Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555903	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Gardens of El Monte	5044 Buffington Rd El Monte, CA 91732

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687 Based on interview and record review, the facility failed to notify the physician of a change in condition (COC- a change in the resident's health or functioning that requires further assessment and intervention) for one of two sampled residents as indicated in the facility's policy and procedure (P&P) titled, Significant Change in Condition, by failing to: 1. Ensure LVN 1 notified Resident 1's Primary Physician (PP/Medical Doctor [MD] 2) promptly (punctually [with little or no delay]) when LVN 1 noted Resident 1 struggled (had a hard time) to drink fluids on his (Resident 1's) own and needed encouragement with drinking fluids. 2. Ensure LVN 1 and LVN 2 communicated with MD 2 to obtain a physician's order for monitoring Resident 1's intake and output. These failures resulted in a delay in providing the necessary care and treatment for Resident 1. Cross Reference F692 Findings: During a review of Resident 1's Admission Record (AR), the AR indicated, the facility initially admitted Resident 1 to the facility on [DATE], and readmitted Resident 1 on 5/16/2024, with diagnoses that included dysphagia (difficulty swallowing) oropharyngeal phase (swallowing problems occurring in the mouth and/or the throat), unspecified chronic kidney disease (damage to the kidneys resulting to the inability of the kidneys to filter blood the way the kidneys should), and abnormalities of gait and other mobility (inability to walk normally due to injuries or underlying conditions). (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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Minimum Data Set (MDS - a standardized resident assessment and care screening tool), dated 4/22/2024, the MDS indicated, Resident 1 had severely impaired cognition (ability to think, remember, and reason). The MDS indicated, Resident 1 was independent (resident completed the activity by himself) with eating, oral hygiene, and personal hygiene. The MDS indicated, Resident 1 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completed the activity) with upper body dressing, putting and taking off footwear, rolling left and right in bed, sitting to lying, lying to sitting on side of bed, sitting to standing, chair/bed-to-chair transfers, and walking 10 feet. The MDS indicated, Resident 1 required partial/moderate assistance (helper did less than half the effort and lifted or held trunk or limbs) with toileting hygiene and showering/bathing self. During a review of Resident 1's General Chemistry (group of tests routinely ordered to determine a person's overall health status) laboratory results (results from testing a sample of blood), dated 5/15/2024, the laboratory results indicated, Resident 1's serum (blood) sodium (Na- amount of sodium [a mineral needed by the body to keep body fluids in balance] in the blood) level was 151 milliequivalents per liter (mEq/L- unit of measurement)(Normal Na level is 135 mEq/L to 145 mEq/L). During a review of Resident 1's Comprehensive Resident Assessment (CRA) dated 5/16/2024, the CRA indicated, Resident 1 needed assistance with eating/nutrition and was dependent on staff for oral hygiene. During a review of Resident 1's Untitled Care Plan (UPC), dated 5/16/2024, the UPC indicated, Resident 1 had the potential for fluid-electrolyte (electrolyte is mineral in the blood or other body fluids that carry electric charge and affect how the body functions) imbalance (the level of one or more electrolytes [in the body is too low or too high) related to hypernatremia. The UPC goal indicated, Resident 1 would have no s/s of hypernatremia. The UPC interventions indicated, for staff to ensure adequate fluid intake, monitor intake and output, and give diet as ordered. A review of Resident 1's Physician Order (PO) dated 5/19/2024, the PO indicated, an order for No Added Salt (NAS) diet, pureed (all food has been ground, pressed, and/or strained to a soft, smooth consistency, like a pudding) texture, and nectar/mildly thick liquid (liquids that are easily pourable and are comparable to heavy syrup in canned fruit) consistency. During a review of Resident 1's Registered Dietician (RD) Nutrition Risk Assessment (RDNRA) completed by RD 1 dated 5/21/2024, the RDNRA indicated, Resident 1 was on nectar thick liquid consistency and drank 400 mL to 900 mL of fluids per day plus the water pitcher at bedside (specific amount not indicated). The RDNRA indicated, Resident 1's estimated fluid needs per day was between 1950 mL to 2040 mL of fluids per day. The RDNRA indicated, Resident 1's oral intake appeared adequate to meet Resident 1's estimated needs. The RDNRA indicated, RD 1's recommendation was to continue the current plan. During a review of Resident 1's Order Summary Report (OSR), active as of 6/1/2024, the OSR indicated there was no order to monitor Resident 1's intake and output. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Situation-Background-Assessment-Recommendation (SBAR- a written communication tool that helps provide essential, concise information, usually during crucial situations) dated 6/1/2024, untimed, the SBAR indicated, on 6/1/2024, untimed, Resident 1 had altered level of consciousness. The SBAR indicated, Resident 1 had a heart rate of 28 beats per minute (bpm- the number of times the heart beats in one minute. Normal heart rate is 60 bpm to 100 bpm). The SBAR indicated, Resident 1's oxygen saturation (O2 sat- a measurement of oxygen level carried in the blood) was 72% (Normal oxygen saturation is 96 percent [%] to 100 %). The SBAR indicated, facility staff (unidentified) called 911 (phone number used to contact emergency services in the event of a medical emergency) and Resident 1 was transferred to GACH 1. During a review of Resident 1's GACH 1 Emergency Department Provider Note (EDPN), dated 6/1/2024 at 6:33 pm, the EDPN indicated, Resident 1 was brought in by ambulance with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions) and ALOC. The EDPN indicated, Resident 1 had a serum Na level of 169 millimoles per liter (mmol/L- unit of measurement). The EDPN indicated, Resident 1 would be admitted to GACH 1 for diagnoses of hypernatremia most likely from dehydration, uremia, and acute kidney injury. During a concurrent interview and record review on 6/14/2024 at 4:30 pm with the Director of Nursing (DON), Resident 1's UCP, dated 5/16/2024, and the OSR with active date of 6/1/2024 were reviewed. The UPC's interventions indicated for staff (in general) to ensure Resident 1 received adequate fluid intake, and to monitor Resident 1's intake and output. The OSR indicated, there was no MD order to monitor Resident 1's intake and output. The DON stated when Resident 1's UPC indicated for staff to monitor intake and output, the staff needed to notify Resident 1's PP/MD 2 to obtain a physician order for it (monitoring Resident 1's intake and output). The DON stated there was no physician order to monitor Resident 1's intake and output. During a concurrent telephone interview and record review on 6/17/2024 at 11:27 am with RD 1, Resident 1's RD Nutrition Risk Assessment (RDNRA) dated 5/21/2024 was reviewed. The RDNRA indicated Resident 1 required 1950 mL to 2040 mL per day of fluids to maintain adequate hydration. RD 1 stated (in general) normal Na level was between 135-145 mmol/L. RD 1 stated when Resident 1's Na level was above 145 mmol/L, it (the high level of Na) could indicate Resident 1 was dehydrated. RD 1 stated based on Resident 1's RDNRA, Resident 1 required 1950 mL to 2040 mL per day of fluids to maintain adequate hydration. RD 1 stated when Resident 1 was not drinking Resident 1's estimated fluid needs, Resident 1 could become dehydrated and require hospitalization . RD 1 stated when Resident 1 was not meeting his estimated fluid needs, it (the fact that Resident 1 did not drink 1950 mL to 2040 mL of fluid per day) should be reported to the licensed nurses daily and reported to RD 1 and MD 2. RD 1 stated facility staff (CNAs and LVNs in general) did not inform RD 1 that Resident 1 was not drinking Resident 1's estimated fluid needs (1950 mL to 2040 mL of liquid) per day. During a follow-up and concurrent telephone interview and record review on 6/17/2024 at 12 pm with RD 1, Resident 1's medical record document titled, Task: Nutrition - Fluids, dated 5/16/2024 to 6/1/2024 was reviewed. The Task: Nutrition -Fluids, under how much did the Resident drink in ml? indicated the following: 1. On 5/16/2024: 120 mL. 2. On 5/17/2024: 350 mL. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 5/18/2024: 440 mL. 4. On 5/19/2024: 930 mL. 5. On 5/20/2024: 840 mL. 6. On 5/21/2024: 360 mL. 7. On 5/22/2024: 360 mL. 8. On 5/23/2024: 420 mL. 9. On 5/24/2024: 180 mL. 10. On 5/25/2024: 340 mL. 11. On 5/26/2024: 500 mL. 12. On 5/27/2024: 530 mL. 13. On 5/28/2024: 360 mL. 14. On 5/29/2024: 200 mL. 15. On 5/30/2024: 700 mL. 16. On 5/31/2024: 280 mL. 17. On 6/1/2024: 600 mL. A concurrent interview was conducted, RD 1 stated according to Resident 1's documented total fluid intake per day, Resident 1 did not meet Resident 1's required estimated fluid needs per day from 5/16/2024 to 6/1/2024. RD 1 stated RD 1 did not review Resident 1's documented fluid intake from 5/16/2024 to 5/21/2024 when RD 1 completed Resident 1's RDNRA on 5/21/2024. RD 1 stated RD 1 could have caught that Resident 1 was not drinking enough fluids and talked to the nursing staff and informed Resident 1's physician about it (regarding Resident 1 did not consume enough fluid per day). RD 1 stated dehydration could perpetuate (to cause to continue) conditions like urinary tract infection, sepsis (a life-threatening complication of an infection), and hypernatremia and could further damage Resident 1's kidneys. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/17/2024 at 1:36 pm with LVN 1, LVN 1 stated LVN 1 was unaware Resident 1 had a history of hypernatremia. LVN 1 stated Resident 1 needed encouragement to drink fluids because Resident 1 would struggle at times to drink on his (Resident 1's) own (unable to recall dates and times). LVN 1 stated LVN 1 was unaware of Resident 1's estimated fluid needs per day (between 1950 mL to 2040 mL of fluids per day) to maintain adequate hydration. LVN 1 stated LVN 1 did not notify RD 1 or MD 2 that Resident 1 needed encouragement and struggled to drink liquid at times. LVN 1 stated the certified nursing assistants (CNAs) were supposed to inform the licensed nurses (LVNs) when Resident 1 was not drinking enough or was having issues with drinking fluids. LVN 1 stated licensed nurses were supposed to ensure Resident 1 was drinking enough fluids before the end of their shift and report any issues to the on-coming shift. LVN 1 stated LVN 1 did not receive any reports from any CNAs about Resident 1 not drinking enough fluids to meet Resident 1's estimated fluid needs per day. During an interview on 6/17/2024 at 1:53 pm with LVN 2, LVN 2 stated LVN 2 was not aware Resident 1 had a history of hypernatremia. LVN 2 stated Resident 1 was good at drinking fluids. LVN 2 stated CNAs documented Resident 1's total fluid intake per shift and not the LVNs. LVN 2 stated Resident 1 drank well (in general) but could not state how much Resident 1 usually drank in a day. LVN 2 stated LVN 2 did not remember Resident 1's estimated fluid needs per day. LVN 2 stated when Resident 1 was not meeting Resident 1's estimated fluid needs per day (between 1950 mL to 2040 mL of fluids per day), LVN 2 needed to encourage Resident 1 to drink fluids and document any hydration issues in Resident 1's medical record. LVN 2 stated LVN 2 did not receive any report regarding Resident 1 was not drinking enough fluids. LVN 2 stated when Resident 1 was not meeting Resident 1's estimated fluid needs per day as assessed by RD 1, LVN 2 needed to notify Resident 1's PP/MD 2 because that was considered a change of condition and LVN 2 needed to obtain new orders from MD 2 for laboratory tests for Resident 1. LVN 2 stated LVN 2 did not notify MD 2 at any point between 5/21/2024 and 6/1/2024 that Resident 1 had not drank Resident 1's estimated fluid needs per day. During an interview and a concurrent record review on 6/17/2024 at 3:17 pm with CNA 1, Resident 1's CRA dated 5/16/2024 indicated, Resident 1 needed assistance with eating/nutrition. CNA 1 stated Resident 1 required a lot of encouragement to drink fluids. CNA 1 stated Resident 1 was unable to drink fluids by himself because Resident 1 did not have balance of Resident 1's hands. CNA 1 stated when Resident 1 was not drinking enough, CNA 1 was supposed to report it to the assigned licensed nurse (unidentified). CNA 1 stated CNA 1 did not report any fluid intake issues to the licensed nurses because Resident 1 usually drank fluids with encouragement. CNA 1 stated CNA 1 was not sure if Resident 1 drank enough fluids during her (CNA 1's) shift and did not know where to find out how much fluids Resident 1 needed to drink during her shift. During an interview on 6/17/2024 at 4:29 pm with the DON, the DON stated licensed nurses (LVNs in general) were supposed to evaluate fluid intake weekly for each resident including Resident 1. The DON stated licensed nurses needed to ensure residents drank their estimated fluid needs per day. The DON stated nursing staff (CNAs and LVNs) could find Resident 1's assessed estimated fluid needs in Resident 1's RD notes and assessments. The DON stated CNAs needed to immediately report to the licensed nurses when Resident 1 was not drinking enough, and the licensed nurses needed to notify the Resident 1's physician (MD 2). The DON stated not drinking enough fluids was considered a change of condition because it could lead to dehydration, or it could be a sign indicated that something else was going on with Resident 1. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Significant Change in Condition, revised in 4/2017, the P&P indicated, all staff communicated any information about resident status changes to appropriate licensed personnel immediately upon observation. The P&P indicated, the resident's change in condition was reported immediately to the nursing supervisor. The P&P indicated, a licensed nurse assessed the resident for signs and symptoms of physical or mental change of condition. The P&P indicated, the assessment was reported to the primary or designated alternate.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687 Based on interview and record review, the facility failed to provide adequate (satisfactory or acceptable in quality or quantity) hydration (process of replacing water in the body through drinking water and eating food with high water content so every cell, tissue, and organ can properly function) for one of two sampled residents (Resident 1) as indicated in Resident 1's Untitled Care Plan (UPC), dated 5/16/2024, and the facility's policy and procedure (P&P) titled, Hydration Management, and Intake (the measurement of the fluids that enter the body) and Output (the fluids that leave the body), by failing to: 1. Ensure Resident 1's assigned Certified Nursing Assistants (CNAs) and Licensed Vocational Nurses (LVNs) provided Resident 1 with adequate fluids to meet Resident 1's estimated fluid requirement of 1950 milliliters [mL- unit of measurement] to 2040 mL as assessed by Registered Dietician (RD) 1 from 5/21/2024 to 6/1/2024. 2. Ensure CNA 1, LVN 1, and LVN 2 monitored Resident 1's intake and output. 3. Ensure LVN 1 notified Resident 1's Primary Physician (PP/Medical Doctor [MD] 2) promptly (punctually [with little or no delay]) when LVN 1 noted Resident 1 struggled (had a hard time) to drink fluids on his (Resident 1's) own and needed encouragement with drinking fluids. 4. Ensure LVN 1 and LVN 2 communicated with MD 2 to obtain a physician's order for monitoring Resident 1's intake and output. As a result, on 6/1/2024 at 4 pm, Resident 1 had altered level of consciousness (ALOC- a change in state of awareness and alertness) and was difficult to arouse (awaken). Resident 1 was transferred and admitted to General Acute Care Hospital (GACH) 1 on 6/1/2024 at 5:55 pm for further evaluation/treatment and was diagnosed with hypernatremia (high concentration of sodium in the blood and occurs with inadequate fluid intake and or increased water loss) most likely from dehydration (a harmful reduction in the amount of water in the body), uremia (a condition involving abnormally high levels of waste products in the blood), and Acute Kidney Injury (AKI is when kidneys suddenly stop working properly). Cross Reference F580 Findings: During a review of Resident 1's Admission Record (AR), the AR indicated, the facility initially admitted Resident 1 to the facility on [DATE], and readmitted Resident 1 on 5/16/2024, with diagnoses that included dysphagia (difficulty swallowing) oropharyngeal phase (swallowing problems occurring in the mouth and/or the throat), unspecified chronic kidney disease (damage to the kidneys resulting to the inability of the kidneys to filter blood the way the kidneys should), and abnormalities of gait and other mobility (inability to walk normally due to injuries or underlying conditions). (continued on next page)

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F 0692

Level of Harm - Actual harm

Residents Affected - Few

During a review of Resident 1's Minimum Data Set (MDS - a standardized resident assessment and care screening tool), dated 4/22/2024, the MDS indicated, Resident 1 had severely impaired cognition (ability to think, remember, and reason). The MDS indicated, Resident 1 was independent (resident completed the activity by himself) with eating, oral hygiene, and personal hygiene. The MDS indicated, Resident 1 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completed the activity) with upper body dressing, putting and taking off footwear, rolling left and right in bed, sitting to lying, lying to sitting on side of bed, sitting to standing, chair/bed-to-chair transfers, and walking 10 feet. The MDS indicated, Resident 1 required partial/moderate assistance (helper did less than half the effort and lifted or held trunk or limbs) with toileting hygiene and showering/bathing self.

During a review of Resident 1's General Chemistry (group of tests routinely ordered to determine a person's overall health status) laboratory results (results from testing a sample of blood), dated 5/15/2024, the laboratory results indicated, Resident 1's serum (blood) sodium (Na- amount of sodium [a mineral needed by the body to keep body fluids in balance] in the blood) level was 151 milliequivalents per liter (mEq/L- unit of measurement)(Normal Na level is 135 mEq/L to 145 mEq/L).

During a review of Resident 1's Comprehensive Resident Assessment (CRA) dated 5/16/2024, the CRA indicated, Resident 1 needed assistance with eating/nutrition and was dependent on staff for oral hygiene.

During a review of Resident 1's first Untitled Care Plan (UPC), dated 5/16/2024, the first UPC indicated, Resident 1 was at risk for dehydration. The first UPC goal indicated, facility staff would identify signs and symptoms (s/s) of dehydration such as dry eyes or mouth, fever, vomiting, urinary tract infection (UTI - infection in any part of the urinary tract, the system of organs that makes urine), poor skin turgor (skin's ability to change its shape and return to normal), change in mental status, and increased in confusion. The first UPC interventions indicated, for staff to provide Resident 1's diet as ordered, assist Resident 1 at mealtime and for all food and fluid offerings, offer fluids during activities, and monitor Resident 1 for s/s of dehydration.

During a review of Resident 1's second UPC, dated 5/16/2024, the second UPC indicated, Resident 1 had the potential for fluid-electrolyte (electrolyte is mineral in the blood or other body fluids that carry electric charge and affect how the body functions) imbalance (the level of one or more electrolytes [in the body is too low or too high) related to hypernatremia. The second UPC goal indicated, Resident 1 would have no s/s of hypernatremia. The second UPC interventions indicated, for staff to ensure adequate fluid intake, monitor intake and output, and give diet as ordered.

A review of Resident 1's Physician Order (PO) dated 5/19/2024, the PO indicated, an order for No Added Salt (NAS) diet, pureed (all food has been ground, pressed, and/or strained to a soft, smooth consistency, like a pudding) texture, and nectar/mildly thick liquid (liquids that are easily pourable and are comparable to heavy syrup in canned fruit) consistency.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Registered Dietician (RD) Nutrition Risk Assessment (RDNRA) completed by RD 1 dated 5/21/2024, the RDNRA indicated, Resident 1 was on nectar thick liquid consistency and drank 400 mL to 900 mL of fluids per day plus the water pitcher at bedside (specific amount not indicated). The RDNRA indicated, Resident 1's estimated fluid needs per day was between 1950 mL to 2040 mL of fluids per day. The RDNRA indicated, Resident 1's oral intake appeared adequate to meet Resident 1's estimated needs. The RDNRA indicated, RD 1's recommendation was to continue the current plan. During a review of Resident 1's Order Summary Report (OSR), active as of 6/1/2024, the OSR indicated there was no order to monitor Resident 1's intake and output. During a review of Resident 1's Situation-Background-Assessment-Recommendation (SBAR- a written communication tool that helps provide essential, concise information, usually during crucial situations) dated 6/1/2024, untimed, the SBAR indicated, on 6/1/2024, untimed, Resident 1 had altered level of consciousness. The SBAR indicated, Resident 1 had a heart rate of 28 beats per minute (bpm- the number of times the heart beats in one minute. Normal heart rate is 60 bpm to 100 bpm). The SBAR indicated, Resident 1's oxygen saturation (O2 sat- a measurement of oxygen level carried in the blood) was 72% (Normal oxygen saturation is 96 percent [%] to 100 %). The SBAR indicated, facility staff (unidentified) called 911 (phone number used to contact emergency services in the event of a medical emergency) and Resident 1 was transferred to GACH 1. During a review of Resident 1's GACH 1 Emergency Department Provider Note (EDPN), dated 6/1/2024 at 6:33 pm, the EDPN indicated, Resident 1 was brought in by ambulance with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions) and ALOC. The EDPN indicated, Resident 1 had a serum Na level of 169 millimoles per liter (mmol/L- unit of measurement). The EDPN indicated, Resident 1 would be admitted to GACH 1 for diagnoses of hypernatremia most likely from dehydration, uremia, and AKI. During a telephone interview on 6/14/2024 at 11:22 am with Resident 1's Medical Doctor from GACH 1 (MD 1), MD 1 stated Resident 1 was MD 1's patient while at GACH 1. MD 1 stated (in general) normal Na level was between 135 and 145 mmol/L. MD 1 stated when Resident 1 was admitted to GACH 1, Resident 1's Na level was 169 mmol/L. MD 1 stated, that kind of Na level was a dangerously high level of Na in Resident 1's blood. MD 1 stated Resident 1 was dehydrated (a harmful reduction in the amount of water in the body), emaciated (abnormally thin or weak, due to illness and/or lack of food), unable to answer questions, and had altered mental status. MD 1 stated Resident 1 required aggressive intravenous (IV- soft, flexible tube placed inside a vein to administer fluids and medication directly into the bloodstream) fluid hydration. MD 1 stated Resident 1's Na level indicated to MD 1 that Resident 1 had not received adequate hydration and nutrition for at least a week. During a concurrent interview and record review on 6/14/2024 at 4:30 pm with the Director of Nursing (DON), Resident 1's second UCP, dated 5/16/2024, and the OSR with active date of 6/1/2024 were reviewed. The second UPC's interventions indicated for staff (in general) to ensure Resident 1 received adequate fluid intake, and to monitor Resident 1's intake and output. The OSR indicated, there was no MD order to monitor Resident 1's intake and output. The DON stated when Resident 1's UPC indicated for staff to monitor intake and output, the staff needed to notify Resident 1's PP/MD 2 to obtain a physician order for it (monitoring Resident 1's intake and output). The DON stated there was no physician order to monitor Resident 1's intake and output. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER The Gardens of El Monte		STREET ADDRESS, CITY, STATE, ZIP CODE 5044 Buffington Rd El Monte, CA 91732	

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 0692 Level of Harm - Actual harm Residents Affected - Few	During a concurrent telephone interview and record review on 6/17/2024 at 11:27 am with RD 1, Resident 1's RD Nutrition Risk Assessment (RDNRA) dated 5/21/2024 was reviewed. The RDNRA indicated Resident 1 required 1950 mL to 2040 mL per day of fluids to maintain adequate hydration. RD 1 stated (in general) normal Na level was between 135-145 mmol/L. RD 1 stated when Resident 1's Na level was above 145 mmol/L, it (the high level of Na) could indicate Resident 1 was dehydrated. RD 1 stated based on Resident 1's RDNRA, Resident 1 required 1950 mL to 2040 mL per day of fluids to maintain adequate hydration. RD 1 stated when Resident 1 was not drinking Resident 1's estimated fluid needs, Resident 1 could become dehydrated and require hospitalization . RD 1 stated when Resident 1 was not meeting his estimated fluid needs, it (the fact that Resident 1 did not drink 1950 mL to 2040 mL of fluid per day) should be reported to the licensed nurses daily and reported to RD 1 and MD 2. RD 1 stated facility staff (CNAs and LVNs in general) did not inform RD 1 that Resident 1 was not drinking Resident 1's estimated fluid needs (1950 mL to 2040 mL of liquid) per day. During a follow-up and concurrent telephone interview and record review on 6/17/2024 at 12 pm with RD 1, Resident 1's medical record document titled, Task: Nutrition - Fluids, dated 5/16/2024 to 6/1/2024 was reviewed. The Task: Nutrition -Fluids, under how much did the Resident drink in ml? indicated the following: 1. On 5/16/2024: 120 mL. 2. On 5/17/2024: 350 mL. 3. On 5/18/2024: 440 mL. 4. On 5/19/2024: 930 mL. 5. On 5/20/2024: 840 mL. 6. On 5/21/2024: 360 mL. 7. On 5/22/2024: 360 mL. 8. On 5/23/2024: 420 mL. 9. On 5/24/2024: 180 mL. 10. On 5/25/2024: 340 mL. 11. On 5/26/2024: 500 mL. 12. On 5/27/2024: 530 mL. 13. On 5/28/2024: 360 mL. 14. On 5/29/2024: 200 mL. 15. On 5/30/2024: 700 mL. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	16. On 5/31/2024: 280 mL. 17. On 6/1/2024: 600 mL. A concurrent interview was conducted, RD 1 stated according to Resident 1's documented total fluid intake per day, Resident 1 did not meet Resident 1's required estimated fluid needs per day from 5/16/2024 to 6/1/2024. RD 1 stated RD 1 did not review Resident 1's documented fluid intake from 5/16/2024 to 5/21/2024 when RD 1 completed Resident 1's RDNRA on 5/21/2024. RD 1 stated RD 1 could have caught that Resident 1 was not drinking enough fluids and talked to the nursing staff and informed Resident 1's physician about it (regarding Resident 1 did not consume enough fluid per day). RD 1 stated dehydration could perpetuate (to cause to continue) conditions like urinary tract infection, sepsis (a life-threatening complication of an infection), and hypernatremia and could further damage Resident 1's kidneys. During an interview on 6/17/2024 at 1:36 pm with LVN 1, LVN 1 stated LVN 1 was unaware Resident 1 had a history of hypernatremia. LVN 1 stated Resident 1 needed encouragement to drink fluids because Resident 1 would struggle at times to drink on his (Resident 1's) own (unable to recall dates and times). LVN 1 stated LVN 1 was unaware of Resident 1's estimated fluid needs per day (between 1950 mL to 2040 mL of fluids per day) to maintain adequate hydration. LVN 1 stated LVN 1 did not notify RD 1 or MD 2 that Resident 1 needed encouragement and struggled to drink liquid at times. LVN 1 stated the certified nursing assistants (CNAs) were supposed to inform the licensed nurses (LVNs) when Resident 1 was not drinking enough or was having issues with drinking fluids. LVN 1 stated licensed nurses were supposed to ensure Resident 1 was drinking enough fluids before the end of their shift and report any issues to the on-coming shift. LVN 1 stated LVN 1 did not receive any reports from any CNAs about Resident 1 not drinking enough fluids to meet Resident 1's estimated fluid needs per day. During an interview on 6/17/2024 at 1:53 pm with LVN 2, LVN 2 stated LVN 2 was not aware Resident 1 had a history of hypernatremia. LVN 2 stated Resident 1 was good at drinking fluids. LVN 2 stated CNAs documented Resident 1's total fluid intake per shift and not the LVNs. LVN 2 stated Resident 1 drank well (in general) but could not state how much Resident 1 usually drank in a day. LVN 2 stated LVN 2 did not remember Resident 1's estimated fluid needs per day. LVN 2 stated when Resident 1 was not meeting Resident 1's estimated fluid needs per day (between 1950 mL to 2040 mL of fluids per day), LVN 2 needed to encourage Resident 1 to drink fluids and document any hydration issues in Resident 1's medical record. LVN 2 stated LVN 2 did not receive any report regarding Resident 1 was not drinking enough fluids. LVN 2 stated when Resident 1 was not meeting Resident 1's estimated fluid needs per day as assessed by RD 1, LVN 2 needed to notify Resident 1's PP/MD 2 because that was considered a change of condition (COC- a change in the resident's health or functioning that requires further assessment and intervention) and LVN 2 needed to obtain new orders from MD 2 for laboratory tests for Resident 1. LVN 2 stated LVN 2 did not notify MD 2 at any point between 5/21/2024 and 6/1/2024 that Resident 1 had not drank Resident 1's estimated fluid needs per day. LVN 2 stated it was possible that Resident 1 could have elevated Na levels from not drinking enough fluids and become dehydrated. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview and a concurrent record review on 6/17/2024 at 3:17 pm with CNA 1, Resident 1's CRA dated 5/16/2024 indicated, Resident 1 needed assistance with eating/nutrition. CNA 1 stated Resident 1 required a lot of encouragement to drink fluids. CNA 1 stated Resident 1 was unable to drink fluids by himself because Resident 1 did not have balance of Resident 1's hands. CNA 1 stated when Resident 1 was not drinking enough, CNA 1 was supposed to report it to the assigned licensed nurse (unidentified). CNA 1 stated CNA 1 did not report any fluid intake issues to the licensed nurses because Resident 1 usually drank fluids with encouragement. CNA 1 stated CNA 1 was not sure if Resident 1 drank enough fluids during her (CNA 1's) shift and did not know where to find out how much fluids Resident 1 needed to drink during her shift. During an interview on 6/17/2024 at 4:29 pm with the DON, the DON stated licensed nurses (LVNs in general) were supposed to evaluate fluid intake weekly for each resident including Resident 1. The DON stated licensed nurses needed to ensure residents drank their estimated fluid needs per day. The DON stated nursing staff (CNAs and LVNs) could find Resident 1's assessed estimated fluid needs in Resident 1's RD notes and assessments. The DON stated CNAs needed to immediately report to the licensed nurses when Resident 1 was not drinking enough, and the licensed nurses needed to notify the Resident 1's physician (MD 2). The DON stated not drinking enough fluids was considered a change of condition because it could lead to dehydration, or it could be a sign indicated that something else was going on with Resident 1. The DON stated, it was important for all nursing staff to know Resident 1's fluid requirements. The DON stated, staff needed to report changes to the appropriate people (RD 1 and or MD 2) so Resident 1 did not suffer the consequences of dehydration. During a review of the facility's P&P titled, Intake and Output, revised in 5/2016, the P&P indicated, fluid intake and output records were evaluated at least weekly, and each evaluation shall be included in the licensed nurses' progress notes. During a review of the facility's P&P titled, Hydration Management, revised in 3/2021, the P&P indicated, the facility offered residents sufficient fluid to maintain proper hydration and health. The P&P indicated, residents received an adequate amount of fluid during the 24-hour day in accordance with each resident's individual needs and within the limitations set by physician orders as applicable. The P&P indicated, residents were screened on admission, quarterly, annually, and when there was a significant COC of status for their hydration and nutritional status. The P&P indicated, residents identified with the potential for, or actual dehydration were assessed for risk factors and appropriate recommendations would be made. The P&P indicated, the resident's plan of care was developed, implemented, evaluated, reevaluated, and revised with input from the resident and/or responsible party to develop resident-specific interventions to prevent/treat potential dehydration that could include interventions to ensure the provision of adequate fluid goals.