025, the care plan indicated the resident would be free from discomfort or adverse reactions related to anticoagulant use. The care plan interventions indicated to monitor for side effects and effectiveness, and monitor/document/report any adverse reactions of anticoagulant therapy. During a concurrent interview and record review on 5/20/2025 at 3:09 p.m. with LVN 3, Resident 29's MAR for 3/2025 and care plan dated 2/21/2025 were reviewed. LVN 3 stated there was no monitoring for anticoagulants documented on Resident 29's MAR from 3/1/2025 through 3/20/2025. LVN 3 stated Resident 29 did not require monitoring for anticoagulant side effects which was why the anticoagulant monitoring was not on the MAR. LVN 3 stated she would only document and monitor the anticoagulant side effects if Resident 29 began to show signs and symptoms of bleeding or bruising. LVN 3 reviewed Resident 29's care plan for Apixaban which indicated to monitor and document Resident 29's side effects. LVN 3 stated she was unaware there was a care plan to monitor the side effects for Apixaban. LVN 3 stated she should have been monitoring and documenting for signs and symptoms for the use of Apixaban if there was a care plan initiated. LVN 3 stated she would have to notify Resident 29's physician that anticoagulant monitoring had not been done for the resident. During an interview on 5/22/2025 at 11:41 a.m., with the Director of Nursing (DON), the DON stated monitoring for anticoagulants should be documented on the MAR daily by the licensed nurse. The DON stated the nurse should have monitored Resident 29 and documented on the MAR whether or not side effects were present. The DON stated it was important to monitor and document anticoagulants for side effects to determine if there were signs of bleeding. The DON stated monitoring would also determine if the medication was effective for the resident. The DON stated not monitoring could lead to negative outcomes for the resident. The DON stated the nurses should follow the plan of care since Resident 29 had a care plan to monitor Apixaban. During a review of the facility's policy and procedures (P&P) titled Physician Orders, revised 2/2014, the P&P indicated the nurse receiving physician orders would carry out the order and print the medications or treatment records. The P&P indicated the orders would be communicated to the nurse and other departments as indicated. (continued on next page)

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	05/22/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Anticoagulation - Clinical Protocol, revised 11/2018, the P&P indicated as part of the initial assessment, the physician and staff would identify individuals who are currently anticoagulated and assess for any signs or symptoms related to adverse drug reactions. The P&P indicated the nurse shall assess and document/report current anticoagulation therapy including drug and current dosage, recent labs including therapeutic dose monitoring. The P&P indicated the staff, and physician would monitor for complications in individuals who are being anticoagulated and will manage related problems.

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	05/22/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 49900 Based on observation, interview, and record review, the facility failed to: 1. Remove one bottle of expired cetirizine hydrochloride (medication to relieve allergy symptoms) 5 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) inside one of two inspected medication carts (Main St Medication Cart). 2. Remove one bottle of expired haloperidol decanoate (antipsychotic medication [to treat psychosis- a severe mental illness where individuals experienced a distorted perception of reality) in one of two inspected medication rooms (Medication Room Nursing Station 2). These deficient practices increased the risk that residents could have received medications that had become expired and/or ineffective, possibly leading to health complications such as uncontrolled allergy symptoms and uncontrolled mental behaviors such as delusions (having false or unrealistic beliefs). Findings: 1. During a concurrent observation and interview on 5/21/2025 at 2:26 p.m. with Licensed Vocational Nurse (LVN) 2, observed one bottle of expired cetirizine hydrochloride 5 mg inside the Main St Medication Cart. The bottle indicated the medication expired on 3/2025. LVN 2 stated the bottle should not be inside the medication cart because it was expired. LVN 2 stated the medication was less effective after expired. LVN 2 stated the registered nurse (RN) audited the medication cart for any expired medication. 2. During a concurrent observation and interview on 5/21/2025 at 2:53 p.m. with LVN 5, in Medication Room Nursing Station 2, observed one bottle of expired haloperidol decanoate stored in the refrigerator. The haloperidol decanoate was observed with a label indicating expired on 1/2025. LVN 5 stated the expired haloperidol decanoate should not be stored in the refrigerator of Medication Room Nursing Station 2. LVN 5 stated the medication should have been disposed before it expired. LVN 5 stated the licensed nurses assigned to the station should be the one checking for expired medication monthly. LVN 5 stated the risks were harm to the residents, reactions from the medication, and medication ineffectiveness. During an interview on 5/21/2025 at 3:05 a.m. with the Director of Nursing (DON), the DON stated the medication carts and medication storage room should not have any expired medications. The DON stated the nurses should not administer any expired medication because of the expired medications were not effective. The DON stated it would be a medication error if the expired medication was administered. The DON stated the licensed nurse should check the medication expiration date before medication administration. The DON stated the pharmacist also audited the medication carts and checked the expiration dates of the medications. (continued on next page)

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	05/22/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's Policy and Procedure (P&P) titled Drug disposition, undated, the P&P indicated that Outdated non-controlled drugs are to be stored in a secured area designated for that purpose until picked up by the pharmaceutical waste disposal service or the pharmacy personnel.

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	05/22/2025

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 52411 Based on observation, interview, and record review, the facility failed to ensure physician ordered therapeutic diets were provided for one of six sampled residents (Resident 90), when Resident 90 did not receive their Magic Cup (a frozen dessert used for providing additional calories and protein to those experiencing involuntary weight loss). This failure could have resulted in insufficient food intake, unintentional weight loss, and a deterioration of Resident 90's overall health condition. Findings: During a review of Resident 90's Admission Record, dated 11/8/2024, the Admission Record indicated the facility initially admitted Resident 90 on 11/8/2024 and readmitted Resident 90 on 2/6/2025, with diagnoses that included cerebral infarction (loss of blood flow to a part of the brain), dysphagia (difficulty swallowing), depression (a common and serious medical illness that can significantly impact how a person feels, thinks, and acts). During a review of Resident 90's Minimum Data Set (MDS - a resident assessment tool), dated 2/14/2025, the MDS indicated Resident 90's cognition (thought process) was severely impaired. The MDS indicated Resident 90 required partial moderate assistance (helper does less than half the effort) from staff for activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting, and eating a person performs daily to care for themselves). During a review of Resident 90's Order Summary Report, dated 4/16/2025, the document indicated, Resident 90 was to receive a fortified diet pureed texture, honey thick liquid consistency magic cup two times a day for supplement. During a review of Resident 90's medication administration record (MAR), dated 5/1/2025 thru 5/21/2025 the document indicated scheduled times for Magic Cup was at 12:00 p.m. and 5:00 p.m. During an observation on 5/21/2025 at 12:00 p.m. in the facility Dining Room, Resident 90 was observed to receive a lunch tray with a meal ticket that indicated Resident 90 was to be served, Pureed, fortified - thick fluids-nectar, magic cup. During a concurrent observation and interview on 5/21/2025 at 12:09 p.m. with Certified Nurse Assistant 7 (CNA7) in the facility Dining Room, CNA 7 was aiding Resident 90 with his meal tray and stated, there was no Magic Cup on Resident 90's meal tray. During an interview on 5/21/2025 at 1:46 p.m. with the Dietary Supervisor (DS), the DS stated he was aware Resident 90 did not receive their Magic Cup. The DS stated that the assigned dietary aide was responsible for ensuring the trays were serve correctly, and the nurse that checked the trays prior to passing them out should have noticed the missing Magic Cup. (continued on next page)

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	05/22/2025

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/2025 at 12:09 p.m. with the Director of Nursing (DON) the DON stated the meal trays were checked twice - first by the dietary department and then by the nursing department who has a list with all the residents diet orders to assist in ensuring the resident receives the proper ordered diet. During a review of the facility's policy and procedure (P&P) titled, Food and Nutrition Services revised 10/2017, the P&P indicated the facility would provide each resident with a nourishing and well-balanced that meets their daily nutritional and dietary needs. The P&P indicated food and nutrition services staff would inspect food trays to ensure that the correct meals was provided to each resident.

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	05/22/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47858 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1. Two containers that contained personal food were stored inside Refrigerator 1. 2. One opened bottle of chocolate syrup, one opened bottle of caramel drizzle, one opened can of whipped cream and one container of white chopped onions were stored and unlabeled in the walk-in refrigerator. 3. One opened carton of ice cream was stored in the walk-in freezer unlabeled. These failures had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 95 of 99 medically compromised residents who received food from the kitchen. Findings: 1. During a concurrent interview and observation on 5/19/2025 at 8:24 a.m. with Dietary Aide (DA) 1, in the facility kitchen, Refrigerator 1 was observed. Refrigerator 1 had two personal plastic food containers that contained personal food items that belonged to one of the dietary staff members stored on the second shelf. DA 1 stated the personal food items should not have been placed in Refrigerator 1. 2. During a concurrent interview and observation on 5/19/2025 at 8:30 a.m. with DA 1, the walk-in refrigerator was observed. One opened bottle of chocolate syrup, one opened bottle of caramel drizzle, one opened can of whipped cream and one container of white chopped onions was stored and unlabeled. DA 1 stated all opened food stored in the refrigerator should have been labeled with the date that it was opened and the date it was stored in the refrigerator. 3. During a concurrent interview and observation on 5/19/2025 at 8:33 a.m. with DA 1, one opened carton of ice cream was stored in the walk-in freezer unlabeled. DA 1 stated the ice cream carton should have been labeled. During an interview on 5/202/2025 at 3:10 p.m. with the Dietary Supervisor (DS), the DS stated it was important all opened and prepared foods were labeled with the date it was opened or prepped, and the date it was stored in the refrigerator. The DS stated personal food items should not have been placed in the refrigerator. The DS stated this placed all residents at risk for cross contamination and food borne illnesses. During a review of the facility's Policy and Procedure (P&P), titled, Sanitation and Infection Control, dated 2018, the P&P indicated the facility staff were to ensure the following: (continued on next page)

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	05/22/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. No outside food would be stored in the Department of Food and Nutrition Services. 2. Leftover foods would be refrigerated, covered, labeled and dated immediately. 3. Frozen food should be labeled with the date it was stored in the freezer.

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	05/22/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on observation, interview, and record review, the facility failed to implement infection (the invasion and multiplication of microorganisms [like bacteria, viruses, etc.] in body tissues, potentially causing illness or harm) control practices for one of six residents (Resident 40) when Resident 40's urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) drainage bag was observed touching the floor on 5/20/2025. This deficient practice placed Resident 40 at risk for infection which could increase the resident's and other residents morbidity (the amount of disease in a population) and mortality (the state of being subject to death). Findings: During an observation on 5/20/2025 at 11:47 a.m. in Resident 40's room, Resident 40 was observed lying on the bed. The urinary catheter drainage bag was touching the floor. During an observation on 5/20/2025 at 1:27 p.m. in Resident 40's room, Resident 40 was observed lying on the bed. The urinary catheter drainage bag was touching the floor. During a review of Resident 40's Admission Record, the record indicated Resident 40 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 40's diagnoses included chronic kidney disease (CKD, when kidneys were damaged and could not filter blood properly, leading to a buildup of waste and fluid in the body) and dementia (a progressive state of decline in mental abilities). During a review of Resident 40's Minimum Data Set (MDS - a resident assessment tool), dated 5/7/2025, the MDS indicated Resident 40 had moderate cognitive impairment (ability to think and reason). The MDS indicated Resident 40 required supervision with oral hygiene and chair/bed-to-chair transferring. The MDS indicated Resident 40 required moderate assistance (helper did less than half the effort) with toileting hygiene, showering/ bathing self, and personal hygiene. The MDS indicated Resident 40 used a wheelchair for mobility. During a review of Resident 40's History and Physical (H&P), dated 4/2/2025, the H&P indicated Resident 40 did not have the capacity to understand and make decisions. During a review of Resident 40's care plan titled, Indwelling catheter, dated 5/19/2025, the care plan indicated the goal was for Resident 40 to have no signs and symptoms of urinary infection. (continued on next page)

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	05/22/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/6/2025 at 1:32 p.m. with Licensed Vocational Nurse (LVN) 4, in Resident 40's room, observed Resident 40 lying in bed with the urinary catheter drainage bag touching the floor. LVN 4 stated the urinary catheter drainage bag should not be touching the floor because of the infection control. LVN 4 stated the urinary catheter drainage bag should be placed inside the basin when the resident was lying on the bed. LVN 4 stated the drainage bag on the floor placed Resident 40 at risk for urinary tract infection (UTI, an infection in the bladder/urinary tract). LVN 4 stated bacteria could enter the urinary catheter drainage bag when touching the floor. LVN 4 stated everyone was responsible for making sure Resident 40's urinary catheter drainage bag was off the floor. LVN 4 stated staff should check the placement of the urinary catheter drainage bag during repositioning every two hours, during certified nursing assistant (CNA) room rounds every 15 minutes, and during LVN room rounds every hour. During a concurrent interview and review of two photos of Resident 40's urinary catheter drainage bag on 5/21/2025 at 11:02 a.m. with the Infection Preventionist Nurse (IPN), the photos dated 5/20/2025 at 11:47 a.m. and 5/20/2025 at 1:27 p.m. were reviewed. The photos showed the urinary catheter drainage bag touching the floor. The IPN stated this was an inappropriate position of the urinary catheter drainage bag. The IPN stated the urinary catheter drainage bag should not be touching the floor because the bag was connected to Resident 40's urinary system. The IPN stated Resident 40 could have infection such as UTI and bladder infection. The IPN stated all staff were responsible for ensuring the urinary catheter drainage bag was off the floor when checking on the residents. During a review of the facility's Policy and Procedure (P&P) titled Catheter Care, Urinary, dated 3/2024, the P&P indicated Be sure the catheter tubbing and drainage bag are kept off the floor.

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	05/22/2025

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 0911 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. 48343 Based on observation, interview, and record review, the facility failed to ensure that resident bedrooms accommodated no more than four residents in four of 42 bedrooms (Rooms A, B, C, and D). This deficient practice could adversely affect the adequacy of space, nursing care, comfort, and privacy to the residents and their visitors residing in Rooms A, B, C, and D. Findings: During a review of the facility's census, dated 5/19/2024, the census indicated Rooms A, B, C, and D had the capacity to accommodate six residents in the room. During a review of the facility's Client Accommodation Analysis (undated), the Client Accommodation Analysis indicated the following measurements for Rooms A, B, C, and D: 1. Rooms A and B measured 478.33 square feet ([sq. ft.]- unit of measurement). 2. Room C measured 487.44 sq. ft. 3. Room D measured 479.79 sq. ft. During the initial tour of the facility, on 5/19/2025 at 9:30 a.m., it was observed Rooms A, B, C, and D were occupied by six residents in each room. During observations made throughout the course of the survey from 5/19/2025 to 5/22/2025, there were no adverse effects that pertained to the adequacy of space, nursing care, comfort, and privacy of the residents in Rooms A, B, C, and D. The rooms had enough space for the resident's beds and dressers. During a concurrent interview and record review on 5/22/2025 at 10:55 a.m., with the Director of Nursing (DON), the facility's Room Waiver Request, dated 5/21/2025, was reviewed. The request indicated the facility normally admitted residents for behavior and psychological problems. The DON stated Rooms A, B, C, and D had six residents in each room. The DON stated the facility would continue to request for a room waiver and in its requesting granting room variance, which will not adversely affect the residents' health and safety. The Department will recommend continuation of the request for a waiver/variance.

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	05/22/2025

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on interview and record review, the facility failed to meet the required room size measurement of 80 square feet per resident in rooms with multiple residents. This deficient practice had the potential for inadequate space for each resident's privacy and unsafe nursing care. Findings: During a review of the facility's Room Waiver Request letter, dated 5/21/2025, the Room Waiver Request Letter indicated the following two-person rooms did not meet the 80 square feet ([sq. ft.]- a unit of measurement) per resident requirement: Room # # of beds Square Foot Per Room room [ROOM NUMBER] 2 139.75 sq. ft. room [ROOM NUMBER] 2 141.31 sq. ft. room [ROOM NUMBER] 2 139.18 sq. ft. room [ROOM NUMBER] 2 139.18 sq. ft. room [ROOM NUMBER] 2 139.18 sq. ft. room [ROOM NUMBER] 2 139.18 sq. ft. room [ROOM NUMBER] 2 140.25 sq. ft. room [ROOM NUMBER] 2 140.25 sq. ft. During observations made throughout the course of the survey, from 5/19/2025 to 5/22/2025, there were no adverse effects that pertained to the residents' care provided by facility staff, residents' privacy, health, and safety related to the provided living space of less than 80 sq. ft. per resident. During a concurrent record review and interview, on 5/22/2025 at 10:55 a.m., with the Director of Nursing (DON), the facility's Room Waiver Request, dated 5/21/2025, was reviewed. The DON stated that the rooms were a little bit under the regulatory requirements and that the facility would ensure patient care and safety would not be compromised or affected.

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	05/22/2025

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to ensure the call system was functional for two of eight sampled residents (Resident 47 and Resident 78). This deficient practice resulted in Resident 47 being unable to summon staff for assistance in a timely manner and had the potential to result in Resident 47's and Resident 78's needs to go unmet and compromise the residents' safety and cause bodily injury from a fall. Findings: a. During a concurrent observation and interview on 5/19/2025 at 10:07 a.m., with Resident 47, Resident 47 was observed in his room, lying in bed awake and alert. Resident 47's call light was observed hanging from a hook on the wall. Resident 47 stated he was cold and asked if he could be covered up with his blanket. Resident 47 stated he could not reach his call light device. Resident 47 stated the call light device was hanging on the wall because it had been working for months. Resident 47 was handed the call light to push at 10:08 a.m. Observed the light on the wall did not light up nor did the light outside of the door light up after the call light was pushed. There was no audible (to hear) sound after the call light device was pushed. Observed nursing staff walking in the hallway at 10:20 a.m., none of the staff responded to the call light. During a review of Resident 47's Admission Record, the Admission Record indicated Resident 47 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses which included bilateral (on both sides) osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of the hip, difficulty walking, lack of coordination, asthma (a chronic disease of the airways that makes breathing difficult), dysphagia (difficulty swallowing), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 47's History and Physical (H&P), dated 3/19/2025, the H&P indicated Resident 47 was able to express his needs. During a review of Resident 47's Minimum Data Set (MDS - a resident assessment tool), dated 3/28/2025, the MDS indicated Resident 47's cognition (ability to think, remember, and reason) was severely impaired. The MDS indicated Resident 47 required supervision (helper provides verbal cues and/or touching/steadying as resident completes the activity) with toileting, bathing, oral and personal hygiene. The MDS indicated Resident 47 required a walker to assist with mobility. During a review of Resident 47's care plan titled, Limited physical mobility (the ability to move freely) related to difficulty walking and lack of coordination, initiated on 3/21/2025, the care plan indicated Resident 47 would remain free of complications related to immobility (state of not being able to move around) and activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) needs would be met safely. The care plan interventions indicated to place call light within reach. (continued on next page)

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	05/22/2025

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 47's care plan titled Activities of Daily Living self-care and mobility deficit, initiated on 4/9/2025, the care plan indicated Resident 47 had impaired cognition, incontinence (lacking control of bowel or bladder) and required assistance with ADLs. The care plan interventions indicated to encourage Resident 47 to use the bell to call for assistance. During a review of Resident 47's Fall Risk Assessment, dated 4/10/2025, the Fall Risk Assessment indicated Resident 47 had a moderate risk for falls. During a concurrent observation and interview on 5/19/2025 at 10:21 a.m., with Certified Nursing Assistant (CNA) 4, CNA 4 observed Resident 47's call light device hanging from a hook on the wall. CNA 4 stated the Resident 47 could not reach the call light. CNA 4 pushed the call light and observed the call light did not light up on the wall or outside of the door. CNA 4 stated Resident 47 could not call out for assistance if the call light was not working. CNA 4 stated it was her responsibility to ensure the call light was working properly and within the resident's reach. During an interview on 5/22/2025 at 11:33 a.m. with the Director of Nursing (DON), the DON stated the nursing staff should check to ensure call lights are working properly and within reach of the residents every change of shift. The DON stated not having a functioning call light device could delay care and services for the residents especially in the event of an emergency. 47858 b. During a review of Resident 78's Admission Record, the Admission Record indicated Resident 78 was originally admitted on [DATE] with diagnoses that included muscle weakness, dementia (a progressive state of decline in mental abilities), fracture (broken bone) of the right humerus (long bone in upper arm) and neck of right femur (the portion of the femur that connects the head of the thigh bone to the shaft of the thigh bone). During a review of Resident 78's MDS, dated [DATE], the MDS indicated Resident 78's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 78 required supervision or touching assistance for the completion of ADLs. During a review of Resident 78's care plan, titled, ADL Self-Care Mobility Performance, initiated 2/11/2025, the care plan indicated the staff's interventions were to encourage Resident 78 to use the call bell for assistance. During a review of Resident 78's care plan, titled, At Risk for Falls, initiated 2/11/2025, the care plan indicated the staff's interventions were to encourage Resident 78 to call for assistance, keep the call light in easy reach, and keep the environment free of safety hazards. During an observation on 5/19/2025 at 9:42 a.m., Resident 78's call light was pushed and the call light indicator located outside of Resident 78's room was not lit. During a concurrent observation and interview on 5/19/2025 at 2:49 p.m. with CNA 6, Resident 78's call light was pushed and the call light indicator located outside of Resident 78's room was not lit. CNA 6 stated Resident 78's call light indicator was not lit on the switchboard located near the nurses' station. CNA 6 stated Resident 78's call light did not work and there was potential for Resident 78's needs to be unmet, and for Resident 78 to fall. (continued on next page)

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	05/22/2025

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/2025 at 3:30 p.m. with the DON, the DON stated if Resident 78's call light was not functioning, Resident 78 would not be able to ask for help to address her needs timely. The DON stated it would increase the likelihood Resident 78 were to fall or sustain an injury. During a review of the facility's policy and procedures (P&P) titled, Call System, Residents, dated 2001, the P&P indicated, Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. The P&P indicated: 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. 2. Call system communication may be audible or visual. The system may be wired or wireless. 3. The resident call system remains functional at all times. If audible communication is used, the volume is maintained at an audible level that can be easily heard. If visual communication is used, the lights remain functional. 4. The resident call system is routinely maintained and tested by the maintenance department. 5. Calls for assistance are answered as soon as possible, but no later than 5 minutes. Urgent requests for assistance are addressed immediately.