

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 12/12/2025
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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. (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 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents receive written notice before the resident's room or roommate in the facility being changed for two of seven sampled residents (Resident 1 and Resident 6). These deficient practices violated Resident 1 and Resident 6's rights and had the potential to affect Resident 1 and Resident 6's psychosocial well-being. (cross reference F656) Findings: a. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to facility on 9/10/2025 with diagnoses including depression (a serious mood disorder causing persistent sadness, loss of interest, and impacting feeling, thinking, and acting, affecting daily life and leading to emotional/physical problems like fatigue, sleep issues, and hopelessness), anxiety disorder (a mental health condition causing excessive, persistent fear and worry disproportionate to the situation), abnormalities of gait and mobility, and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 1's History and Physical (H&P), dated 9/11/2025, the H&P indicated that the resident could make needs known but cannot make medical decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 9/16/2025, the MDS indicated Resident 1 was mildly impaired in cognitive skills (ability to make daily decisions). The MDS indicated the resident required partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with toileting hygiene, shower/bathe self, upper and lower body dressing, and personal hygiene. The MDS indicated the resident required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating and oral hygiene. During a review of Resident 1's Notice of Room Change (NORC), dated 12/4/2025, the NORC indicated that Resident 1 had a room change from room [ROOM NUMBER]A to room [ROOM NUMBER]A on 12/4/2025. During a phone interview on 12/9/2025 at 3:43 PM with Resident 1, Resident 1 stated that Resident 1 did not receive any written notice of room change prior to the facility changing Resident 1's room from room [ROOM NUMBER]A to room [ROOM NUMBER]A on 12/4/2025 and Resident 1 did not want the room change. b. During a review of Resident 6's AR, the AR indicated Resident 6 was originally admitted to facility on 1/30/2025, readmitted on [DATE] with diagnoses including abnormalities of gait and mobility, depression, anxiety disorder, hypertension (high blood pressure), and schizophrenia. During a review of Resident 6's H&P, dated 11/27/2025, the H&P indicated that the resident has the capacity to understand and make decisions. During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6 was mildly impaired in cognitive skills. The MDS indicated the resident required setup or clean-up assistance (Helper sets up or cleans up; resident completes activity) with toileting hygiene and shower/bathe self. The MDS indicated the resident was independent with upper and lower body dressing and personal hygiene. During a review of Resident 6's NORC, dated 12/5/2025, the NORC indicated that Resident 6 had a room change from room [ROOM NUMBER]A to room [ROOM NUMBER]A on 12/5/2025. During an interview on 12/10/2025 at 9:15 AM with Resident 6, Resident 6 stated Resident 6 did not receive any written notice of room change before the facility changed Resident 6's room from room [ROOM NUMBER]A to room [ROOM NUMBER]A and did not want room change on 12/5/2025. During a concurrent interview and record review on 12/12/2025 at 10:28 AM with the Assistant Director of Nursing (ADON), Resident 1 and Resident 6's NORC were reviewed. The ADON stated that there were no residents' signatures on the NORCs to verify that Resident 1 and Resident 6 had received the written NORC form before changing Resident 1's room on 12/4/2025 and Resident 6's room on 12/5/2025. The ADON stated the ADON did not give the written NORC form to Resident 1 before Resident 1's room change on 12/4/2025. The ADON stated it was the Social Service (SS)'s responsibility to give the NORC to residents and obtain consent from residents for room change. During a concurrent interview and record review on 12/12/2025 at 10:55 AM with the Social Service Director (SSD), Resident 1 and Resident 6's NORC were reviewed. The SSD stated the SSD did not give the written NORC form to Resident 1 and Resident 6 and obtain a signature from residents on the NORC form before changing Resident 1's room on 12/4/2025 and Resident 6's room on 12/5/2025. The SSD stated that the facility should give the written NORC to residents and obtain signature from them to verify the consent to change resident's room. During a review of the facility's Policy and Procedure (P&P) titled, Resident Rights, revised 9/2017, the P&P indicated that the facility must protect and promote the rights of each resident, including the rights to receive written notice, including the reason, before the resident's room or roommate is</p>		

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>(continued on next page)</p>

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure a safe and orderly transfer or discharge from the facility for three of ten sampled residents (Resident 1, Resident 3, and Resident 19) by failing to ensure: 1. not discharge Resident 1 to another same level care Skilled Nursing Facility (SNF) 2 without physician's order, indicating the appropriate reason for discharge and providing Notice of Transfer/Discharge (NTD) to the resident to obtain a consent from the resident prior to discharge on [DATE]. 2. not discharge Resident 3 to another same level care SNF 3 without indicating the reason for discharge and providing NTD to the resident to obtain a consent prior to discharge 11/21/2025. 3. not discharge Resident 19, who needs assistance for dressing and personal hygiene upon discharge, to an Independent Living Home (ILH) 1 on 8/1/2025, which does not meet the resident's needs. These deficient practices violated Residents 1, 3 and 19's rights and had the potential to result in impairing Residents 1, 3, and 19's physical, mental, and psychosocial well-being, and possible readmission of Resident 19. (cross reference F628) Findings: 1. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to facility on 9/10/2025 with diagnoses including depression (a serious mood disorder causing persistent sadness, loss of interest, and impacting feeling, thinking, and acting, affecting daily life and leading to emotional/physical problems like fatigue, sleep issues, and hopelessness), anxiety disorder (a mental health condition causing excessive, persistent fear and worry disproportionate to the situation), abnormalities of gait and mobility, and schizophrenia (a mental illness that is characterized by disturbances in thought). The AR indicated that Resident 1's responsible party (RP) is resident self. During a review of Resident 1's History and Physical (H&P), dated 9/11/2025, the H&P indicated that the resident could make needs known but cannot make medical decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 9/16/2025, the MDS indicated Resident 1 was mildly impaired in cognitive skills (ability to make daily decisions). The MDS indicated the resident required partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with toileting hygiene, shower/bathe self, upper and lower body dressing, and personal hygiene. The MDS indicated the resident required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating and oral hygiene. During a review of Resident 1's Order Summary (OS), dated 12/5/2025, the OS indicated discharge resident with home health and did not indicate the facility or location where Resident 1 would be discharged. The OS indicated there was no physician order to discharge Resident 1 to SNF 2. During a review of Resident 1's NTD, dated 12/5/2025, the NTD indicated the reason for transferring or discharging Resident 1 to SNF 2 is resident's health had improved sufficiently so that no longer require services provided by the facility. The NTD indicated there is no resident/representative's signature to verify the facility provided the NTD to Resident 1 to get a consent prior to discharge. During a phone interview on 12/9/2025 at 3:43 PM with Resident 1, Resident 1 stated Resident 1 did not get the NTD form to sign prior to his discharge on [DATE] to SNF 2. Resident 1 stated Resident 1's discharge goal was to be discharged to a lower-level care facility, not the same level care SNF. During an interview on 12/9/2025 at 2:44 PM with the Marketer/Designated Social Service (DSS), the DSS stated the DSS did not provide the NTD form to Resident 1 prior to Resident 1's discharge on [DATE]. During an interview on 12/10/2025 at 2:55 PM with the Registered Nurse (RN) 2, RN 2 stated RN 2 did not provide the NTD form to Resident 1 prior to Resident 1's discharge on [DATE]. During an interview on 12/10/2025 at 3:39 PM with the Social Service Director (SSD), the SSD stated it was social service's responsibility to assess the discharge goal and do the discharge plan for residents. The SSD stated Resident 1's discharge plan was to be discharged to a lower-level care facility, not another SNF since admission until 12/4/2025. During a concurrent interview and record review on 12/12/2025 at 10:28 PM with the Assistant Director of Nursing (ADON), Resident 1's NTD form, dated 12/5/2025, was reviewed. The ADON stated the reason for discharge Resident 1 is The transfer or discharge is appropriate because your health has improved sufficiently so that you no longer required services provided by this facility and there was no resident's signature to verify the consent on the NTD form. The ADON stated Resident 1's discharge plan was to be discharged to a lower-level care facility on 12/5/2025. The ADON stated SNF 2 is the same level care facility as this facility, not a lower-level care facility. During a concurrent interview and record review on 12/12/2025 at 3:31 PM with the Director of Nursing (DON), Resident 1's NTD form, dated 12/5/2025, was reviewed. The DON stated</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure document the appropriate content on the Notice of Transfer/Discharge (NTD) form for three of ten sampled residents (Resident 1, Resident 3, and Resident 19) by failing to ensure:1. indicate the appropriate reason to transfer Resident 1 to another same level care Skilled Nursing Facility (SNF) 2 on 12/5/2025.2. indicate the appropriate reason to transfer Resident 3 to another same level care SNF 3 on 11/21/2025.3. indicate the location of an Independent Living Home (ILH) 1, where Resident 19 was transferred on 8/1/2025.These deficient practices result in inappropriate documentation and placing the resident at risk of misunderstanding the information in the medical records and sufficiently preparing the residents for discharge, which had the potential to impair residents' physical, mental and psychosocial well-being for Resident 1, 3, and 19.(cross reference F627)Findings:1. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to facility on 9/10/2025 with diagnoses including depression (a serious mood disorder causing persistent sadness, loss of interest, and impacting feeling, thinking, and acting, affecting daily life and leading to emotional/physical problems like fatigue, sleep issues, and hopelessness), anxiety disorder (a mental health condition causing excessive, persistent fear and worry disproportionate to the situation), abnormalities of gait and mobility, and schizophrenia (a mental illness that is characterized by disturbances in thought). The AR indicated that Resident 1's responsible party (RP) is resident self. During a review of Resident 1's History and Physical (H&P), dated 9/11/2025, the H&P indicated that the resident could make needs known but cannot make medical decisions.During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 9/16/2025, the MDS indicated Resident 1 was mildly impaired in cognitive skills (ability to make daily decisions). The MDS indicated the resident required partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with toileting hygiene, shower/bathe self, upper and lower body dressing, and personal hygiene. The MDS indicated the resident required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating and oral hygiene.During a review of Resident 1's NTD, dated 12/5/2025, the NTD indicated the reason for transferring or discharging Resident 1 to SNF 2 is resident's health had improved sufficiently so that no longer require services provided by the facility. The NTD indicated that the resident was transferred to a same level care SNF as the facility.During a phone interview on 12/9/2025 at 3:43 PM with Resident 1, Resident 1 stated Resident 1 did not know the reason that the facility transferred Resident 1 on 12/5/2025 to SNF 2. Resident 1 stated Resident 1's discharge goal was to be discharged to a lower-level care facility, not the same level care SNF. During an interview on 12/9/2025 at 2:44 PM with the Marketer/Designated Social Service (DSS), the DSS stated the DSS did not provide the NTD form to Resident 1 prior to Resident 1's discharge on [DATE]. During an interview on 12/10/2025 at 3:39 PM with the Social Service Director (SSD), the SSD stated it was social service's responsibility to assess the discharge goal and do the discharge plan for residents. The SSD stated Resident 1's discharge plan was to be discharged to a lower-level care facility, not another SNF since admission until 12/4/2025. During a concurrent interview and record review on 12/12/2025 at 10:28 PM with the Assistant Director of Nursing (ADON), Resident 1's NTD form, dated 12/5/2025, was reviewed. The ADON stated the reason for discharge Resident 1 is The transfer or discharge is appropriate because your health has improved sufficiently so that you no longer required services provided by this facility. The ADON stated Resident 1's discharge plan was to be discharged to a lower-level care facility on 12/5/2025. The ADON stated SNF 2 is the same level care facility as this facility, not a lower-level care facility. During a concurrent interview and record review on 12/12/2025 at 3:31 PM with the Director of Nursing (DON), Resident 1's NTD form, dated 12/5/2025, was reviewed. The DON stated it is important to check the appropriate reason for transfer and make sure residents agree, understand, and involve in the appropriate orientation and preparation for the discharge. The DON stated it is important to follow the discharge process and document appropriately.2. During a review of Resident 3's AR, the AR indicated Resident was admitted to facility on 11/14/2025 with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and schizophrenia. The AR indicated that Resident 3's responsible party (RP) is resident self. During a review of Resident 3's H&P, dated 11/15/2025, the H&P</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the nurse staff developed and implemented the person-centered care plan (a treatment plan that focused on the needs and preferences of a resident or individual) for one of seven sampled residents (Resident 1) to monitor Resident 1's psychosocial well-being and satisfaction after Resident 1 was being moved to a new room. This deficient practice had the potential to place Resident 1 at risk of not receiving the individualized care services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. (cross reference F559) Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to facility on 9/10/2025 with diagnoses including depression (a serious mood disorder causing persistent sadness, loss of interest, and impacting feeling, thinking, and acting, affecting daily life and leading to emotional/physical problems like fatigue, sleep issues, and hopelessness), anxiety disorder (a mental health condition causing excessive, persistent fear and worry disproportionate to the situation), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 1's History and Physical (H&P), dated 9/11/2025, the H&P indicated that the resident could make needs known but cannot make medical decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 9/16/2025, the MDS indicated Resident 1 was mildly impaired in cognitive skills (ability to make daily decisions). The MDS indicated the resident required partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with toileting hygiene, shower/bathe self, upper and lower body dressing, and personal hygiene. The MDS indicated the resident required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating and oral hygiene. During a review of Resident 1's Notice of Room Change (NORC), dated 12/4/2025, the NORC indicated that Resident 1 had a room change from room [ROOM NUMBER]A to room [ROOM NUMBER]A on 12/4/2025. During a review of Resident 1's current Care Plan (CP), received 12/10/2025, the CP indicated there is no care plan for room change. During a concurrent interview and record review on 12/12/2025 at 12:36 PM with the Licensed Vocational Nurse (LVN) 2, Resident 1's NORC, dated 12/4/2025 and current CP were reviewed, LVN 2 stated there was no care plan for Resident 1 regarding Resident 1's room change. LVN 2 stated the nurse staff should develop a care plan right after the room change. During a concurrent interview and record review on 12/11/2025 at 3:21 PM with the Assistant Director of Nursing (ADON), Resident 1's NORC, dated 12/4/2025 and current CP were reviewed, the ADON stated there was no care plan for Resident 1 after changing Resident 1's room from room [ROOM NUMBER]A to room [ROOM NUMBER]A on 12/4/2025. The ADON stated the facility should develop and implement a care plan for Resident 1 to monitor resident's the psychosocial condition right after Resident 1 was moved to a new room. During an interview on 12/12/2025 at 3:31 PM with the Director of Nursing (DON), the DON stated that the facility should have developed a care plan regarding room change for residents. The DON stated that it is important to develop a care plan to monitor the residents' adjustment to the new room. During a review of the facility's Policy and Procedure (P&P) titled, Comprehensive Care Planning, revised 3/2019, the P&P indicated that the facility should develop a comprehensive resident-centered care plan for each resident, that includes measurable objectives and timeframes to meet each resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The P&P indicated, The care plan must be reviewed and revised periodically, ., and on an ongoing basis to reflect changes in the resident and the services provided or arranged must be consistent with each resident's written plan.</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>Based on interview and record review, the facility failed to ensure the staff provided social services to assist one of three sampled residents (Resident 1) to get a legal personal identification (ID) card. This deficient practice violated Resident 1's right and had the potential to affect Resident 1's mental and psychosocial well-being. Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to facility on 9/10/2025 with diagnoses including depression (a serious mood disorder causing persistent sadness, loss of interest, and impacting feeling, thinking, and acting, affecting daily life and leading to emotional/physical problems like fatigue, sleep issues, and hopelessness), anxiety disorder (a mental health condition causing excessive, persistent fear and worry disproportionate to the situation), abnormalities of gait and mobility, and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 1's History and Physical (H&P), dated 9/11/2025, the H&P indicated that the resident could make needs known but cannot make medical decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 9/16/2025, the MDS indicated Resident 1 was mildly impaired in cognitive skills (ability to make daily decisions). The MDS indicated the resident required partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with toileting hygiene, shower/bathe self, upper and lower body dressing, and personal hygiene. The MDS indicated the resident required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating and oral hygiene. During a phone interview on 12/9/2025 at 3:43 PM with Resident 1, Resident 1 stated Resident 1 had requested the facility for assistance on going to Department of Motor Vehicles (DMV- the government agency that handles driver licensing [issuing licenses, ID cards, testing]) and applying for California ID since Resident 1 was admitted to the facility in September 2025. Resident 1 stated the facility did not provide assistance to apply ID cards from DMV when Resident 1 was residing in the facility. During an interview on 12/10/2025 at 3:39 PM with the Social Service Director (SSD), the SSD stated that Resident 1 had asked for help to get an ID from DMV after Resident's admission, but the facility did not assign a staff to assist the resident to go to DMV to apply the ID. The SSD stated the facility should provide service to help resident getting their personal ID cards. During an interview on 12/11/2025 at 1:35 PM with the Director of Staff Development (DSD), the DSD stated the facility did not assist Resident 1 to go to DMV to get an ID card during Resident 1's stay in the facility. The DSD stated that the DSD is responsible for assigning staff with resident to go to DMV to assist with applying ID to coordinate with SSD. During a review of the facility's Policy and Procedure (P&P) titled, Social Service Program, revised 1/2017, the P&P indicated that the facility should provide medically related social services based on each resident's comprehensive assessment to ensure that each resident achieves and maintains his/her highest practicable physical, mental and psycho-social well-being. The P&P indicated that the facility Social Service should provide financial and legal assistance through referral to appropriated resources, when appropriate, and making arrangements for obtaining needed adaptive equipment, clothing and personal items.</p>		