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	055367	A. BUILDING _____ B. WING _____	C 03/27/2025

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MONROVIA GARDENS HEALTHCARE CENTER	615 W. DUARTE RD. MONROVIA, CA 91016

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey for two complaints and one Facility Reported Incident. Complaint Numbers: CA00951577 and CA00952922 Facility Reported Incident Numbers: CA00953718 The inspection was limited to the specific complaints and Facility Reported Incident investigated and does not represent the findings of a full inspection of the facility. Deficiencies were issued for complaints: CA00951577 at F583, F677, F806, and F807 and CA00952922 at F697 and F725. No deficiencies were issued for Facility Reported Incident: CA00953718.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the	F 583	**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** Resident 8 was informed of the breach on March 26, 2025, and was assured that the facility would take all appropriate steps to mitigate any potential negative consequences resulting from the incident. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;**	

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

Administrator | 4/18/25

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.

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F 583	Continued From page 1 residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to protect resident's rights to privacy and confidentiality of protected health information (PHI, any information in the medical record that can be used to identify an individual and that was created, used, or disclosed in the course of providing a health care service such as diagnosis or treatment) for one of 15 sampled residents (Resident 8) when the Social Services Director (SSD) emailed Resident 8 ' s Face Sheet (Admission Record) and podiatry (medical care and treatment of the feet) care needs to an unauthorized recipient. This deficient practice had the potential to compromise Resident 8's privacy and confidentiality.	F 583	All residents had the potential to be affected by this deficient practice. Beginning on March 27, 2025, the Social Services Director conducted outreach to residents within the facility to identify any additional potential breaches and to ensure there were no further incidents or concerns related to the confidentiality of Protected Health Information (PHI). No additional findings were identified as a result of this review. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.** From March 27 to March 28, 2025, licensed nurses and department supervisors participated in an in-service training conducted by the Administrator or designee. The training focused on the protection of residents' rights to privacy and the confidentiality of Protected Health Information (PHI), in accordance with HIPAA regulations. On March 27, 2025, the Administrator conducted a one-on-one training with the Social Services Director, emphasizing the importance of secure communication practices and the protection of residents' rights to privacy and the confidentiality of Protected Health Information (PHI), in compliance with HIPAA regulations. The Social Services Director will adhere to safe communication practices and	

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F 583	Continued From page 2 Findings: During a review of Resident 8 ' s Admission Record (AR), the AR indicated the facility admitted Resident 8 on 11/17/2022, with diagnoses including anemia (a condition in which the blood does not have enough healthy red blood cells to carry oxygen throughout the body), chronic pain, and gout (a form of arthritis [a disease that causes joint damage] that causes pain and swelling in the joints). The AR indicated Resident 8 ' s PHI including Resident 8 ' s Medicaid (government program that provides health insurance for persons with limited income and resources), Medicare (federal health insurance program for anyone age 65 and older), and insurance policy numbers, home address, and care providers. The AR indicated Resident 8 ' s emergency contact and financial representative was Family Member (FM) 1. During a review of Resident 8 ' s History and Physical Examination (H&P), dated 8/16/2024, the H&P indicated Resident 8 can make his needs known but cannot make medical decisions. During a review of an electronic mail (e-mail) dated 10/14/2024, timed at 10:45 am, sent by the facility ' s SSD, the email indicated the email subject was Resident 8 ' s name. The email indicated information regarding Resident 8 ' s podiatry care needs and had Resident 8 ' s AR attached. The email was sent to another resident ' s (Resident 1 ' s) family member (FM 2). During a review of Resident 8 ' s Minimum Data Set (MDS, a resident assessment tool), dated 2/25/2025, the MDS indicated Resident 8 had	F 583	will promptly report any potential breaches of confidentiality to the Administrator for further review and appropriate action. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The ADMIN/designee will provide any negative findings to QAPI committee monthly x 3 months for further monitoring and action planning as indicated or until QAA committee determines compliance. **Date of Compliance: April 1st, 2025**	

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F 583	Continued From page 3	F 583		

severely impaired cognition (ability to think, learn and remember). The MDS indicated Resident 8 required substantial/maximal assistance (helper does more than half the effort) with toileting, shower/bathe self, upper and lower body dressing, and putting on/taking off footwear.

During a concurrent interview and record review on 3/25/2025 at 4:49 pm with the SSD, the SSD ' s email dated 10/14/2024 and timed at 10:45 am was reviewed. The SSD stated the SSD sent the email containing Resident 8 ' s Face Sheet and information regarding podiatry care to FM 2 (Resident 1 ' s family member) by mistake. The SSD stated the SSD thought she was sending the email to Medical Provider 1 who had the same first name as FM 2.

During a follow-up interview on 3/27/2025 at 1:45 pm with the SSD, the SSD stated after the SSD recognized SSD's mistake of sending the email to the wrong recipient, the SSD recalled SSD's email right away. The SSD stated SSD could not remember when SSD recalled the email. The SSD stated the SSD did not report the accidental emailing of Resident 8 ' s confidential information to unauthorized recipient to anyone.

During an interview on 3/27/2025 at 2:16 pm with the Administrator (ADM), the ADM stated the SSD needed to report the breach of protected health information to the ADM and the DON immediately. The ADM stated for any breach of PHI, the facility needed to investigate to find out what transpired and reach out to the resident and/or responsible party (RP) to notify them of description of breached information and guide them on how to protect themselves from any threats because of the breach. The ADM stated

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F 583	Continued From page 4 the facility needed to notify the receiving party and ask the receiving party to destroy or return the PHI. During an interview on 3/27/2025 at 3:55 pm with the Director of Nursing (DON), the DON stated for any breach of PHI, as soon as facility staff found out PHI was sent to the wrong recipient, staff needed to notify the wrong recipient that the information was sent in error and needed to communicate the incident to the resident and/or RP. The DON stated the SSD needed to immediately report the incident to the ADM so the ADM could follow-up and guide the SSD on what to do and provide the SSD education on privacy/confidentiality. During a review of the facility ' s policy and procedure (P&P) titled, "Confidentiality of Information and Personal Privacy," revised 10/2017, the P&P indicated, "The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records." The P&P indicated, "Access to resident personal and medical records will be limited to authorized staff and business associates."	F 583		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 1) who required	F 677	**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** On March 27, 2025, Resident #1 was promptly provided with Activities of Daily Living (ADL) care by a facility CNA as soon as the deficient practice was identified.	

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F 677	Continued From page 5 assistance with activities of daily living (ADLs-tasks of everyday life such as bathing, dressing, and toileting) was provided care when staff did not change Resident 1 ' s incontinence (involuntary loss of urine or feces) brief (diaper) promptly. This failure resulted in Resident 1 to not receive assistance with ADL as needed and had the potential to result in skin breakdown and affect Resident 1 ' s well-being. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was admitted to the facility on 10/4/23, with diagnoses which included conversion disorder (condition where a mental health issue causes physical symptoms), anarthria (loss of speech due to inability to control the muscles used for speaking), and aphonia (loss of voice). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 1/9/25, the MDS indicated Resident 1 had no speech but was able to express ideas and wants and had moderately impaired cognition (ability to think, learn, and remember). The MDS indicated Resident 1 was dependent on staff for toileting hygiene, lower body dressing, and for putting on/taking off footwear and required substantial/maximal assistance (helper does more than half the effort) with showering/bathing and personal hygiene. During a review of Resident 1 ' s care plan (CP) titled, "Care Plan Report," revised 3/25/25, the CP indicated Resident 1 had ADL decline and	F 677	**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents had the potential to be affected by this deficient practice. On March 28th, 2025, Department supervisors conducted room rounds to follow up with residents to ensure there were no other concerns pertaining to ADL care. No additional findings were identified as a result. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.** From March 27 to March 28, 2025, licensed nurses and CNAs participated in an in-service training conducted by the Administrator/designee. The training focused on the importance of providing timely ADL care, with an emphasis on promptly responding to call lights to ensure residents' needs are consistently and adequately met. The Director of Staff Development (DSD)/ Designee will conduct random daily rounds to ensure timely ADL care is being provided and that residents' needs are being consistently met. Any negative findings will be reported to the Director of Nursing (DON) for further review and appropriate follow-up.	

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F 677	Continued From page 6 alteration in physical functioning. The CP interventions included to check Resident 1 for incontinence every two hours and as needed (PRN) and provide good peri-care (the cleaning and maintenance of the genitals and anal areas) after episodes. During a concurrent observation and interview on 3/27/25 at 9:45 am with Resident 1, in Resident 1 ' s room, Resident 1 was in bed. Resident 1 gestured with Resident 1's hand and mouthed words for the surveyor to put on gloves. Resident 1 pulled off Resident 1 ' s thick blankets to show that Resident 1 was wet. Resident 1 ' s bottom bedsheet, pad, top cover sheet, and gown were wet. Resident 1 moved Resident 1's shoulders up and mouthed "long time ago" when asked when Resident 1 was last changed. Resident 1 pressed Resident 1's call light and showed Certified Nursing Assistant (CNA) 6 that Resident 1 was wet. During an interview on 3/27/25 at 9:50 am with CNA 6, CNA 6 stated CNA 6 did not change Resident 1 ' s diaper yet that morning (3/27/25) because Resident 1 usually called for help when Resident 1 was wet. During an interview on 3/27/25 at 12:51 pm with CNA 6, CNA 6 stated CNA 6 normally checked all the residents assigned to CNA 6 and changed the residents as needed in the morning upon the start of CNA 6's shift. CNA 6 stated that morning (3/27/25), CNA 6 did not know CNA 6's assignment when CNA 6's started CNA 6's shift, so CNA 6 passed trays to all the different stations while waiting for CNA 6's assignment. CNA 6 stated the morning shift CNAs got behind on checking on their assigned residents because the	F 677	**How the facility plans to monitor its performance to make sure that solutions are sustained;** The DON/designee will provide any negative findings to QAPI committee monthly x 3 months for further monitoring and action planning as indicated or until QAA committee determines compliance. **Date of Compliance: April 1st, 2025**	

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F 677	Continued From page 7 CNA staffing assignment was not done. During an interview on 3/27/25 at 12:58 pm with the Director of Staff Development (DSD), the DSD stated the DSD made the CNA staffing assignment for the morning shift on 3/27/25. The DSD stated the DSD took longer to complete the CNA staffing assignment because it had to be revised more than once due to registry staff (staff personnel provided by a placement service on a temporary or on a day-to-day basis, in a facility). The DSD stated the CNA assignment was not done until after 7:30 am. The DSD stated it was important to have the CNA staffing assignment ready at the beginning of the shift so the CNAs could start tending to the residents, providing care, changing, and making sure everybody was safe. The DSD stated the morning CNAs needed to check on their residents at the start of their shift and change the residents who needed immediate changing. During an interview on 3/27/25 at 3:55 pm with the Director of Nursing (DON), the DON stated facility staff needed to check the residents, provide incontinent care, peri-care, and change residents every two hours and as needed. The DON stated the outgoing licensed nurse needed to complete the staffing assignment for the incoming shift. The DON stated it was important to have the staffing assignment ready as soon as the CNAs came in to work so the CNAs would know their assigned residents right away and could provide care right away. During a review of the facility ' s policy and procedure (P&P) titled, "Activities of Daily Living (ADL), Supporting," revised 3/2018, the P&P indicated, "Appropriate care and services will be	F 677		

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F 677	Continued From page 8 provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with ... hygiene (bathing, dressing, grooming, and oral care) ... elimination (toileting) ..."	F 677		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to manage pain for one of seven sampled residents (Resident 2) as indicated in Resident 2's care plan and the facility's policy and procedure (P&P) titled, "Pain Assessment and Management," by failing to: 1. Ensure licensed nurses (LNs) assessed and documented Resident 2's pain level before and after administration of oxycodone (medication used to treat moderate to severe pain) for pain management. 2. Ensure LNs assessed and documented Resident 2's abdominal pain level and characteristic and administered pain medication as needed and ordered by the physician on 1/13/2025 and 1/14/2025. These deficient practices had the potential for Resident 2 to experience unrelieved/uncontrolled pain that could result in physical, mental, and	F 697	**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** Resident #2 was transferred to the hospital on January 14, 2025, and is no longer residing at the facility. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All Residents have the potential to be affected by this deficient practice. On March 27, 2025, the Medical Records Supervisor/designee reviewed pain level documentation for the 30 days prior, focusing on pre- and post-pain medication administration, to ensure no other residents were affected by this deficient practice. No additional findings identified. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.**	

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F 697	Continued From page 9 emotional distress. Findings: During a review of Resident 2's Admission Record (AR), the AR indicated the facility admitted Resident 2 on 12/13/2024, with diagnoses that included fracture (break in a bone) of the right femur (thigh bone), subsequent encounter for closed fracture (broken bone without puncture or open wound) with routine healing, other abnormalities of gait and mobility, and other muscle spasm. During a review of Resident 2's History and Physical Examination (H&P) dated 12/14/2024, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2's Care Plan (CP) titled, "Care Plan Report," initiated on 12/14/2024, the CP indicated Resident 2 was at risk for unrelieved pain due to right hip fracture status post (s/p- condition after) open reduction and internal fixation (ORIF- surgical procedure to treat bone fractures). The CP interventions included for staff to monitor/document pain on a scale of zero (0) to 10 (0 = no pain and 10 = the worst pain) before and after implementing measures to reduce pain. During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 12/18/2024, the MDS indicated Resident 2 was able to understand others and express ideas and wants. The MDS indicated Resident 2 had severely impaired cognition (ability to think, learn, and remember), required substantial/maximal assistance (helper does more than half the effort)	F 697	From March 24 to March 28, 2025, licensed nurses received in-service training conducted by the Administrator/ designee. The training focused on pain management, including proper procedures and protocols for pain assessment and timely intervention, to prevent physical, mental, and emotional distress. The Medical Records Supervisor will conduct bi-weekly reviews of the Medication Administration Record (MAR) to ensure pain level documentation is completed both prior to and following the administration of pain medication. Any negative findings will be reported to the Director of Nursing (DON) during the daily clinical stand-up meeting to ensure timely identification and resolution of concerns. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The DON/designee will provide any negative findings to QAPI committee monthly x 3 months for further monitoring and action planning as indicated or until QAA committee determines compliance **Date of Compliance: April 1st, 2025**	

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F 697	Continued From page 10	F 697		

with toileting hygiene, showering/bathing self, lower body dressing, putting on/taking off footwear, and rolling left and right on the bed, and was dependent on staff for chair/bed-to-chair transfer. The MDS indicated Resident 2 received scheduled pain medication regimen and had no pain in the last five days of assessment.

During a review of Resident 2's Physician Order (PO) dated 12/20/2024, the PO indicated Resident 2 had an order for licensed staff to administer oxycodone hydrochloride (HCl) oral tablet 5 milligrams (mg- unit of measurement), one (1) tablet by mouth two times a day for pain management.

During a review of Resident 2's Medication Administration Records (MAR) for 12/2024 and 1/2025, the MAR indicated Resident 2 received the oxycodone HCl two times a day at 9 am and 5 pm from 12/20/2024 to 12/31/2024 and 1/1/2025 to 1/13/2025.

During a review Resident 2's Progress Notes (PN) dated 1/13/2025, timed at 11:53 am, the PN indicated Nurse Practitioner (NP 1) visited Resident 2 at the bedside and ordered abdominal ultrasound (US- imaging test that uses sound waves to take pictures of the inside of the body) due to Resident 2's complaint of right upper abdominal pain. The PN indicated no documentation of Resident 2's pain level and characteristic and what interventions were provided to address Resident 2's pain on 1/13/2025.

During a review of Resident 2's PO dated 1/13/2025, the PO indicated Resident 2 had an order for licensed staff to administer oxycodone

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MONROVIA GARDENS HEALTHCARE CENTER	615 W. DUARTE RD. MONROVIA, CA 91016

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HCl oral tablet 5 mg, one tablet by mouth every 12 hours as needed for moderate to severe pain (pain level of 4 to 10 out of 10).

During a review of Resident 2's Change in Condition Evaluation (CICE) dated 1/14/2025, timed at 3:30 pm, the CICE indicated Resident 2 complained of abdominal pain and was requesting to be transferred to the hospital for further evaluation and treatment. The CICE indicated no documentation of Resident 2's pain level and pain characteristic.

During an interview on 3/26/2025 at 8:01 am with Licensed Vocational Nurse 2 (LVN) 2, LVN 2 stated Resident 2 complained of frequent back and hip pain and received routine oxycodone at 9 am and 5 pm. LVN 2 stated any resident who complained of pain needed to be assessed for facial grimacing (expression of pain/strong dislike) and pain level from a scale of 0 to 10. LVN 2 stated depending on the resident's pain level, LVN 2 would provide non-pharmacological (treatment or strategies that do not involve medications) interventions first and if ineffective, would follow with pain medication as ordered. LVN 2 stated, LNs needed to assess and document the resident's (in general) pain level on the electronic MAR (eMAR) and/or progress notes before giving routine and/or as needed (PRN) pain medication. LVN 2 stated LNs needed to reassess and document the resident's pain level an hour after giving the pain medication to evaluate if the pain medication was effective in relieving the resident's pain.

During a concurrent interview and record review on 3/26/2025 at 8:58 am with Registered Nurse Supervisor (RNS) 1, Resident 2's MAR for

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12/2024 and 1/2025 and Resident 2's PN from 12/2024 to 1/2025 were reviewed. The MAR for 12/2024 and 1/2025 indicated Resident 2 received oxycodone HCl every day at 9 am and 5 pm routinely (regularly) for pain management as ordered by the physician. RNS 1 stated Resident 2's MAR and PN indicated no documented evidence LNs assessed and documented Resident 2's pain level before and after administering oxycodone. RNS 1 stated LNs needed to assess and document the residents' (in general) pain level before and after giving routine and/or PRN pain medication.

During the same concurrent interview and record review on 3/26/2025 at 8:58 am with RNS 1, Resident 2's PN dated 1/13/2025 and 1/14/2025, CICE dated 1/14/2025, and MAR for 1/2025 were reviewed. RNS 1 stated she was the RNS on duty on 1/13/2025 and 1/14/2025, and RNS 1 completed Resident 2's CICE dated 1/14/2025. RNS 1 stated Resident 2 complained of abdominal pain on 1/14/2025 and told RNS 1 her pain (Resident 2's) was "bad." RNS 1 stated Resident 2 was crying at that time and requested to be transferred to the hospital. RNS 1 stated RNS 1 notified NP 2 and NP 2 ordered to transfer Resident 2 to the hospital per Resident 2's request. RNS 1 stated Resident 2's PN and CICE indicated no documentation of Resident 2's abdominal pain level and characteristic. RNS 1 stated LNs needed to assess and document residents' (in general) pain level and characteristic, provide non-pharmacological and pharmacological interventions to address the pain, and evaluate effectiveness of the interventions. RNS 1 stated Resident 2's MAR for 1/2025 indicated no documentation staff administered any pain medication to Resident 2

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for Resident 2's complaints of abdominal pain on 1/13/2025 at 11:53 am and 1/14/2025 at 3:30 pm. RNS 1 stated LNs needed to give Resident 2 pain medication for Resident 2's abdominal pain and document the medication administration in the MAR.

During a telephone interview on 3/26/2025 at 11:32 am with the Director of Nursing (DON), the DON stated LNs should assess and document the resident's (in general) pain level before and after administering routine and prn pain medications. The DON stated a resident's new onset of pain was considered a change of condition and LNs needed to address it. The DON stated LNs needed to notify the resident's physician of the change of condition, obtain physician orders, and carry out the orders. The DON stated LNs needed to document the change of condition in the CICE form on the date and time the change of condition first started and LNs needed to monitor the resident. The DON stated LNs should administer pain medications as needed for pain and as ordered by the physician.

During a review of the facility's P&P titled, "Pain Assessment and Management," revised 10/2022, the P&P indicated, "Acute pain (or significant worsening of chronic pain) should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained. The P&P indicated, "Monitor the resident for the presence of pain and the need for further assessment when there is a change of condition." The P&P indicated, "During the pain assessment gather the following information as indicated from the resident ... Characteristics of pain: (1) Location of pain; (2) Intensity of pain (as measured on a standardized pain scale); (3)

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F 697	Continued From page 14 Characteristics of pain (e.g. aching, burning, crushing, numbing, burning, etc.); (4) pattern of pain (e.g., constant or intermittent); and (5) frequency, timing and duration of pain) ..." The P&P indicated, "Document the resident's reported level of pain with adequate detail (i.e., enough information to gauge the status of pain and the effectiveness of interventions for pain) as necessary and in accordance with the pain management program. Upon completion of the pain assessment, the person conducting the assessment shall record the information obtained from the assessment in the resident's medical record."	F 697		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not	F 725	**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** Resident 3's needs were immediately addressed to ensure their care needs were adequately met. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All Residents have the potential to be affected by this deficient practice. On 3/28/25, department supervisors conducted rounds to ensure that no other individuals were impacted by this deficiency. No additional issues were identified.	

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F 725	Continued From page 15 limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide sufficient nurse staffing for one of two night shifts (11 pm to 7 am shift) staffing reviewed to provide incontinent (unable to control excretion of urine or the contents of the bowels) care to one of 15 sampled residents (Resident 3) on 3/26/2025, in accordance with the facility's Policy and Procedure (P&P) titled, "Staffing, Sufficient and Competent Nursing," and the facility's Facility Assessment (a guide used by the facility to evaluate what resources are necessary to care for the facility's residents). This failure had the potential to delay the provision of care and services for Resident 3 and other residents in the facility. Findings: During a review of Resident 3's Admission Record (AR), the AR indicated the facility admitted Resident 3 on 3/18/2025 with diagnoses that included Type 2 diabetes mellitus (a condition where the body has trouble controlling blood sugar) with foot ulcer (open sore), other abnormalities of gait (pattern of walking) and mobility (ability to move freely), and benign prostatic hyperplasia (enlargement of the prostate gland [gland that sits below a male's bladder] with lower urinary tract symptoms.	F 725	**What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.** A in-service training was conducted on 4/1/2025 with the DSD and DON by the Administrator, focusing on the importance of sufficient staffing and meeting staffing per patient day (PPD) requirements. On 10/29/24, QAPI centered on sufficient staffing created by Administrator/DON. The QAPI is On-Going. The facility will reinforce and ensure adherence to the 4-2 staffing ladder for CNAs. The Director of Staff Development (DSD) will be responsible for ensuring adequate CNA coverage for the AM, PM, and NOC shifts. The Director of Staff Development (DSD) will report any staffing shortages to the administrator daily (Monday-Friday) during morning stand-up meetings to ensure effective communication regarding CNA and Licensed Nurse staffing levels The Administrator/designee will collaborate with the organization's HR Recruiter to ensure CNA hiring efforts remain a hyper-focus. The facility is working closely with a dedicated recruiter to prioritize the recruitment of qualified nursing staff. This partnership focuses on sourcing, screening, and hiring skilled	

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F 725	Continued From page 16 During a review of Resident 3's Admission/Readmission Data Tool (ARDT) dated 3/18/2025, timed at 4:25 pm, the ARDT indicated Resident 3 was alert and cooperative and required one-person physical assistance with bed mobility and activities of daily living (ADL- basic task needed to perform for daily self-care). During a review of Resident 3's History and Physical Examination (H&P) dated 3/19/2025, the H&P indicated= Resident 3 had the capacity to understand and make decisions. During a review of Resident 3's Care Plan (CP) titled, "Care Plan Report," dated 3/20/2025, the CP indicated Resident 3 was frequently incontinent of bowel and bladder (urine) and was at risk for skin breakdown. The CP interventions included for the certified nursing assistant (CNA) to check Resident 3 for bladder incontinence at least every two hours and as needed and increase frequency as needed. During a general observation of the facility on 3/26/2025 at 5:15 am, there were two CNAs observed providing care to the residents, two licensed vocational nurses (LVNs) observed passing medications, and one Registered Nurse Supervisor (RNS) observed doing deskwork at the nursing station. During a concurrent interview and record review on 3/26/2025 at 6:05 am with CNA 4, the facility's census (the number of residents currently under the care of the facility), Assignment Sheet (AS), and Nursing Staffing Assignment and Sign-In Sheet (NSASS) dated 3/25/2025 were reviewed. The census indicated there were 89 residents	F 725	nursing staff. Facility will also collaborate with sister facilities in an effort to meet staffing needs as needed. The facility will continue to implement a bonus incentive on an as-needed basis for licensed nurses/CNA's, effective January 27, 2025, to help maintain adequate staffing levels and effectively address staffing needs. The DSD/designee will continue to maintain a call log when staffing hours for CNA's are insufficient. The log will document all staff members contacted and the outcomes of those communications. The DSD/designee will report any pattern of findings related to staffing to the Administrator for further review and action. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The Administrator/ designee will provide any pattern of findings to QAPI committee monthly x 3 months for further monitoring and action planning as indicated or until QM committee determines compliance **Date of Compliance: April 1st 2025**	

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currently in the facility. The AS and NSASS indicated there were two CNAs on duty during the 11 pm to 7 am night shift on 3/25/2025. CNA 4 stated usually there were four CNAs on the night shift and each CNA would have 16 to 17 residents. CNA 4 stated CNA 4 was assigned to provide care for 33 residents in the North Station. CNA 4 stated LVN 2 was assigned to provide incontinent care to the residents in the West Station. CNA 4 stated it was "hard for her (CNA 4) to change everyone." CNA 4 stated CNA 4 did not provide care to the residents in the West Station because LVN 2 was supposed to do "it."

During an interview on 3/26/2025 at 6:55 am with CNA 5, CNA 5 stated there were only two CNAs working on 3/25/2025 for 11 pm to 7 am shift. CNA 5 stated normally night shift was staffed with four to five CNAs. CNA 5 stated CNA 5 was assigned to 40 residents in the South Station. CNA 5 stated CNA 5 was able to provide the care, finish assigned tasks, and "change" the residents, but it was very hard. CNA 5 stated CNA 5 always answered the call light and did CNA 5's best when caring for CNA 5's residents.

During an interview on 3/26/2025 at 8:01 am with LVN 2, LVN 2 stated the facility only had two CNAs who worked on 3/25/2025 during the 11 pm to 7 am shift. LVN 2 stated LVN 2 had to provide ADL care last night because the facility was short of CNAs. LVN 2 stated "usually" the night shift was staffed with four to five CNAs for a census of 89. LVN 2 stated LVN 2 did not mind providing ADL care, but it was hard for LVN 2. LVN 2 stated it put LVN 2 behind on her work.

During an interview on 3/26/2025 at 8:35 am with LVN 3, LVN 3 stated facility management was

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aware the facility was short of CNAs on 3/25/2025 for the 11 pm to 7 am shift. LVN 3 stated this was the first time LVN 3 experienced being short of CNA at night as a charge nurse in the facility. LVN 3 stated LVN 3 assisted CNA 5 with some basic patient care and helped change two residents who were "lightweight." LVN 3 stated LVN 3 was not sure if all residents who needed incontinent care were changed. LVN 3 stated the night shift team tried to do their best within their capabilities.

During a concurrent observation and interview on 3/26/2025 at 9:50 am with Resident 3, Resident 3 was observed lying in bed. Two nursing aide students and one licensed staff were observed coming out of Resident 3's room. Resident 3 stated staff just finished changing Resident 3. Resident 3 stated no one checked and changed Resident 3 throughout the night and that was the first time Resident 3 got changed (on 3/26/2025). Resident 3 stated normally staff would check and change Resident 3 more often throughout the night. Resident 3 stated, "They lowered the number of people during the night. I think that's why no one got to check me."

During a telephone interview on 3/26/2025 at 11:32 am with the Director of Nursing (DON), the DON stated the facility's night shift staffing normally had two LVNs and at least six CNAs for a census of 89. The DON stated one night shift CNA would normally be assigned to care for 15 to 17 residents. The DON stated facility management was aware of the short staffing issue on 3/25/2025 for the night shift and attempted to look for CNA replacement but was unsuccessful. The DON stated RN Supervisor 2 stayed longer in the facility to help. The DON stated the facility was currently working on hiring

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F 725	Continued From page 19 more staff, offering incentives for current staff to pick up extra shifts or stay over, and using staffing registry as needed. During a review of the facility's P&P titled, "Staffing, Sufficient and Competent Nursing," revised 8/2022, the P&P indicated, "Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment." The P&P indicated, "Staffing numbers and the skill requirements of direct care staff (CNAs) are determined by the needs of the residents based on each resident's plan of care, the resident assessments and the facility assessment." During a review of the facility's document titled, "Requirements of Participation: Facility Assessment (FA)," dated 8/2024, the FA indicated the average ratio for one night shift (11 pm to 7 am shift) CNA was 12 to 16 residents per CNA.	F 725		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by:	F 806	**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** Resident #1 was seen by the Dietary Supervisor on March 27, 2025, and the dietary preferences were updated to ensure there are no further concerns regarding the residents' meal schedule. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;**	

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F 806	Continued From page 20 Based on interview and record review, the facility failed to honor 1 of 15 sampled residents' (Resident 1's) food preferences when the dietary services department did not provide Resident 1's requested meal for dinner on 3/26/25. This failure resulted in Resident 1's food choices not being honored and had the potential for unmet nutritional needs to Resident 1. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was admitted to the facility on 10/4/23, with diagnoses which included conversion disorder (condition where a mental health issue causes physical symptoms), anarthria (loss of speech due to inability to control the muscles used for speaking), and aphonia (loss of voice). During a review of Resident 1's care plan (CP) titled, "Care Plan Report," revised on 9/24/24, the CP indicated "Resident (Resident 1) has special foods request for dietary; dietary will provide foods per resident preference however resident 1 will decline the food tray ..." The CP's interventions indicated dietary to review food preferences as needed and provide and serve diet as ordered. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 1/9/25, the MDS indicated Resident 1 had no speech but was able to express ideas and wants and had moderate impaired cognition (ability to think, learn, and remember). The MDS indicated Resident 1 was dependent on staff for toileting hygiene, lower body dressing, putting on/taking	F 806	All residents had the potential to be affected by this deficient practice. On March 28, 2025, the Dietary Supervisor/designee reviewed resident preferences as documented on individual meal slips to ensure all preferences were current and being appropriately followed. No additional findings were identified as a result of the review. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.** From March 26 to March 27, 2025, the Dietary Supervisor or designee conducted in-service training for dietary staff on the importance of following resident preferences and adhering to the established meal slips. Licensed nurses will report any inconsistencies related to meal slips to the Dietary Supervisor for further review. The Dietary Supervisor will report any negative findings to the Administrator for appropriate follow-up and resolution. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The Administrator/designee will provide any negative findings to QAPI committee monthly x 3 months for further monitoring and action planning as indicated or until QAA committee determines compliance.	

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F 806	Continued From page 21 off footwear, and required substantial/maximal assistance (helper does more than half the effort) with showering/bathing and with personal hygiene. During an interview on 3/26/25 at 1:18 pm with the Dietary Services Supervisor (DSS), the DSS stated Resident 1 requested 240 milliliters (ml - unit of fluid volume) of strawberry smoothie with ice three times a day every day, liked fresh fruits, and a bowl of lemon for her water. The DSS stated Resident 1 would then let dietary know what Resident 1 wanted to eat for each meal on that day and if Resident 1 wanted to have more than a smoothie. During an interview on 3/26/25 at 1:25 pm with Resident 1, Resident 1 stated the facility's kitchen already had a list of foods Resident 1 wanted to eat for each meal. During a concurrent interview and record review on 3/26/25 at 1:50 pm with Resident 1 and the DSS, Resident 1 showed an undated written list/menu of Resident 1's preferred foods for breakfast, lunch, and dinner for the week. The written list/menu was reviewed and indicated Resident 1's food preferences included the following: 1. Breakfast: two (2) soft boiled eggs, not burnt or greasy bacon, a smoothie. 2. Lunch: red chicken pozole with lots of chicken with chopped jalapenos, finely chopped onions, thinly shredded cabbage, finely chopped cilantro, finely chopped diced tomatoes, and finely chopped round relish on the side, and cookies, or buffalo chicken salad.	F 806	**Date of Compliance: March 28th, 2025**	

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F 806	Continued From page 22	F 806		

3. Dinner: fried crispy burger with melted cheese and bacon wrapped lettuce with lots of sliced onion, tomatoes, jalapenos, and barbecue sauce.

The written list/menu had the DSS's signature on the top. Resident 1 stated Resident 1 discussed her preferred menu for the week with the DSS. Resident 1 and the DSS agreed that moving forward, every Tuesday, Resident 1 and DSS would discuss a new menu for the week (Wednesday to Wednesday) and agreed to implement this plan (on 3/26/25) for dinner.

During an interview on 3/26/25 at 7:14 pm with Certified Nursing Assistant (CNA) 11, CNA 11 stated Resident 1 only received a strawberry smoothie for dinner. CNA 11 stated Resident 1 did not request any other food from the kitchen for dinner.

During an interview on 3/27/25 at 11:58 am with the DSS, the DSS stated there was a miscommunication with the facility's cook (Cook 1) from the previous night (3/26/25). The DSS stated the cook probably thought the kitchen only had to serve a smoothie to Resident 1 for dinner. The DSS stated the kitchen needed to serve the resident's (in general) food preferences. The DSS stated the kitchen needed to provide Resident 1's food preferences according to Resident 1's written list/menu.

During an interview on 3/27/25 at 12:39 pm with Cook 1 and Cook 2, Cook 1 and Cook 2 stated they prepared and provided food according to resident (in general) food preferences. Cook 1 and Cook 2 stated Resident 1 only ordered strawberry smoothies and lemons for breakfast,

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	055367	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROVIA GARDENS HEALTHCARE CENTER	615 W. DUARTE RD. MONROVIA, CA 91016

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F 806	Continued From page 23 lunch, and dinner. Cook 1 and Cook 2 stated the DSS did not inform Cook 1 and Cook 2 to prepare and provide something else to Resident 1 for dinner (on 3/26/25). During a telephone interview on 3/27/25 at 3:55 pm with the Director of Nursing (DON), the DON stated it was important for the residents to receive their food preferences because that was their right and that was their source of nutrition. During a review of the facility's policy and procedure (P&P) titled, "Resident Food Preferences," undated, the P&P indicated "When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes." The P&P indicated, "If the resident refused or is unhappy with his or her diet, the staff will create a care plan that the resident is satisfied with." The P&P indicated, "The food services department will offer a variety of foods at each scheduled meal, as well as access to nourishing snacks throughout the day and night."	F 806		
F 807 SS=D	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 1 of 15	F 807	**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** Resident 1 was provided with immediate proper hydration on March 27th, 2025 to ensure residents hydration needs are being met. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;**	

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F 807	Continued From page 24 sampled residents (Resident 1) was provided with water according to Resident 1's need and preference when Resident 1's water pitcher was not filled during the morning of 3/27/25. This deficient practice had the potential for Resident 1 to not receive proper hydration. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was admitted to the facility on 10/4/23, with diagnoses which included conversion disorder (condition where a mental health issue causes physical symptoms), anarthria (loss of speech due to inability to control the muscles used for speaking), and aphonia (loss of voice). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 1/9/25, the MDS indicated Resident 1 had no speech but was able to express ideas and wants and had moderate impaired cognition (ability to think, learn, and remember). The MDS indicated Resident 1 was dependent on staff for toileting hygiene, lower body dressing, putting on/taking off footwear, and required substantial/maximal assistance (helper does more than half the effort) with showering/bathing and with personal hygiene. During an observation on 3/27/25 at 9:45 am, Resident 1 was lying in bed. Resident 1's water tumblers and cups were empty. During a concurrent observation and interview on 3/27/25 at 9:55 am with Licensed Vocational Nurse (LVN) 6 and CNA 6, in Resident 1's room,	F 807	All residents had the potential to be affected by this deficient practice. On March 28, 2025, department supervisors conducted room rounds to follow up with residents and ensure there were no additional concerns related to water hydration. No further issues were identified as a result of these rounds. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.** From March 27 to March 28, 2025, licensed nurses and CNAs participated in an in-service training conducted by the Director of Staff Development (DSD)/ designee. The training focused on the importance of proper hydration to support residents' overall health and well-being. To reinforce this practice, department supervisors will conduct daily room rounds (Monday through Friday) to ensure water pitchers are filled and within reach of each resident. Any negative findings will be reported to the Director of Nursing (DON) during the daily clinical stand-up meeting for immediate and appropriate follow-up **How the facility plans to monitor its performance to make sure that solutions are sustained:**	

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F 807	Continued From page 25 Resident 1 was observed pointing to Resident 1's empty water tumblers. LVN 6 left Resident 1's room to refill Resident 1's water tumblers and brought the tumblers back to Resident 1's room. LVN 6 and CNA 6 stated night shift nurses passed out fresh waters for the residents in the beginning of their shift. CNA 6 stated if residents needed more water in the morning, the morning CNAs refilled the residents' water pitchers. During an interview on 3/27/25 at 12:51 pm with CNA 6, CNA 6 stated CNA 6 usually refilled the residents' water pitchers in the morning if the pitchers were empty. During an interview on 3/27/25 at 12:58 pm with the Director of Staff Development (DSD), the DSD stated night shift CNAs provided freshwater pitchers to residents during the night shift and pitchers needed to be refilled as needed. During a follow-up interview on 3/27/25 at 3:18 pm with the DSD, the DSD stated it was important to provide residents with water, the water to be within reach, and important to refill residents' water to keep residents hydrated. The DSD stated it was important to provide fluids according to residents' needs and preferences to honor a residents' basic right. During an interview on 3/27/25 at 3:55 pm with the Director of Nursing (DON), the DON stated residents' water pitchers needed be within the residents' reach, needed to be filled, and ready for the residents to drink. The DON stated water pitchers must be checked at least every two hours and refilled as needed. During a review of the facility's policy and	F 807	The DON/designee will provide any negative findings to QAPI committee monthly x 3 months for further monitoring and action planning as indicated or until QAA committee determines compliance. **Date of Compliance: March 28th, 2025**	

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F 807	Continued From page 26 procedure (P&P) titled, "Resident Hydration and Prevention of Dehydration," revised 10/2017, the P&P indicated, "This facility will strive to provide adequate hydration and to prevent and treat dehydration."	F 807		