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	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Gardens of El Monte	5044 Buffington Rd El Monte, CA 91732

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote and treat two of two sampled residents (Residents 9 and 37) with respect, privacy and dignity in accordance with the facility's policy and procedure (P&P) titled Resident Right to Dignity and Privacy. These failures had the potential to cause psychosocial (mental and emotional well-being) decline and low self-esteem.Findings: a. During a review of Resident 9's admission Record (AR), the AR indicated Resident 9 was admitted to the facility on [DATE] with diagnoses including a gastrostomy (creation of an artificial external opening into the stomach for nutritional support) and Parkinson's Disease (a progressive disease marked by tremor, muscular rigidity, and slow, imprecise movements) without dyskinesia (uncontrolled movements). During a review of Resident 9's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 2/27/2026, the MDS indicated Resident 9 had severely impaired cognition (ability to understand) for daily decision making. The MDS indicated Resident 9 was dependent (helper did all the effort) on staff for oral hygiene, toileting, lower body dressing, putting on/taking off footwear, and personal hygiene. During an observation on 4/8/2026 at 8:20 am in Resident 9's room, Licensed Vocational Nurse 2 (LVN 2) pulled up Resident 9's gown and assessed Resident 9's gastrostomy tube (GT) site. LVN 2 did not pull and close the privacy curtain to provide Resident 9's privacy exposing Resident 9's abdominal area to the two roommates present in the room. During an observation on 4/8/2026 at 8:34 am, LVN 2 performed the medication pass and did not pull Resident 9's privacy curtain completely, leaving the resident's abdomen exposed to two roommates in the room. b. During a review of Resident 37's AR, the AR indicated Resident 37 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (brain dysfunction caused by diseases or toxins in the body) and dementia (a progressive state of decline in mental abilities) with other behavioral disturbances. During a review of Resident 37's MDS dated [DATE], the MDS indicated Resident 37 was rarely/never understood. The MDS indicated Resident 37 was dependent on staff for oral hygiene, toileting, lower body dressing, putting on/taking off footwear, and personal hygiene. During an observation on 4/8/2026 at 8:54 am, LVN 2 did not pull Resident 37's privacy curtain and Resident 37's door remained open during the medication pass, leaving the resident exposed to anyone passing in the hallway. During an interview on 4/8/2026 at 9:06 am with LVN 2, LVN 2 stated LVN 2 forgot to close the privacy curtains for Residents 9 and 37 and they should have been closed for privacy reasons to respect the residents' dignity during any procedures. During an interview on 4/9/2026 at 3:54 pm with the Director of Nursing (DON), the DON stated the nursing staff should pull the curtain closed for resident's privacy and dignity during any care given to a resident. During a review of the facility's P&P titled, Resident's Right to Dignity and Privacy, dated 9/2017, the P&P indicated Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect and individuality. Facility staff promotes, maintains, and protects resident privacy, including bodily privacy, when assisting with personal care and during treatment procedures.

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document in the residents' medical record the transfer report of two of two sampled residents (Residents 6 and 8) to a General Acute Care Hospital (GACH). These deficient practices resulted in incomplete records for Residents 6 and 8 and had the potential to affect the continuity of care.Findings: a. During a review of Resident 6's admission Record (AR), the AR indicated Resident 6 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including encephalopathy (disease or dysfunction of the brain that alters brain function), spondylolisthesis (a spinal condition where one vertebra slips forward or backward over the one below it), low back pain and polyneuropathy (a condition characterized by damage to multiple peripheral nerves simultaneously). During a review of Resident 6's History and Physical (H&P) dated 11/27/25, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 6's Minimum Data Set (MDS - a comprehensive standardized assessment and screening tool) dated 2/13/26, the MDS indicated Resident 6 required partial/moderate (helper does less than half the effort) assistance for showers and supervision (helper provides verbal cues and/or touching/steadying and/or contact guard) assistance for upper and lower body dressing, and toileting hygiene. The MDS indicated Resident 6 required setup or clean up (helper sets up or clean up) assistance for oral hygiene and was independent (resident completes the activity by themselves with no assistance from a helper) for eating and personal hygiene. During a review of Resident 6's SBAR (Situation-Background-Assessment-Recommendation) Communication Form dated 4/2/26, the SBAR indicated Resident 6 had a change in condition of generalized pain, weakness, back pain and lethargy. During a review of Resident 6's Physician's Order (PO) dated 4/3/26 at 10:54 AM, the PO indicated to transfer Resident 6 to the GACH related to increased generalized weakness, lower back pain, and status post fall. During a review of Resident 6's Nurses Notes (NN) dated 4/3/26 at 2:32 PM, the NN indicated Resident 6 was transferred to the GACH. During a review of Resident 6's Notice of Transfer/Discharge to the Ombudsman (an official appointed to investigate individuals' complaints) dated 4/3/26, the notice indicated Resident 6's transfer or discharge was necessary for Resident 6's welfare and Resident 6's needs could not be met in the facility. During a record review of Resident 6's entire medical record (MR) in the presence of Licensed Vocational Nurse 4 (LVN 4) on 4/9/26 at 1:50 PM, there was no documented evidence indicating that the facility staff gave/provided a transfer report to the GACH for Resident 6's transfer on 4/3/26. During an interview on 4/9/2026 at 1:53 PM with LVN 4, LVN 4 stated that when a resident was transferred out to the hospital, nursing staff should call the hospital and give an endorsement report. LVN 4 stated the nursing staff should document that information in the resident's medical chart. LVN (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4 stated it was important to keep a copy of the report in the resident's chart to ensure there was documentation of the hospital transfer report. During an interview with the Director of Nursing (DON) on 4/9/2026 at 2:02 PM, the DON stated the Charge Nurse (CN) or Supervisor were responsible for documenting the resident's transfer information. The DON stated nursing staff needed to document the actual report that was given to the hospital and leave a copy in the resident's chart. The DON stated if the report was not in the chart, then there was no record of the resident's transfer report. The DON stated the nursing staff who called the GACH for endorsement also needed to document when and to whom the report was given. The DON stated it was important to have transfer documentation because it included critical information given to the hospital staff that could potentially reduce errors in providing care to the residents. During a review of the facility's Policies & Procedure (P&P) titled, Discharging the Resident, revised 9/2017, the P&P indicated if the resident is being discharged to a hospital or another facility, ensure that a transfer summary is completed and that a telephone report is made to the receiving facility. b. During a review of Resident 8's AR, the AR indicated Resident 8 was admitted to the facility on [DATE] with diagnoses including a gastrostomy (creation of an artificial external opening into the stomach for nutritional support) and dementia (a progressive state of decline in mental abilities). During a review of Resident 8's H&P dated 1/20/2026, the H&P indicated Resident 8 was recently hospitalized for poor oral intake for the past one week. During a review of Resident 8's PO dated 1/5/2026 at 7:38 pm, the PO indicated Resident 8 will be transferred to a GACH for poor intake (eating/drinking) and unable to swallow food/pocketing. During a review of Resident 8's NN dated 1/5/2026 at 11:00 pm, the NN indicated Resident 8 was transferred out of the facility at 9:30 pm via ambulance to a GACH. During a concurrent interview and record review on 4/9/2026 at 10:45 am with Licensed Vocational Nurse 4 (LVN 4), Resident 8's entire MR were reviewed. Resident 8's MR did not indicate transfer report documents for 1/5/2026. LVN 4 stated, LVN 4 did not find the transfer packet that should be in the resident's medical record which showed the resident left the facility, the location where the resident was sent, the reason for transfer, proof of notifications, and the resident's skin assessment. During an interview on 4/9/2026 at 2:02 pm with the DON, the DON stated the transfer documents were completed by the charge nurse or supervisor. The DON stated the nursing staff needed to document the actual report given to the hospital and maintain a copy in the resident's chart. The DON stated if the documents were not in the resident's medical record, the facility did not have any records of when and to whom the transfer report was given. During a review of the facility's policy and procedure (P&P) titled, Discharging the Resident, last dated 9/2017, the P&P indicated when the resident was discharged to a hospital or another facility, (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff should ensure a transfer summary was completed and that a telephone report was made to the receiving facility. The P&P indicated, staff assessed and documented the resident's condition at discharge, including skin assessment, if medical condition allowed.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the policy and procedure (P&P) on Advance Directive (AD, a legal document indicating resident preference on end-of-life treatment decisions) was implemented for one of one sampled resident (Resident 37) by failing to ensure Resident 37's AD Acknowledgment Form (ADAF) was updated to reflect whether the resident had an AD. This failure had the potential for the facility staff to provide medical treatment and services against the will of the residentFindings: During a review of Resident 37's admission Record (AR), the AR indicated Resident 37 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (brain dysfunction caused by diseases or toxins in the body) and dementia (a progressive state of decline in mental abilities) with other behavioral disturbance. During a review of Resident 37's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 3/12/2026, the MDS indicated Resident 37 was rarely/never understood. The MDS indicated Resident 37 was dependent (helper did all the effort) on staff for oral hygiene, toileting, lower body dressing, putting on/taking off footwear, and personal hygiene. During a concurrent interview and record review on 4/7/2026 at 3:57 pm with Registered Nurse Supervisor 1 (RN 1), Resident 37's ADAF dated 7/30/2025 was reviewed. Resident 37's ADAF indicated Resident 37 had executed an AD and also indicated Resident 37 had not executed an AD. RN 1 stated, the statements in the ADAF were conflicting and the nursing staff would not know if Resident 37 had an AD or not. RN 1 stated, it was important to know whether Resident 37 had an AD to allow nursing staff to know how to care for Resident 37 when Resident 37 was unable to make decisions or when incapacitated during emergencies. During a concurrent interview and record review on 4/8/2026 at 11:23 am with the Social Services Director (SSD), Resident 37's ADAF dated 7/30/2025 was reviewed. Resident 37's ADAF indicated Resident 37 had executed an AD and also indicated Resident 37 had not executed an AD. The SSD stated Resident 37's ADAF needed to be clarified because one portion stated Resident 37 had an AD and the other stated Resident 37 did not have an AD. The SSD stated the ADAF needed to be accurate to determine if the resident had an AD. During an interview on 4/9/2026 at 3:55 pm with the Director of Nursing (DON), the DON stated the ADAF indicated whether the residents had an AD or not. The DON stated when both statements were checked on the ADAF, staff were unable to determine if the resident had an AD or not. The DON stated Resident 37's ADAF was confusing and the nursing staff would not be able to determine if Resident 37 had an AD or not. During a review of the facility's P&P titled, Advance Directives, revised 4/2017, the P&P indicated a resident may develop an AD relative to his/her refusal of medical or surgical treatment, which will be followed in accordance with this P&P and current State law.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to encode the resident's bilateral bolster wedge cushions (used to offer support to various parts of the body) on the Minimum Data Set (MDS- a resident assessment and care screening tool) dated 2/26/2026 as a restraint for one of one sampled resident (Resident 3). This violation had the potential to negatively impact Resident 3's quality of care. Findings: During a review of Resident 3's admission Record (AR), the AR indicated Resident 3 was admitted to the facility 8/1/2024 and readmitted on [DATE] with the diagnoses including dementia (decline in mental ability), bipolar disorder (mental health condition characterized by extreme mood swings), and depression (persistent sadness). During a review of Resident 3's History & Physical (H&P) dated 1/13/2026, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 2/26/2026, the MDS indicated Resident 3's cognition (ability to think and process information) was severely impaired (never/rarely made decisions) and Resident 3 was dependent (helper does all the effort) on staff for eating, oral and toileting hygiene, showers, upper and lower body dressing. During a review of Resident 3's Order Summary Report (OSR) dated 1/12/2026, the OSR indicated for staff to apply bilateral bolster wedge cushion in bed as enabler (support) to assist Resident 3 to identify the edge of the bed due to poor safety awareness and unsafe self-positioning. During a review of Resident 3's undated Informed Consent (IC) signed by Resident 3's Responsible Party (RP), the IC indicated a proposed treatment for bilateral booster wedge cushion in bed as enabler to assist the resident to identify the edge of the bed due to poor safety awareness and unsafe self-positioning. During an observation of Resident 3 inside Resident 3's room on 4/7/2026 at 9:34 AM, Resident 3 was resting in bed with bilateral pillow wedges placed on each side of Resident 3. During an interview and record review (RR) with the Minimum Data Set Consultant (MDSC) in the presence of the Administrator (ADM) and Administrative Assistant (AA) on 4/8/26 at 3:00 PM, the MDSC stated bilateral bolster wedge cushions were considered to be restraints and had not been coded in Resident 3's MDS. The MDSC stated the MDS Nurse should have coded the bilateral bolster wedge cushion for Resident 3 as restraints since there was a physician's order. The MDSC stated the bilateral bolster wedge cushions were considered restraint since it was used to limit Resident 3's movements. During an interview and RR with the MDS Nurse on 4/8/26 at 3:07 PM, the MDS Nurse stated there was a signed restraint consent form in Resident 3's chart for the bilateral bolster wedge cushions but the MDS Nurse did not consider the bilateral bolster wedge cushions as restraints. The MDS Nurse stated before coding the bilateral bolster wedge cushions as a restraint in the MDS, the MDS Nurse should have clarified with the nursing staff. During an interview with Licensed Vocational Nurse 4 (LVN 4) on 4/8/2026 at 3:30 PM, LVN 4 stated the bilateral bolster wedge cushions for Resident 3 were used because Resident 3 would wiggle out of bed and the bilateral cushions prevented Resident 3 from having a fall. During an interview and RR with Registered Nurse 1 (RN1) on 4/8/2026 at 3:39 PM, RN1 stated Resident 3 had a physician's order for restraints and RN1 confirmed there was a care plan and a consent form signed by Resident 3's RP specifically for restraints. RN1 stated the bilateral bolster wedge cushions should have been coded as restraints in Resident 3's MDS. During an interview with the Director of Nursing (DON) on 4/8/2026 at 4:00 PM, the DON stated the purpose of the MDS was to document a complete assessment of a resident. The DON stated if Resident 3 had a restraint order, then it should have been coded in Resident 3's MDS. The DON stated the MDS nurse was responsible for completing the documentation. The DON stated if the restraints were not coded, then the medical record would not show the interventions for Resident 3, and the nurses would not know if they needed monitoring and/or precautionary measures for Resident 3. During an interview and RR with License Vocational Nurse 3 (LVN 3) on 4/8/2026 at 4:15 PM, LVN 3 stated bilateral bolster wedge cushions were ordered as a restraint for Resident 3. LVN 3 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated there was an order, care plan and a restraint consent that was signed for bilateral bolster wedge cushion in Resident 3's chart. LVN 3 stated it was important to have the restraints coded in the MDS because nursing staff needed access to that information for interventions and monitoring. LVN 3 stated if the restraints were not coded in the MDS then that information was not being communicated to the staff so they could provide the care, interventions and monitoring Resident 3 needed. During a concurrent interview and RR with LVN 4 on 4/9/2026 at 9:13 AM, LVN 4 stated the consent and care plan for Resident 3 indicated the bilateral bolster wedge cushion was a restraint. LVN 4 stated LVN 4 was the one who had Resident 3's RP sign the consent for the bilateral bolster wedge cushions since the resident was at risk for falls. LVN 4 stated the resident would tend to wiggle and try to get out of bed and could suffer a fall. LVN 4 stated Resident 3 had a history of a fall and it was necessary for Resident 3 to have the bilateral booster wedges in place to help prevent a fall. During a review of the facility's Policy and Procedure (P&P), titled Resident Assessment Instrument (RAI) Process, revised 4/2017, the P&P indicated the facility will utilize the Resident Assessment Instrument (RAI) process for the accurate assessment of each resident's functional capacity and health status. During a review of the facility's P&P titled, Physical Restraints, revised September 2017, the P&P indicated, It is the policy of the facility that restraints will only be used after other alternatives have been tried unsuccessfully and only with a thorough assessment, informed consent from the resident or their responsible party, a physician's order and a plan of care to address the use of the restraint. Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached to or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. If a resident cannot mentally or physically self-release, then the device is considered a restraint.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise the Care Plan (CP) for Fall for one of one sampled resident (Resident 1). This deficient practice resulted in a care plan that was not individualized, placing the resident at risk for preventable falls. Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including pneumonia (lung infection), acute and chronic respiratory failure with hypoxia (life-threatening, sudden worsening of gas exchange with long-term lung disease), and abnormalities of gait and mobility (deviations from normal walking). During a review of Resident 1's History & Physical (H&P) dated 12/31/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 2/27/2026, the MDS indicated Resident 1 had intact cognition (ability to think and process information) and required supervision or touch assistance with sit to stand and walk 10 to 50 feet with two turns. During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR) dated 1/23/2026, the SBAR indicated Resident 1 had an unwitnessed fall. During a concurrent interview and record review on 4/9/2026 at 12:05 p.m., with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated Resident 1 had a fall and the interventions included more monitoring for Resident 1. LVN 4 stated Resident 1 used Resident 1's wheelchair to ambulate. During a review of Resident 1's At Risk for Falls Care Plan dated 12/30/2025 and Actual Fall Care Plan dated 1/22/2026 and 1/23/2026, LVN 4 stated Resident 1's Care Plans did not have any revisions. During a concurrent review and interview on 4/9/2026 at 2:19 p.m., with the Director of Nursing (DON), Resident 1's At Risk for Falls Care Plan and Actual Fall Care Plans dated 1/22/2026 & 1/23/2026 were reviewed. The DON stated the Care Plans were not revised and should have been revised. The DON stated it was important to revise the Care Plan so that the care will be updated and prevent further falls for the residents. During a review of the facility's Policy and Procedure (P&P), titled, Comprehensive Care Planning, revised March 2019, the P&P indicated the care plan must be reviewed and revised periodically, at least quarterly, 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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to monitor behavior for a high-risk elopement (a resident with an increased risk of leaving a supervised care facility) resident to prevent an elopement (patient leaves a healthcare facility without authorization or proper discharge) for one of one resident (Resident 16). This deficient practice resulted in Resident 16 eloping from the facility. Findings:During a review of Resident 16's admission Record (AR), the AR indicated Resident 16 was admitted to the facility 3/5/2026 metabolic encephalopathy (brain dysfunction), bipolar disorder (mental health condition characterized by extreme mood swings), and depression (persistent sadness). During a review of Resident 16's History & Physical (H&P), dated 3/5/2026, the H&P indicated Resident 16 had fluctuating capacity to understand and make decisions.During a review of Resident 16's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/9/2026, the MDS indicated Resident 16's cognition (ability to think and process information) was intact and had neurological conditions and required partial/moderate assistance to walk 10 feet (ft).During a record review of Resident 16's Elopement/Wander Risk Assessment, dated 3/5/26, Resident 16 had a score above 10, indicating Resident 16 was at a high risk for elopement. The Elopement/Wander Risk Assessment indicated Resident 16 had a history of 5150 (qualified officers or clinicians to involuntarily detain a person for a 72-hour mental health psychiatric hold), verbalizing wanting to go home, and closely monitored (monitor for one-to-one monitoring).During a record review of Resident 16's Elopement Risk Assessments Care Plan (ERCP), dated 3/5/26, the ERCP indicated Resident 16's elopement risk score was above 10 (high-risk) and frequent staff monitoring of resident's whereabouts.During a concurrent observation and interview, on 4/9/26, at 2:28 p.m., with the Director of Nursing (DON), an off-white-colored outside gate was observed. The DON stated the facility exit door at the back of the facility was thought to be used by Resident 16 to elope. The DON stated the facility exit door is not locked because the residents walk around the back outside area of the facility. The DON stated they think Resident 16 may have stepped on some piping observed on the ground nearby the gate and jumped over. The DON stated Resident 16 was supposed to wait for the ambulance to be transferred to the hospital and Resident 16 kept yelling and cursing at the staff. The DON stated Resident 16 was gone from the facility for about one hour and was returned to the facility by the Police Department.During a concurrent interview & record review of the Wandering Care Plan, on 4/9/26, at 3:03 p.m., with the DON, the Care Plan indicated frequent monitoring but did not indicate the frequency. The DON stated but the frequent is every hour. The DON stated the Behavior Monitoring form is used to document frequent monitoring of a resident. The DON stated the DON did not remember if the DON gave the nursing staff this form to complete for Resident 16. The DON stated that the monitoring of elopement and behavior for Resident 16 was not continuously or regularly done because they did not have the form. The DON stated there was not consistent documentation of Resident 16's whereabouts. The DON stated monitoring of Resident 16's behavior for increased wandering and exit seeking behaviors was not being monitored and documented. The DON stated monitoring was important because Resident 16 may not have been able to elope.During a record review of the facility's Policy and Procedures (P&P, titled Wandering/Exit Seeking Behavior, revised September 2019, indicated the facility will evaluate for wandering and/or exit seeking behavior and implement appropriate interventions as indicated via the evaluation process. If the resident exhibits wandering/and or exit seeking behavior, the episodes should be documented in the progress notes of the medical record. Documentation should include interventions used and their effectiveness.

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	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Gardens of El Monte	5044 Buffington Rd El Monte, CA 91732

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to follow its policy to complete and post the nurse staffing information hours at the start of each shift. On 4/7/26, the facility did not post the nurse staffing information for the current dates and did not indicate the total number of projected hours and the actual hours of licensed and unlicensed nursing staff directly responsible for resident care per shift. This deficient practice violated the residents' right and had the potential to inaccurately reflect the actual nurses providing direct care to the residents.Findings:During a general observation at the entrance of the facility's notice board across nurse's station 1 on 4/7/26 at 9:01 AM, the Census and Direct Care Service Hours Per Patient Day (NHPPD) posted dated 4/6/26 and 4/7/26 were not updated or completed. During an interview and record review (RR) with the Director of Staff Development (DSD) on 4/09/2026 at 3:30 PM, the DSD stated the NHPPD dated 4/6/26 and 4/7/26 were not completed. DSD stated the DSD was the staff responsible to complete the nurse staffing information, but the document was being submitted by Payroll Staff (PS). During a concurrent interview with the DSD on 4/09/2026 at 3:51 PM, the DSD stated the NHPPS document was supposed to be completed and posted in the morning before 8:00 AM and the form must be completed daily. The DSD stated it was important to have the NHPPD document completed daily so staff, visitors and residents could see that the facility had enough staff to provide the care for the residents. During an interview and RR with PS on 4/09/2026 at 4:02 PM, PS stated the PS would completed the NHPPD document the next day around 12:00 PM. PS stated PS was the one to calculate the hours including the nightshift. The PS stated it was important to have an updated NHPPD so that anyone visiting the facility could see the actual and projected hours the nurses were providing care. The PS stated the NHPPD documents that had been posted dated 4/6/26 and 4/7/26 were incomplete and only had the projected hours but not the actual hours. During an interview with License Vocational Nurse (LVN1) on 4/09/2026 at 4:30 PM, LVN1 stated it was important to have the NHPPD document updated daily so the residents were aware of the actual hours they received care in the facility. LVN1 also stated it was important for staff to have access to a completed NHPPD to see if the facility was following the safe patient staffing ratios. During an interview with the Director of Nursing (DON) on 4/10/2026 at 8:00 AM, the DON stated the NHPPD documents should be completed and posted early in the morning at the beginning of the day shift. The DON stated that the PS assigned to completing the NHPPD should prioritize completing the NHPPD as one of the first tasks at the beginning of the shift. The DON stated the importance of the NHPPD was so residents, staff and visitors could have information of the staffing for the day. The DON also stated that the NHPPD also served as a record to verify that the staff listed as working were actually present and provided the resident care daily and for every shift. A review of the facility's policy and procedure titled, Staffing Nurse Information reviewed January 2017, indicated, It is the policy of the facility to post nurse staffing information daily.A. The Facility will post the following information daily at the beginning of each shifti. Facility nameii. The current dateiii. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure safe provision of pharmaceutical services when one pill was found lying on the hallway floor. This failure had the potential to result in a resident taking the pill and leading to adverse side effects (unwanted undesirable effects that are related to a drug).Findings: During an observation on 4/7/2026 at 12:37 pm in the hallway across from Nursing Station 1, one small, round, white pill was on the hallway floor. There were two nurses in Nursing Station 1, other staff and residents were walking through the hall. During a concurrent observation and interview on 4/7/2026 at 12:41 pm with Registered Nurse Supervisor 1 (RN 1) in the hallway across from Nursing Station 1, the small, round, white pill was observed on the floor. RN 1 went to retrieve a glove to pick it up and stated, there shouldn't have been a pill on the floor. RN 1 stated, a resident could have picked it up, eaten it, and some harm could've occurred to the resident depending on what the medication was. RN 1 stated, RN 1 was unsure what the pill was and would properly dispose of it. During an interview on 4/9/2026 at 3:51 pm with the Director of Nursing (DON), the DON stated, there shouldn't be any medication on the floor because the nurse should ensure the medication was taken by the resident. The DON stated, there were confused residents who resided in the facility, one of them could have taken the pill and the staff wouldn't know what was affecting the resident. The DON stated, it was an unsafe situation for the residents. During a review of the facility's policy and procedure (P&P) titled, Medication Storage in the Facility, dated 4/2008, the P&P indicated medications and biologicals were stored safely, securely, and properly. The P&P indicated the medication supply was accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized. During a review of the facility's policy and procedure (P&P) titled, Facility Guidelines, dated 3/2019, the P&P indicated medications were stored in locked areas.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately date a resident's Care Plan (CP) for one of one sampled resident (Resident 16). This failure resulted in inaccurate documentation and had the potential to negatively impact the resident's quality of care.Findings: During a review of Resident 16's admission Record (AR), the AR indicated Resident 16 was admitted to the facility 3/5/2026 with diagnoses including metabolic encephalopathy (brain dysfunction caused by chemical or metabolic imbalance), bipolar disorder (mental health condition characterized by extreme mood swings), and depression (persistent sadness). During a review of Resident 16's History & Physical (H&P) dated 3/5/2026, the H&P indicated Resident 16 had fluctuating capacity to understand and make decisions. During a review of Resident 16's Minimum Data Set, dated [DATE], the MDS indicated Resident 16 had intact cognition (ability to think and process information) and required partial/moderate assistance to walk 10 feet (ft). During a concurrent interview and record review on 4/9/2026 at 3:03 p.m., Resident 16's Elopement Risk Care Plan dated of 3/6/2026 was reviewed with the Director of Nursing (DON). The DON stated the incorrect date was indicated by her as 3/6/2026 on the Elopement Risk Care Plan update. The DON stated the correct date should be 4/6/2026, the date of Resident 16's elopement. During a review of the facility's Policy and Procedure (P&P), titled, Documentation Principles, revised February 2018, the P&P indicated it is the policy of the facility that resident's clinical records shall be current and kept in detail consistent with good medical and professional practice based on the care provided to each resident. Entries must be accurate, timely, objective, specific, concise, legible, clear and descriptive.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview, and record review, the facility failed to ensure six of 23 resident rooms (Rooms 2, 8, 10, 11, 15, and 16) met the square footage requirement of 80 square feet (sq. ft.) per resident in multiple resident rooms. This failure had the potential for these rooms to lack enough space for activities of daily living and hinder staff from providing care to these residents.Findings: During observation of the facility on 4/7/2026 at 9:11 am to 10:21 am, Rooms 2, 8, 10, 11, 15, and 16 did not meet the minimum requirement of 80 sq. ft. per resident. The residents in these rooms were able to ambulate freely and/or maneuver in their wheelchairs freely. Nursing staff had enough space to provide care to these residents with dignity and privacy. There was space for beds, side tables, dressers and other medical equipment. During an interview with the Administrator on 04/10/2026 at 10:02 am with the Administrator (ADM), ADM stated the facility submitted a room size requirement waiver for Rooms 2, 8, 10, 11, 15, and 16.During a review of the facility's room waiver request letter dated 4/9/2026, the room waiver letter indicated there was enough space for nursing care and the health and safety of the residents occupying these rooms were not in jeopardy (harm). The room waiver letter indicated these rooms were in accordance with the needs of the residents and would not have an adverse effect on the residents' health and safety or impede the ability of any residents to attain his or her highest practicable well-being. The room waiver letter indicated the following measurements: RoomBedsSq. Ft.24286.9282151.40102152.24112151.92152147.50162147.50 The minimum square footage for a 2-bedroom is 160 sq. ft. The minimum square footage for a 4-bedroom is 320 sq. ft. During interviews with the residents both individually and collectively during the recertification survey (4/7/2026-4/10/2026), the residents did not express any concerns regarding the size of their rooms.