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	06/24/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to:1. Send Resident 1 for timely medical treatment after falling and hitting his head on the floor.2. Ensure three of five sampled residents (Resident 3, Resident 4, and Resident 5) received treatment and care in accordance with the physician's order for orthostatic blood pressure monitoring (involves measuring blood pressure (BP) while lying down, sitting, and standing to assess changes) by failing to ensure Resident 3, Resident 4, and Resident 5 were monitored for orthostatic hypotension (condition in which the blood pressure quickly drops upon standing up after sitting or lying down) with two blood pressure (BP) readings on 6/7/26, 6/14/26 and 6/21/26 and observed for adverse side effects.These deficient practices had the potential to result in adverse outcomes:1. Resident 1's delay of care with possible internal bleeding from the head injury from the fall;2. Hypotension (very low blood pressure) with dizziness and fainting and could lead to falls and injuries for Resident 3, Resident 4, and Resident 5.a. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was initially admitted to the facility on [DATE] and then readmitted on [DATE] with diagnoses that included other abnormalities of gait and mobility (any noticeable, irregular change in your walking pattern) and atrial fibrillation (irregular and often very fast heart rhythm).During a review of Resident's 1's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/13/26, the MDS indicated Resident 1 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 1 needed substantial/maximal assistance with eating, oral hygiene, toileting hygiene, shower/bathe self, upper/lower body dressing, putting on/taking off footwear, and personal hygiene.During a review of Resident 1's History and Physical (H&P), dated 5/2/26, the H&P indicated Resident 1 had altered mental status to understand and make medical decisions.During a review of Resident 1's Fall Risk Evaluation, dated 5/1/26, the evaluation indicated Resident 1 scored 16 on 5/1/26, 18 on 5/28/26 and 18 on 6/11/26. The evaluation indicated a total score of 10 or above represented high risk.During a review of Resident 1's Order Summary Report, dated 6/24/26, the Order Summary Report indicated Resident 1 was ordered Eliquis (a blood thinner, used to prevent and treat blood clots) oral tablet 5 milligrams (mg, unit of measurement), one tablet by mouth two times a day for atrial fibrillation.During a review of Resident 1's Medication Administration Record (MAR) for the month of June 2026, the MAR indicated Resident 1 was prescribed Eliquis from 6/1/26 to 6/10/26 as scheduled at 09:00 a.m. and 5:00 p.m. The MAR indicated on 6/10/26 at 5:00 p.m., the scheduled does was given to Resident 1. During a review of Resident 1's Nurses Notes, dated 6/11/26 at 3:15 a.m., the note indicated CNA (unnamed) reported Resident 1 had a fall and a skin tear on Resident 1's right side of the head measuring 3 centimeters (cm, unit of measurement) length x 1-2cm width, bleeding and irregularly shaped.During a review of Resident 1's Change of Condition (COC), dated 6/11/26 indicated Resident 1 had a fall after rolling out of bed. The COC indicated resident struck the right side of Resident 1's head during the fall. Assessment indicated a skin tear, irregular shape and approximately 3 cm in length and 1-2 cm in width, bleeding, and resident alert and responsive. The COC indicated the Clinician was notified at 5:13 a.m. and the Responsible Person (RP) at 05:20 a.m. on 6/11/26.During a review of Resident 1's (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurses Notes, dated 6/11/26 at 7:15 a.m., the note indicated Resident 1 transferred to General Acute Care Hospital 2 (GACH 2) via 911.During a review of Resident 1's Medical Record, the record indicated the facility was aware of Resident 1's fall with head injury on 6/11/26 at 3:15 a.m. and Resident 1 was not transferred to GACH 2 until 7:15 a.m.During a review of Resident 1's GACH 2 medical records, the records indicated Resident 1 was seen in the Emergency Department at 7:31 a.m.During an interview on 6/25/26 with Registered Nurse 1 (RN 1), RN 1 stated LVN 5 asked RN 1 for help with Resident 1 because Resident 1 had a fall that was reported to LVN 5 at 3:15 a.m. in the morning on 6/11/26. RN 1 stated LVN 5 told RN 1 that LVN 5 texted the DON with Resident 1's [head] wound picture. RN 1 stated LVN 5 told her the DON did not respond.RN 1 stated she did not know the time when the DON called back and told LVN 5 not to send out Resident 1 via 911 because Resident 1 had a superficial wound. RN 1 stated she assessed Resident 1; she removed the bandage and Resident 1 had on and was still actively bleeding. RN 1 stated Resident 1 was on Eliquis 5 mg, twice a day for atrial fibrillation.RN 1 stated she got an MD order at 7:15AM to transfer Resident 1 to GACH 2 via 911 and Resident 1 was sent out to the hospital.RN 1 was asked why Resident 1 was not transferred to the hospital in a timely manner, and RN 1 stated, LVN 5 is a new nurse and still needed guidance from the DON. RN 1 was asked: Why is it important to send Resident 1 to the hospital in a timely manner? RN 1 stated Resident 1 might have blood clots due to the fall injury to the head or because Resident 1 was on blood thinners, there may be excessive internal bleeding in Resident 1's head.b. During a review of Resident 3's AR, the AR indicated Resident 3 was initially admitted to the facility on [DATE] and then readmitted on [DATE] with diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and bipolar disorder (a lifelong mental health condition characterized by severe shifts in mood, energy, and activity levels.During a review of Resident 3's H&P, dated 6/16/26, the H&P indicated Resident 3 had minor memory impairments, but had the capacity to make medical decisions.During a review of Resident's 3's MDS, dated [DATE], the MDS indicated Resident 3 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 3 needed help with oral hygiene, upper body dressing, putting on/taking off footwear.During a review of Resident 3's MAR for the month of June 2026, the MAR indicated Resident 3 was prescribed one antipsychotic medication (medications to treat psychosis) and for staff to monitor side effects related to hypotension.During a review of Resident 3's Medication Review Report for active physician orders, the report indicated the following:1. Monitor BP lying and sitting for orthostatic hypotension every week on Sunday 3-11 p.m. shift. Notify Medical Doctor (MD) if difference of systolic blood pressure (SBP, top number in a reading, measuring the maximum pressure in the arteries when your heart beats) is 20mmHg or greater or if diastolic blood pressure (DBP, the bottom number in a reading, measuring the pressure in the arteries when your heart rests between beats) is 10 mmHg or greater for use of Risperdal.During a review of Resident 3's Weights and Vitals Summary for 6/7/26 and 6/21/26, the summary indicated the orthostatic blood pressure (BP) reading was taken within a minute of the sitting and lying BP orthostatic readings. The sitting position BP was taken at 4:59 p.m. followed by the lying position BP taken at 5:00 p.m. The BP readings on 6/7/26 were as followed:6/7/26 at 4:59 p.m., 125/70 mmHg (Sitting, left arm)6/7/26 at 5:00 p.m., 128/88 mmHg (Lying, right arm)6/7/26 at 7:47 p.m., 128/88 mmHg Sitting, left arm)c. During a review of Resident 4's AR, the AR indicated Resident 4 was initially admitted to the facility on [DATE] and then readmitted on [DATE] with diagnoses that included borderline personality disorder (a mental health condition characterized by severe difficulties regulating emotions), unspecified dementia (a progressive state of decline in mental abilities), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and anxiety disorder (intense, persistent fear and dread that is disproportionate to the situation and interferes with daily life).During a review of Resident 4's H&P, dated 4/11/26, the H&P indicated Resident 4 had fluctuating capacity to understand and make decisions.During a review of Resident's (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4's MDS, dated [DATE], the MDS indicated Resident 4 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 4 needed supervision with eating, oral hygiene, and personal hygiene; partial/moderate assistance with toileting hygiene, shower/bathe self, upper/lower body dressing, and putting on/taking off footwear.During a review of Resident 4's MAR for the month of June 2026, the MAR indicated Resident 4 was prescribed two antipsychotic medications (medications to treat psychosis) and for staff to monitor side effects related to hypotension. The MAR also indicated Resident 4 refused orthostatic blood pressure monitoring on Sunday, 6/7/26, Sunday, 6/14/26 and Sunday, 6/21/26. No change of condition for Resident 4's refusal for orthostatic blood pressure monitoring was found in Resident 4's medical records.During a review of Resident 4's Medication Review Report for active physician orders, the report indicated the following:1. Monitor BP lying and sitting for orthostatic hypotension every week on Sunday 3-11 p.m. shift. Notify MD if difference of SBP is 20mmHg or greater or if DBP is 10 mmHg or greater for use of Seroquel (used to treat schizophrenia, bipolar disorder, and major depressive disorder); Rexulti (used to treat schizophrenia, agitation in Alzheimer's dementia, and as an add-on therapy for major depressive disorder).During a review of Resident 4's Weights and Vitals Summary for 6/7/26, 6/14/26 and 6/21/26, the summary indicated no orthostatic blood pressure (BP) readings were taken during the 3-11 p.m. shift.d. During a review of Resident 5's AR, the AR indicated Resident 5 was initially admitted to the facility on [DATE] and then readmitted on [DATE] with diagnoses that included unspecified dementia (a progressive state of decline in mental abilities), and bipolar disorder, depression (a serious mood disorder that causes persistent sadness, loss of interest, and physical or emotional fatigue) and anxiety disorder.During a review of Resident 5's H&P, dated 4/1/26, the H&P indicated Resident 5 had fluctuating capacity to understand and make decisions.During a review of Resident's 5's MDS, dated [DATE], the MDS indicated Resident 5 was independent in eating, needed supervision with oral hygiene and personal hygiene; partial/moderate assistance with toileting hygiene, shower/bathe self, upper/lower body dressing, and putting on/taking off footwear.During a review of Resident 5's MAR for the month of June 2026, the MAR indicated Resident 5 was prescribed one antipsychotic medication and for staff to monitor side effects related to hypotension. The MAR also indicated Resident 5 refused orthostatic blood pressure monitoring on Sunday, 6/14/26 and Sunday, 6/21/26. No change of condition for Resident 5's refusal for orthostatic blood pressure monitoring was found in Resident 5's medical records.During a review of Resident 5's Medication Review Report for active physician orders, the report indicated the following:1. Monitor BP lying and sitting for orthostatic hypotension every week on Sunday 3-11 p.m. shift. Notify MD if difference of SBP is 20mmHg or greater or if DBP is 10 mmHg or greater for use of Olanzapine (used to treat schizophrenia and bipolar disorder).During a review of Resident 5's Weights and Vitals Summary for 6/14/26 and 6/21/26, the summary indicated no orthostatic blood pressure (BP) readings were taken during the 3-11 p.m. shift.During an interview on 6/23/26 at 11:06 a.m. LVN 1, LVN 1 stated LVN 1 was aware of orthostatic blood pressure monitoring because LVN 1 worked at another facility with psychiatric residents, but that some CNAs and nurses at this facility might not know because there were no policy and procedure. LVN 1 stated it was important to measure orthostatic blood pressure as ordered by the physician because psychotropic medications taken by residents could make them a high risk for falls with injury, especially if they already have trouble with their gait and mobility.During an interview with the Medical Records Director (MRD) on 6/24/26 at 4:35 p.m., MRD stated the facility did not have an orthostatic blood pressure policy.During the exit conference on 6/24/26 at 5:00 p.m. with the facility's Director of Nursing (DON), the DON stated the facility does not have a blood pressure or orthostatic hypotension blood pressure policy and procedure because taking blood pressure is a nursing standard of care.During a review of the facility's Policy and Procedure (P&P) titled, Change of Condition, revised March 2021, the P&P indicated, Policy: It is the policy of this facility that any changes in a resident's condition be thoroughly assessed and evaluated with physician notification for early clinical (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	management to avoid unnecessary readmissions to acute hospitals. The facility may use the SBAR process to assess and evaluate the resident's change of condition.During a review of the facility's P&P titled, Fall Risk & Prevention of Injury to include Pathological Fractures, revised March 2019, the P&P indicated, Policy: It is the policy of the facility to identify residents that are at risk for falls and to implement a plan of care in an attempt to prevent falls. The P&P further indicated, If the Fall Risk Assessment score is ten (I 0) or above, the resident is at risk for falls and a plan of care will be developed with approaches in an attempt to prevent falls, including falls with serious injury. The Fall Risk Assessment will be reviewed quarterly and after each fall. If a resident sustains a fall, the licensed nurse is to be notified immediately prior to moving the resident. The licensed nurse will assess the resident immediately and an incident report will be completed with an investigation. The incident report and investigation will be given to the Director of Nurses for review.During a review of the facility's P&P titled, Medication Administration, revised April 2025, the P&P indicated, Policy: It is the policy of the facility that medications for residents be administrated in a safe and timely manner, and as prescribed. The P&P further indicated, Medications ordered for a specific resident may not be administered to another resident.During a review of the facility's P&P titled, Physician Services and Orders, revised January 2017, the P&P indicated, Policy: It is the policy of the facility that each resident remains under the care of a physician. Drugs, biologicals, laboratory services, radiology and other diagnostic services shall be administered or performed only upon the written order of a person duly licensed and authorized to prescribe such drugs and services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to maintain proper storage of medications in one of two medication carts (Medication Cart 1).This deficient practice had the potential for medication dispensing errors for 25 residents who resided in the facility's Station 1 Unit. During an observation of Medication Cart 1 on 6/23/26 at 2:15 p.m., in Station 1 Unit, with Licensed Vocational Nurse 1 (LVN 1), the locked narcotics (a drug that is classified as a Schedule IV controlled substance and in moderate doses dulls the senses, relieves pain, and induces sleep) drawer with active medications was observed with 4 loose medications in the back of the narcotics drawer. The loose medication pills included one Klonopin [Clonazepam, 1mg, light green tablet, TEVA- used to prevent and treat panic disorders, seizure disorders, and acute muscle spasms] and three Ativan [Lorazepam, 0.5mg, white tablet, 5R- used to treat anxiety disorders, trouble sleeping, and seizures] tablets.During an interview on 6/23/26 at 2:15 p.m. with LVN 1, LVN 1 stated LVN 1 did not know the loose medications were in the locked box.LVN 1 stated she was not usually assigned to Station 1 Medication Cart.LVN 1 stated a resident may have refused the medication and a different nurse may have placed the medication back in the drawer.LVN 1 stated there should not be any loose medications in the narcotics drawer because someone can take them without anyone knowing.LVN 1 stated the loose medications could be compromised by light or moisture since they were not in the bubble packs (individual sealed plastic compartments corresponding to the exact date and time they should be taken) or cause a medication error, if you can not identify the pills correctly, which posed a risk to the residents.During an interview on 6/23/26 at 2:36 p.m. with the Director of Nursing (DON), the DON stated, It is not our practice to have loose medications in the narcotics drawer; I don't know how that happened. DON stated once a month the DON does the medication disposal process with the Pharmacist.During a review of the facility's Policy & Procedure (P&P) titled, Preparation and General Guidelines - IIA5: Controlled Medications, revised April 2025, the P&P indicated Policy: It is the policy of the facility that medications for residents be administrated in a safe and timely manner, and as prescribed. The P&P further indicated, .Medications ordered for a specific resident may not be administered to another resident. When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It must be destroyed according to facility policy in the presence of two licensed nurses and the disposal documented on the accountability record on the line representing that dose. The same process applies to the disposal of unused partial tablets and unused portions of single dose ampules.