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	11/14/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555903	A. Building B. Wing	11/14/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 2) was free of unnecessary restraint. This failure had the potential for Resident 2 being unable to move around freely and placed Resident 2 at risk of injuries. Findings: a. During a review of Resident 2's admission Record (AR), the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (brain disease, damage, or malfunction caused by an illness or organs that are not working as well as they should), abnormalities of gait and mobility (changes in walking pattern caused by medical conditions), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). During a review of Resident 2's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 8/22/25, the H&P indicated Resident 2 did not have the capacity to understand and make medical decisions. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 8/25/25, the MDS indicated Resident 2 had severely impaired cognition (thinking, knowing and being aware) for daily decision making. The MDS indicated Resident 2 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 2 required partial/moderate assistance (helper does more than half the effort) to walk and transfer. b. 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 primary generalized osteoarthritis (a type of arthritis that affects multiple joints), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and abnormalities of gait and mobility. The AR indicated Resident 1 was self-responsible (accountable for their own actions and decisions). During an interview on 11/14/25 at 11:15 a.m. with the Director of Nursing (DON), the DON stated the facility does not use any type of restraint. During an interview on 11/14/25 at 11:20 a.m. with Resident 1, Resident 1 stated Resident 1 had seen other residents tied to chairs. Resident 1 stated Resident 1 had seen Resident 2 tied to Resident 2's wheelchair on 11/13/25. Resident 1 stated Resident 2 tried to get out of the wheelchair, but Resident 2 could not because Resident 2 was tied to the wheelchair. Resident 1 stated, (Resident 2) was sent to the hospital last night [11/13/25]. During an interview on 11/14/25 at 12:29 p.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated, Yes, I have seen residents tied to their wheelchair. CNA 1 stated, It happens early in the morning, when I come in at 6:50 a.m. the residents are in the hallways sitting in wheelchairs already. CNA 1 stated, The residents are covered with a blanket, but you can see that there is a white sheet wrapped around the resident and the resident is tied to the wheelchair. CNA 1 stated, The white sheet is used for the resident's safety to prevent a fall. The resident can't move. CNA 1 acknowledged that a white sheet used to tie a resident to a wheelchair was considered a restraint if the resident cannot untie the sheet and get out of the wheelchair on their own. CNA 1 was unable to state the names of the residents, how many residents, and when CNA 1 saw residents tied to wheelchairs. During an interview on 11/14/25 at 11:41 p.m. with CNA 2, CNA 2 stated, A restraint is when you tie up a patient and hold them from doing something. CNA 2 was asked, Do you ever see residents tied to chairs, so they can't get up? CNA 2 stated, In the early morning I have seen residents that are already in chairs covered with blankets and tied to the Geri chairs [a large, padded, and reclinable chair]. CNA 2 was unable to state the names of the residents, how many residents, and when CNA 2 saw residents tied to Geri chairs. During an interview on 11/14/25 at 1:04 p.m. with CNA 4, CNA 4 stated, A restraint is a form of abuse because it restricts freedom of movement. CNA 4 stated the facility did not use restraints. During a review of Resident 2's medical record, there were no physician orders for any type of restraint during Residents 2's stay at the facility. During a review of the facility's current Policy & Procedure (P&P) titled, Resident Rights, revised 9/2017, the P&P indicated, Policy: The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the following rights: 1) To be free from mental and physical abuse; 2) To be free from psychotherapeutic drugs and physical restraints used for the purpose of discipline or staff convenience. During a review of Resident 2's medical record, there were no physician orders for any type of restraint during Residents 2's stay at the facility. During a review of the facility's current Policy & Procedure (P&P) titled, Resident Rights, revised 9/2017, the P&P indicated, Policy: The resident has a right to a dignified

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	11/14/2025

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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a care plan for mental health services and increased socialization to prevent isolation for one of three sampled residents (Resident 2) who was being seen by the psychiatrist (a medical doctor who diagnoses and treats mental, emotional, and behavioral disorders). This failure resulted in Resident 2 feeling sad and isolated and had the potential for Resident 2 to receive inappropriate care. Findings: During a review of Resident 2's admission Record (AR), the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (brain disease, damage, or malfunction caused by an illness or organs that are not working as well as they should), abnormalities of gait and mobility (changes in walking pattern caused by medical conditions), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). During a review of Resident 2's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 8/22/25, the H&P indicated Resident 2 did not have the capacity to understand and make medical decisions. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 8/25/25, the MDS indicated Resident 2 had severely impaired cognition (thinking, knowing and being aware) for daily decision making. The MDS indicated Resident 2 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 2 required partial/moderate assistance (helper does more than half the effort) to walk and transfer. During a review Resident 2's Psychiatric Note, dated 9/26/25, the note indicated, Consoled resident and reviewed all medications.Patient still trying to adjust to environment. Patient confused, wants to go home. Unable to verbalize a logical plan for discharge or self-care. The note indicated Resident 2's mood was depressed, behavior was withdrawn, and psychomotor activity was agitated, pacing and restless. Resident 2's insight and memory were indicated as poor. The note also indicated the plan was to provide emotional support for compliance with treatment and to increase socialization to prevent isolation. During a review of Resident 2's medical record, there was no care plan regarding mental health services, withdrawn behavior, or need for increased socialization found in the medical record. During an observation on 11/14/25 at 2:43 p.m. in the dining room, Resident 2 was observed seated in a wheelchair at a table in the dining room. Resident 2 was by herself and not speaking to any other residents in the room. Facility staff were observed watching all residents including Resident 2 but not interacting with Resident 2. During a concurrent observation and interview on 11/14/25 at 3:15 pm with Resident 2, Resident 2 was seated in a wheelchair. Resident 2 was observed with the corners of Resident 2's mouth pulling down with eyebrows lowered. Resident 2 stated Resident 2 felt sad and bored at the facility. Resident 2 stated Resident 2 had no one to speak with and had no friends at the facility. Resident 2 stated Resident 2's family and friends did not come to visit in the facility. During a review of the facility's current Policy & Procedure (P&P) titled, Resident Rights, revised 9/2017, the P&P indicated, Policy: The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the following rights: 1) To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs; 2) To meet with others and participate in activities of social, religious and community groups.