| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555903 | A. Building<br>B. Wing | 11/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Gardens of El Monte | 5044 Buffington Rd<br>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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>(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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement and revise the care plan for one of three sampled residents (Resident 1) who were assessed at high risk for falls in accordance with the facility's policy and procedure (P&P) titled, Falls by a Resident by failing to ensure: 1. Resident 1 was supervised and assisted while walking in the hallway on 9/6/25 in accordance with Resident 1's fall risk care plan. This failure resulted in Resident 1 falling on 9/6/25 and sustaining bruises, swelling, and an open wound on the forehead. 2. Resident 1's fall risk care plan was not revised with new interventions after Resident 1 fell on 9/6/25. This failure placed Resident 1 at risk for future falls and injury. Resident 1 fell on [DATE] and sustained bruises on the right side of the forehead, on the right eye, and on the right side and left side of the face. Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (disturbance of the brain's functioning that leads to problems like confusion and memory loss), other abnormalities of gait and mobility (changes in walking pattern caused by medical conditions), and anxiety disorder (excessive, persistent worry or fear). During a review of Resident 1's Nursing admission Assessment (NAA), dated 8/21/25, the NAA indicated, Resident 1's skin condition upon admission included: 1) upper lip abrasion, 2) right cheek bluish discoloration, 3) right shoulder bluish discoloration, 4) knee scabs, and 5) left under arm bluish discoloration. During a review of Resident 1's Fall Risk Evaluation (FRE) form, dated 8/21/25, the FRE indicated Resident 1's risk for fall was rated high risk with a score of 12. The form indicated a total score of 10 or above represented high risk for fall. During a review of Resident 1's care plan titled, At Risk for Fall/Injury related to History of Falls Prior to Admission, the care plan indicated the date initiated was 8/21/25 with a goal date of 11/2025 (November 2025). The care plan indicated the re-evaluation date was 11/2025 (November 2025). The care plan interventions included to provide visual checks to Resident 1 at least every two hours, to keep room well lighted, to maintain the resident's bed in lowest position, to ensure brakes are applied during transfers in and out of bed/chair, to assess for side effects from meds as cause of fall, optometry/ophthalmology consult and follow up as needed, and laboratory tests as ordered by the physician. The care plan indicated it has not been revised since it was initiated on 8/21/25. During a review of Resident 1's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 8/22/25, the H&P indicated Resident 1 did not have the capacity to understand and make medical decisions. The H&P also indicated Resident 1 needed fall precautions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 8/25/25, the MDS indicated Resident 1 had severely impaired cognition (thinking, knowing and being aware) for daily decision making. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying assistance as resident completes activity) with oral hygiene, toileting hygiene, and personal hygiene. The MDS indicated Resident 1 required partial/moderate assistance (helper does more than half the effort) to walk and transfer. During a review of Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 9/6/25, the SBAR indicated Resident 1 had a fall in hallway while ambulating (walking) with FWW [front-wheeled walker used to help a patient walk]. Resident 1 lost her balance and hit the left side of her forehead on the floor when landing. The SBAR indicated Resident 1 had a bump to the front of left forehead. The SBAR did not indicate, and there was no documented evidence in Resident 1's medical record, that a staff member supervised or assisted Resident 1 to walk with a FWW when Resident 1 fell on 9/6/25. During a review of Resident 1's medical record, there was no care plan regarding Resident 1's fall on 9/6/25 found in the medical record. Resident 1's care plan titled, At Risk for Fall/Injury related to History of Falls Prior to Admission, dated 8/21/25, was not updated after Resident 1 fell on 9/6/25. During a review of Resident 1's FRE, dated 9/6/25, the FRE indicated Resident 1's risk for fall was rated high risk with a score of 16. The form indicated a total score of 10 or above represented high risk for fall. During a review of Resident 1's Nurse Notes from 9/6/25 through 9/9/25 the notes indicated Resident 1 was on monitoring and Neuro-check (neurological exam, a group of questions and tests to check for disorders of the nervous system often performed after a suspected head injury) after a fall with bruising to left forehead. During a review of Resident 1's Status Post Fall Assessment (SPFA) completed by the physical therapist (PT), dated 9/8/25, indicated Resident 1 fell on 9/6/25 at 2:50 pm. The SPFA indicated Resident 1 was confused and did |