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	04/02/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to administer Depakote (a medication used to help control mood symptoms and behavior issues) per the physician's order for one of three sampled residents (Resident 1). This violation had the potential to compromise Resident 1's health and safety.Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility originally admitted Resident 1 on 1/9/2026 and readmitted Resident 1 on 3/20/2026 with diagnoses including dementia (a progressive state of decline in mental abilities) and schizophrenia (a mental illness that was characterized by disturbances in thought). During a review of Resident 1's History and Physical (H&P) dated 1/10/2026, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment and care screening tool) dated 1/13/2026, the MDS indicated Resident 1 had severely impaired cognition (ability to understand). The MDS indicated Resident 1 was independent with eating, oral hygiene and personal hygiene. The MDS indicated Resident 1 required moderate assistance (helper did less than half the effort) from staff with toileting hygiene, showering/ bathing, and bed-to-chair transferring. During a review of Resident 1's Order Summary Report (OSR) dated 3/20/2026, the OSR indicated a physician's order to administer Depakote three times a day for angry outburst. During an interview on 4/1/2026 at 3:32 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated she did not administer Depakote to Resident 1 on 3/21/2026, 3/22/2026, and 3/23/2026 on the morning shifts. LVN 1 stated Resident 1's Depakote was not available in the medication cart and was pending pharmacy delivery. During an interview on 4/2/2026 at 11:21AM with LVN 2, LVN 2 stated it was important to administer Depakote for Resident 1's anger outburst, because it was what the physician ordered and part of the care plan. LVN 2 stated missing seven out of eight doses of Depakote would increase the risk of uncontrolled behavior. LVN 2 stated the licensed nurse should have checked with the pharmacy to obtain the Depakote from the emergency kit while waiting for the Depakote delivery. During a concurrent interview and record review on 4/2/2026 at 12:34 PM with the Director of Nursing (DON), Resident 1's March 2026 Medication Administration Record (MAR) was reviewed. The MAR indicated Resident 1 did not receive Depakote at 9 AM on 3/21/2026, 3/22/2026, and 3/23/2026. The MAR indicated Resident 1 did not receive Depakote at 1 PM on 3/21/2026, 3/22/2026, and 3/23/2026. The MAR indicated Resident 1 did not received Depakote at 5 PM on 3/22/2026. The DON stated the Depakote was part of Resident 1's psychotropic medication combination for behavioral management. The DON stated Resident 1 should have received Depakote per the physician's order because it was part of the plan of care. The DON stated it was not acceptable that the licensed nurse did not administer Depakote to Resident 1. The DON stated it was important for Resident 1 to receive Depakote because of safety. During a review of the facility's Policy and Procedure (P&P) titled Medication Ordering And Receiving From Pharmacy, dated 4/2008, the P&P indicated medications were received from the dispensing pharmacy on a timely basis. The P&P indicated if the new medications were needed before the next regular delivery, staff should inform the pharmacy of the need for prompt delivery. The P&P further indicated that the staff should use the emergency kit or emergency drug supply, as applicable, when the resident needed a (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication prior to pharmacy delivery. During a review of the facility's P&P titled Medication Administration, dated 4/2025, the P&P indicated the licensed nurse must administer medications in accordance with the physician orders. The P&P further indicated that the licensed nurse must administer medications within one hour before or after their prescribed time.