STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055367	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

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

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F0000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey for two complaints and two Facility Reported Incidents (FRIs). Complaint Numbers: CA00969811 and CA00971156 FRI Numbers:CA00969820 and CA00971141 The inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility. Two deficiencies were issued for complaint number: CA00971156 (F684 and F558). One deficiency was issued for ERI number: CA00969820 (F604) No deficiency was issued for ERI number: CA00971141	F0000		
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility staff failed to ensure one of three sampled residents (Resident 3) who was unable to speak would have a communication board to assist her to communicate with the facility staff as indicated in the care plan. This deficient practice had the potential for the resident's inability to express her needs Findings: During a review of Resident 3's nursing care plan dated 10/14/2024, the care plan indicated Resident 3 had communication problem. The care plan goal was for Resident 3 to maintain current level of communication	F0558	**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** Resident 3 was immediately offered with an alternative method of communication on July 9, 2025. **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 July 9th, 2025, the Director of Nursing (DON)/ designee ensured that all non-verbal residents were provided with appropriate means of communication. This measure was implemented to prevent any lapses in communication between the facility and the affected residents.	

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F0558 SS = D	Continued from page 1 by (how, with what assistance i.e. making sounds, using appropriate gestures, responding to yes/no questions, using communication board, writing messages). The care plan interventions were to ensure availability and functioning of adaptive communication equipment message board, telephone. Use alternative communication tools as needed, such as communication book/board, writing pad, gestures, signs, and pictures. During an observation on 7/9/2025 at 12:55 PM, in the presence of Certified Nurse Assistant 3 (CNA 3), Resident 3 was observed sitting on the bed. Resident 3 was not able to verbally communicate but able to nod and shake her head when spoken to. During an interview on 7/9/2025 at 1 PM with Certified Nurse Assistant 3 (CNA 3), the evaluator requested CNA 3 to look for Resident 3's communication board. CNA 3 was unable to locate the communication board, was not available for the use of Resident 3, to ensure there was continued communication. During a review of the facility's policy and procedure (P&P) titled, "Accommodation of Needs," revised 2021, indicated 'The resident's individual needs and preferences are accommodated to the extent possible,' and includes access to assistive and adaptive devices.	F0558	No additional findings were noted. **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 July 10, 2025 to July 11h, 2025, the Director of Staff Development (DSD) or designee conducted an in-service training for licensed nursing staff and Certified Nursing Assistants (CNAs). The training focused on the importance of ensuring that non-verbal residents are provided with an effective and reliable means of communication, in order to support continuous and timely interaction within the facility. Incoming admissions will be reviewed during the daily Interdisciplinary Team (IDT) Clinical Meeting to promptly identify non-verbal residents and ensure appropriate communication tools are made available. Any findings requiring additional follow-up will be reported to the Administrator for further review and action.	
F0604 SS = D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F0604	**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. **Date of Compliance: July 11th, 2025** **F604** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** Resident 1 was immediately released from the wheelchair and appropriately assessed for injury on June 26, 2025. CNA 1 was terminated following the substantiated allegation of abuse. **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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F0604 SS = D	Continued from page 2 §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is NOT MET as evidenced by: Based on interview, and record review, the facility failed to follow the facility's Use of Restraints policy and procedure (P&P) to ensure one of two sampled residents (Resident 1) freedom from physical restraint (any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria: Is attached or adjacent to the resident's body; Cannot be removed easily by the resident; and Restricts the resident's freedom of movement or normal access to his/her body) not required to treat the resident's medical symptoms (an indication or characteristic of a physical or psychological condition) by using a gown to confine Resident 1 on Resident 1's wheelchair to prevent resident's falling on 6/26/205. This deficient practice violated Resident 1's right and had the potential to result in impairing Resident 1's physical and psychosocial wellbeing. Findings: During an interview on 7/9/2025 at 2:12 p.m. with Licensed Vocational Nurse (LVN)/Treatment Nurse (TN) 1, LVN/TN 1 stated on 6/26/2025 around 1:30 p.m., when a clinical team (members including LVN/TN 1, a physician, case manager [CM], social worker, a Certified Nurse Assistant [CNA]) were making round, they found Resident 1 was tied on the wheelchair by using a gown across Resident 1's waist and Resident 1 could not lift from the wheelchair. LVN/TN 1 stated it is a physical restraint to tie a resident on wheelchair and need to be reported right away. During an interview on 7/9/2025 at 2:57 p.m. with the Director of Nursing (DON), the DON stated on 6/26/2025 around 1:30 p.m., the Case Manager (CM) reported that the clinical team found Resident was found be tied on the wheelchair by using a gown when doing rounds. The DON stated it was a restraint if a resident was tied on wheelchair by using a gown. During an interview on 7/9/2025 at 3:05 p.m. with the	F0604	*All residents have the potential to be affected by this deficient practice.* On June 27, 2025, department supervisors conducted room rounds with residents and/or their responsible parties (RPs) to ensure there were no similar concerns regarding interactions with facility staff and to assess residents' perceptions of their safety within the facility. No additional concerns were identified during 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 June 26, 2025 to June 27th 2025, the Director of Staff Development (DSD), designee conducted multiple in-service training for licensed nursing staff and Certified Nursing Assistants (CNAs). The trainings emphasized the importance of implementing appropriate fall prevention interventions. Inservice's also covered the recognition and prevention of abuse, reinforcing staff responsibilities in reporting and maintaining resident safety. Training also highlighted the proper use of restraints, stressing that restraints must only be applied when absolutely necessary and always with a valid physician's order obtained prior to utilization along with informed consent. This training aimed to ensure compliance with facility policies and regulatory standards while promoting the health, safety, and dignity of residents. Any negative findings identified throughout daily operations from staff will be reported to the Administrator for further review and action in accordance with our abuse policy. **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. **Date of Compliance: June 27th, 2025**	

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F0604 SS = D	Continued from page 3 Administrator, the Administrator stated on 6/26/2025 around 1:30 p.m., the case manager reported to the Administrator that Resident 1 was found tied on the wheelchair by using a gown. The administrator stated the facility suspended CNA 1 who tied Resident 1 on the wheelchair right away and terminated CNA 1 after the investigation. The administrator stated tying a resident on a wheelchair was a physical restraint and physical restraint was a type of abuse. During a concurrent interview and record review on 7/9/2025 at 4:10 p.m. with the DON, Resident 1's Order Summary Report (OSR), dated 7/9/2025, and Resident 1's Care Plan (CP) were reviewed. The DON stated there were no orders and no CP for using physical restraint. Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 6/28/2025, was reviewed. The DON stated the MDS indicated restraints were not used for Resident 1. Resident 1's Change in Condition Evaluation (CICE) dated 6/26/2025 was reviewed. The DON stated The CICE indicated that Resident 1 was noted having a hospital gown around Resident 1's waist and tied behind the wheelchair on 6/26/2025 around 1:20 p.m. Resident 1's Multidisciplinary Care Conference (MCC), dated 6/26/2025 was reviewed. The DON stated the MCC indicated that Resident 1 was found with a hospital gown lace tied around the wheelchair which prevented the resident from moving freely on 6/26/2026 at around 1:20 p.m. and was considered restraint. The DON stated the MCC indicated there was no physical and chemical restraint order for Resident 1 at that time. Resident 1's Post-Event Review (PER) dated 6/26/2025 at 2:09 p.m. was reviewed. The DON stated the PER indicated that Resident 1 was found confined to wheelchair with a hospital gown on 6/26/2025 at 1:30 p.m. Resident 1's Progress Note (PN) dated 6/2025 and 7/2025 were reviewed. The DON stated the PN dated 6/26/2025 at 5:07 p.m. indicated that Resident was on monitoring for being a victim of alleged abuse. The DON stated the facility needs a physician's order, a consent from patient or family for permission and tried other less restrictive measures to use a restraint. The DON stated it was abuse if using a physical restraint without physician order and family and patient's consent. During a review of resident 1's History and Physical (H&P), dated 6/1/2025, the H&P indicated Resident 1 had the fluctuating capacity to understand and make decisions. During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 originally on 6/4/2024 and readmitted on 6/23/2025 with diagnoses including dementia (a	F0604		

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F0604 SS = D	Continued from page 4 progressive state of decline in mental abilities), cognitive impairment, hypertension (HTN-high blood pressure), left lower leg contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of muscle, lack of coordination, history of transient ischemic attack (TIA- is a temporary blockage of blood flow to the brain) and cerebral infarction (a region or area of brain tissue that dies as a result of reduced or blockage of vessel blood flow). During a review of Resident 1's Change in Condition Evaluation (CICE), dated 6/26/2025 at 1:20 p.m., the CICE indicated Resident 1 was noted having a hospital gown around Resident 1's waist and tied behind the wheelchair. During a review of Resident 1's Multidisciplinary Care Conference (MCC), dated 6/26/2025 at 1:30 p.m., the MCC indicated that Resident 1 was found with a hospital gown lace tied around the wheelchair which prevent the resident from moving freely and was considered restraint. The MCC indicated there was no physical and chemical restraint order for Resident 1 at that time. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 6/28/2025, the MDS indicated the resident had severe impaired cognitive (ability to remember things, solve problems, or make decisions) skills for daily decision making. The MDS indicated the resident required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with eating, oral hygiene, toileting hygiene, and upper body dressing. The MDS indicated the resident is dependent (helper does all of the effort resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with lower body dressing, shower/bathe self, putting on/taking off footwear, sit to lying, lying to sitting on side of bed, and sit to stand). The MDS indicated restraints were not used for Resident 1. During a review of Resident 1's Order Summary Report (OSR), the OSR indicated there was no order for physical restraint. During a review of the facility's Verification of Investigation (VOI) report, dated 6/30/2025, the VOI report indicated that on 6/26/2025, the facility's clinical team found Resident 1 was confined to the wheelchair using a gown during routine rounds. The VOI report indicated that Certified Nurse Assistant (CNA) 1	F0604		

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F0604 SS = D	Continued from page 5 who tied the resident on wheelchair stated CNA 1 used a gown to secure the resident to the wheelchair with the intent of preventing the resident from leaning forward and falling. The VOI indicated that CNA 1 confirmed that CNA 1 did not follow proper facility protocol to prevent fall. During a review of CNA 1's Employee Termination (ET), dated 7/3/2025, the ET indicated CNA 1 was terminated due to a reported abuse allegation on 6/26/2025 and the investigation findings that CNA 1 did not comply with the facility policies, resident rights, or standard care protocol and had confined a resident to wheelchair using a gown. During a review of the facility's policy and procedure (P&P) titled, "Use of Restraints," dated 4/2017, the P&P indicated, "Practice that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including placing a resident in chair that prevents the resident from rising". The P&P indicated that "Restraint shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully". The P&P indicated that "Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls".	F0604		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure a physician-ordered diagnostic test (MRI) was scheduled and completed for one of three residents (Resident 3) reviewed for follow-up medical care. This failure resulted in a delay in diagnostic testing for Resident 3 and had the potential to result in delayed diagnosis and treatment for the resident. Findings: During a review of Resident 3's Admission	F0684	F684 **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** On July 9, 2025, the Facility Case Manager promptly followed-up on MRI appointment for Resident 3 to prevent any further delays in diagnosis and treatment. **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 July 10, 2025, the Medical Records Supervisor/ designee conducted a review of all appointments within the previous 30 days to ensure appropriate follow-up was documented and completed, preventing any delays in diagnosis or treatment.	

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F0684 SS = D	Continued from page 6 Record (Face Sheet), the facility admitted Resident 3 on 10/4/2023 with diagnoses including Aphonia (Loss of Voice), Dysarthria and anarthria (refer to a condition that interferes with the muscles that control speech). During a review of Resident 3's "History and Physical" (H&P), dated 10/4/2024 indicated, Resident 3 had the mental capacity to make medical decisions. During a review of the After Visit Summary (AVS) from the resident's neurology appointment, dated 11/12/2024, the neurologist assessment and plan for Resident 3 was an MRI of the thoracic and lumbar spine (without contrast). During a review of Resident 3's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 4/8/2025, indicated the cognitive (the ability to think and process information) skills for daily decisions making was intact, and needed supervision to extensive assistance from the staff for the activities of daily living. During a concurrent interview and record review on 7/9/2025 at 4:30 PM with the Director of Nursing (DON), Resident 3's AVS was reviewed. The DON stated that the MRI was ordered by the physician but was never scheduled. The DON confirmed this was an oversight and stated corrective measures would be taken. During a review of the facility's policy and procedure (P&P) titled, "Request for Diagnostic Services", revised 2007, indicated that orders for diagnostic services will be promptly carried out as instructed by the physician's order. 020Gigi$	F0684	No further concerns were reported or identified during 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 July 10, 2025 to July 11th, 2025, licensed nursing staff participated in an in-service training conducted by the Director of Nursing(DON)/ designee. The training emphasized the importance of appropriate follow-up related to documentation and communication with outside providers after each resident appointment, ensuring continuity of care and timely interventions. A one-on-one in-service was conducted by the DON on July 9th, 2025, with the Facility Case Manager to reinforce the timely scheduling of resident appointments as required and the appropriate communication of follow-up appointments. Any negative findings or barriers will be reported 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 Administrator/designee will provide any pattern of 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: July 11th, 2025**	