

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555903	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 5) was treated with respect and dignity by failing to ensure Activities Assistant (AA) 1 allowed Resident 5 to get up from the reclining wheelchair (wheelchair with backrest that moves backward so users can transition from an upright seated position to a horizontal position) on 12/1/2025 at 1:25 pm. This failure resulted in Resident 5 being confined (restricted) to Resident 5's reclining wheelchair and had the potential for Resident 5 to develop a decline in range of motion (ROM- how far and in what direction a joint or muscle can move), the ability to stand, quality of life, and lead to psychosocial (mental, emotional, social, and spiritual effects) harm. Findings: During a review of Resident 5's admission Record (AR), the AR indicated the facility admitted Resident 5 on 7/11/2025 with diagnoses that included abnormalities of gait and other mobility (inability to walk normally due to injuries or underlying conditions), other lack of coordination (uncoordinated movement due to muscle control that causes an inability to coordinate movements) and cognitive communication deficit (a common consequence of brain injuries that affects the ability to communicate effectively). During a review of Resident 5's untitled Care Plan (CP) dated 10/3/2025, the CP indicated Resident 5 had the potential for impaired physical mobility related to limited movement. The CP goals indicated Resident 5 would demonstrate full ROM of the affected limb daily, for 3 months. The CP approach plan indicated to encourage Resident 5 to participate in his/her own care and decision-making to the extent permitted by his/her condition, and to encourage Resident 5 to the activity of choice. During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool), dated 10/15/2025, the MDS indicated Resident 5 had severely impaired cognition (ability to think, reason, and function). The MDS indicated Resident 5 required partial/moderate assistance (helper does less than half the effort and lifts or holds trunk or limbs but provides less than half the effort) with sitting to lying, lying to sitting on side of bed, rolling left and right (in bed), sitting to standing, chair/bed-to-chair transfers, toilet transfers and walking 50 feet. During an observation on 12/1/2025 at 7:49 am, in the dining room, Resident 5 was observed. Resident 5 was observed in a large reclining wheelchair with high back and foldable sides near the shoulders and head. The chair itself resembled a sitting chair (on wheels). The chair was tilted back. Resident 5 was observed lying in the chair, with Resident 5's feet up in the footrest. During an observation on 12/1/2025 at 9:12 am, in the dining room, Resident 5 was observed. Resident 5 was in the large, reclining chair, at one of the tables, with the chair tilted back, and Resident 5's feet up in the footrest. During an observation on 12/1/2025 at 11:30 am, in the dining room, Resident 5 was observed. Resident 5 was in the large, reclining chair, at one of the tables, with the chair tilted back, and Resident 5's feet up in the footrest. During a concurrent observation and interview on 12/1/2025 at 12:16 pm, with Licensed Vocational Nurse/Treatment Nurse (LVN) 1, Resident 5 was observed in the dining room. Resident 5 was in the reclining wheelchair with the head tilted back. LVN 1 stated, Resident 5 was usually in the reclining wheelchair most of the day, in the dining room, and the head was generally tilted back because Resident 5 was a fall risk. During a concurrent observation and interview on 12/1/2025 at 1:25 pm, with AA 1 in the hallway outside the dining room, Resident 5 was observed in the reclining wheelchair. Resident 5's wheelchair was slightly tilted back with the footrest up. Resident 5 was attempting to get out of the chair when AA 1 put AA 1's hands on Resident 5's right shoulder and stated, No, no, you need to stay in the chair. AA 1 stated, [Resident 5] wants to get up but we can't allow [Resident 5] to (get up). Resident 5 frowned and stayed in the chair. During an interview on 12/1/2025 at 1:29 pm with AA 1, AA 1 stated Resident 5 was not allowed to get out of the wheelchair because Resident 5 was a fall risk and staff did not want Resident 5 up because they needed to assist Resident 5. AA 1 stated, We use the chair to keep [Resident 5] in there so [Resident 5] doesn't get up. Sometimes we tilt chair back so [Resident 5] is more comfortable and will stop [Resident 5] from trying to get up. During an interview on 12/1/2025 at 2:49 pm, with Certified Nurse Assistant (CNA) 3, CNA 3 stated Resident 5 was not dependent (helper does ALL 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). CNA 3 stated Resident 5 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half effort). CNA 3 stated Resident 5 could stand from the bed and transfer to the chair. CNA 3 stated Resident 5 was a fall risk because Resident 5 was unsteady. CNA 3 stated, Since I've been working here, [Resident 5] has been going in the reclining wheelchair. CNA 3 stated if a resident was in a reclining wheelchair and wanted to get out of the wheelchair staff were</p>		