STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055293	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Anita Convalescent Hospital	5522 Gracewood Ave. Temple City, CA 91780

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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 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 interview and record review, the facility failed to ensure an accurate assessment to reflect the resident's weight loss on the Minimum Data Set (MDS, a resident assessment and tool) for one (1) of six (6) sampled residents (Resident 6) in accordance with the facility policy. This deficient practice had the potential for the facility not to develop and implement an individualized care plan (a document that outlines the facility's plan to provide personalized care to a resident that includes measurable objectives, interventions and timeframes to meet a resident's medical, nursing, and mental psychosocial needs) to prevent further weight loss and negatively affect Resident 6's overall well-being. Cross reference F692 Findings: During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE], with the diagnoses including but not limited to Parkingson's disease (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement), dementia (progressive brain disorder that slowly destroys memory and thinking skills), type 2 diabetes mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel), and dysphagia (difficulty swallowing). During a record review of Resident 6's Weights Summary, the weight summary indicated the following: 10/29/2024 = 163 pounds (lbs) 11/25/2024 = 149 lbs (a weight loss of 8.59 % in one month) During a record review of Resident 6's Minimum Data Set, dated [DATE], the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were severely impaired. The MDS indicated Resident 6 required substantial/maximal assistance for eating, toileting hygiene, upper and lower body, and personal hygiene. The MDS also indicated Resident 6 did not have a loss of 5 % or more in the last month or loss of 10 % or more in the last 6 months. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/17/2025 at 4:24 PM with the MDS nurse (MDS nurse) of Resident 6's MDS, the MDS nurse stated the MDS indicated Resident 6 had not lost more than 10% in the last six (6) months. MDS nurse stated the MDS was not accurate and needed to reflect Resident 6's weight loss of more than 10% in the last 6 months since Resident 6 lost 19% in the last 6 months. During an interview on 6/17/2025 at 4:45 PM with the Director of Nursing (DON), the DON stated Resident 6's MDS should be accurate for weight loss in order for the nurses to develop a plan of care for the weight loss. The DON stated the MDS should indicate a weight when the resident experienced weight loss in order for the nurses to monitor any trends for the weight loss. During a record review of the facility's policy and procedure titled, RAI (Resident Assessment Instrument, standardized tool used in nursing homes and long-term care facilities to assess resident's needs, strengths, and potential risks) Process, revised 10/1/2019, the policy indicated all information recorded within the MDS Assessment must reflect the resident's status at the time of the Assessment Reference Date. The RAI was used in conducting comprehensive assessments as part of an ongoing process through which the facility identifies each resident's preferences and goals of care, functional and health status, strengths and needs, as well as offering guidance for further assessment once problems have been identified.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to provide safety and supervision for two out of three sampled residents (Resident 3 and 4) to prevent fall. 1. On 2/17/2025, Certified Nurse Assistant (CNA) 1 provided bed mobility, dressing, and personal hygiene (bedside care) to Resident 3 without the assistance of another facility staff. 2. On 4/28/2025, the facility failed to provide documented evidence 1:1 sitter (a caregiver or facility staff who provides continuous, one- on- one supervisions t a resident who requires constant monitoring due to safety concerns) was provided to Resident 4 in accordance with the physician's order dated 1/22/2025. This deficient practice resulted in Resident 3 falling from bed during bedside care on 2/17/2025, and Resident 4 was found on the floor unwitnessed, although she had a physician's order for continuous one-on-one supervision through a sitter and a bed alarm. Findings: 1.During a review of Resident 3's admission Record, indicated Resident 3 was admitted to the facility on [DATE] with diagnosis of dementia (progressive impaired ability to think, remember or make decisions that interferes with doing everyday activities), osteoporosis, metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood. The imbalance is caused by an illness or organs that are not working as well as they should. It is not caused by a head injury. When the imbalance affects the brain, it can lead to personality changes), muscle weakness, abnormal posture, and readmitted on [DATE] with diagnosis of right femur fracture (broken thighbone) with routine healing (without normal/ uncomplicated healing process after an injury). During a review of Resident 3's Minimum Data Set: (MDS- resident assessment tool), dated 3/10/2025, the MDS indicated Resident 3 had severe impaired cognition (ability to think, remember and make decisions) for daily decision making. The MDS indicated Resident 3 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff for eating, oral hygiene, toileting, showering, upper and lower body dressing, putting on taking off footwear, personal hygiene, rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair to bed transfer, and toilet transfer. During a review of Resident 3's Documentation Survey Report for interventions/tasks performed by the Certified Nursing Assistants (CNAs), dated 2/17/2025, the report indicated that only one-person physical assist was implemented to provide Resident 3 with bed mobility, dressing, personal hygiene (bedside care), and transferring in the evening of 2/17/2025. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's Nursing Progress Notes, dated 2/17/2025, the Progress notes indicated that in the evening of 2/17/2025, CNA 1 reported that Resident 3 was moving around and rolled off the bed during bedside care. During an interview on 6/17/2025 at 12:37 PM with CNA2, CNA2 stated she was assigned to care for Resident 3 a few times and she was aware that Resident 3 was dependent on staff for transferring, toileting, personal hygiene/ bedside care, and all other activities of daily living (ADLs), and should always have a second staff to help turn, reposition, and roll resident from one side to the other of the bed to ensure resident's safety and to prevent Resident 3 from falling form the bed. During an interview on 6/17/2025 at 1 PM with the Director of Staff Development (DSD)1, the DSD1 stated that a minimum 2-person assist should be implemented when providing care to residents who are dependent on staff for ADLs based on their MDS functional abilities in order to prevent falls and injuries. The DSD1 stated assisting a total dependent resident with only one person places the resident at increased risk of falls, fractures, skin tears, or dislocations. 2. During a review of Resident 4's admission Record, indicated Resident 4 was admitted to the facility on [DATE] with diagnosis of cerebral ischemia (a condition where the brain doesn't receive enough blood flow, resulting in a lack of oxygen and nutrients), dementia, and readmitted back to the facility on 1/21/2025 with facial fractures following a fall. During a review of Resident 4's MDS, the MDS indicated Resident 4 had severely impaired cognition for daily decision making. The MDS indicated Resident 4 required partial assistance (helper does less than half the effort to lift, hold, or support trunk or arms and legs, but provides less than half the effort) for eating, roll left and right, sit to lying, and lying to sitting. The MDS indicated Resident 4 required maximal assistance (helper does more than half the effort to lift or hold trunk or limbs and provides more than half the effort) for oral hygiene, toileting, upper body dressing, sit to stand, chair to bed transfer, toilet transfer, walking 10 feet, and personal hygiene. The MDS indicated Resident 4 was dependent on staff to shower, lower body dressing, putting on taking off footwear, and shower transfer. During a review of Resident 4's Order Summary, the Order Summary indicated the physician ordered a 1:1 sitter status post fall on 1/22/2025. During a review of Resident 4's nursing staffing assignment on 4/18/2025, the nursing assignment did not indicate Resident 4 had an assigned 1:1 sitter from 3 PM to 11 PM shift. During a review of Resident 4's Situation, Background, Assessment, and Recommendation (SBAR- a communication framework used to structure information exchange in healthcare setting), dated 4/28/2025, the SBAR indicated Resident 4 had an unwitnessed fall on 4/28/2025 and was found on the floor sitting on her right hip at around 4:10PM. During an interview on 6/17/2025 at 1 PM with the DSD1, DSD 1 stated a resident who has a 1:1 sitter should not be found on the floor and have an unwitnessed fall since the 1:1 sitter's main role was to ensure resident's safety and prevent that from happening. DSD1 stated this represents a lapse in supervision and the physician's order not being followed to ensure the safety of residents and prevent harm. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/17/2025 at 2 PM with the Director of Nursing (DON), the DON stated if Resident 4 had a sitter on 4/28/2025 the fall could have been prevented or Resident 4 should not have been seen on the floor. During a review of the facility's policy and procedure titled Transfer, the policy indicated safe and efficient transfers are combination of the resident's physical ability and perceptual capacity, proper equipment, appropriate techniques and good planning. If staff require help, they should ask for it and use assistive devices, and one or more caregivers. During a review of the facility's P&P titled Fall Management Program dated June 2017, indicated the facility is to provide the highest quality care in the safest environment for residents to prevent resident falls through meaningful assessments, interventions, education, and reevaluation. Following a resident's fall, the IDT-falls committee will meet within 72 hours of a fall to review and document summary of event following a fall, root cause analysis, referrals, and interventions to prevent future falls. During a review of the facility's P&P titled Sitters dated June 2017, the P&P indicated a sitter's sole responsibility is to provide companionship to a resident and notify facility staff if and or when resident attempts to get out of bed unassisted, accompany resident to the bathroom if resident is able to ambulate, and may not perform any other job of any employee of the facility. The sitter must notify the facility staff when taking a break or when the sitter will be away from the resident during his/ her work shift.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide nutritional care and services for one (1) of six (6) sampled residents (Resident 6) who had a significant weight loss in accordance with the facility's policy by failing to: a. Complete a Change of Condition (COC, tool used by health care professionals when communicating about critical changes in a resident's status) when Resident 6 had significant weight loss b. Follow the Registered Dietician recommendations when Resident 6 had a significant weight loss This deficient practice had the potential to place Resident 6 at risk for further weight loss and negatively affect the resident's overall wellbeing. Cross reference F641 Findings: During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE], with the diagnoses including but not limited to Parkingson's disease (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement), dementia (progressive brain disorder that slowly destroys memory and thinking skills), type 2 diabetes mellitus (DM, a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel), and dysphagia (difficulty swallowing). During a record review of Resident 6's Weights Summary, the weight summary indicated the following: 10/29/2024 = 163 pounds (lbs) 11/25/2024 = 149 lbs (a weight loss of 8.59 % in one month) 4/27/2025 = 132 lbs (a weight loss of 19% in 6 months). During a record review of Resident 6's Nutrition/Dietary Note, dated 11/26/2024, the note indicated Resident 6 lost 12 lbs in one week (7.5%). The Registered Dietician 1 (RD 1) recommended a referral to the physician for accuchecks (monitor resident's blood sugar level) due to history of type 2 DM, add four-ounce sugar free home parenteral nutrition (HPN, a medical nutrition therapy utilized in residents who are unable to maintain adequate nutrition and hydration) every day with lunch for two (2) months, add Boost Glucose Control (nutritional drink designed to help residents with diabetes manage their blood sugar levels as part of a balanced diet) every day with breakfast for 1 month, and lab orders. During a record review of Resident 6's medical records, the medical records did not indicate a COC, nursing notes, or follow up done for the Registered Dietician's (RD) recommendation for the significant weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 6's Minimum Data Set (MDS, a resident assessment and tool), dated 4/21/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were severely impaired. The MDS indicated Resident 6 required substantial/maximal assistance for eating, toileting hygiene, upper and lower body, and personal hygiene. The MDS also indicated Resident 6 did not have a loss of 5 % or more in the last month or loss of 10 % or more in the last 6 months. During an interview on 6/17/2025 at 1:08 PM with RD 2, RD 2 stated an intervention is needed to be done when a resident has a weight loss of 5%. RD 2 stated the nurse needed to notify the physician of the significant weight change and the RD's recommendations. During a concurrent interview and record review on 6/17/2025 at 1:48 PM with RD 2 of Resident 6's Nutrition/Dietary Note and physician's order, RD 2 stated Resident lost 8.59 % from 10/29/2024 to 11/25/2024. RD 2 stated on 11/26/2024, RD 1 had recommended for the nurses to refer to the physician for accuchecks due to history of type 2 DM, add four-ounce sugar free HPN every day with lunch for 2 months, add Boost Glucose Control every day with breakfast for 1 month, and lab orders. RD 2 stated Resident 6 did not and should have a physician's order for accuchecks, sugar free HPN, Boost Glucose Control or lab orders done after RD 1's recommendation on 11/26/2024. RD 2 stated the expectation was for the nurses to carry out the recommendations from the RD. RD 2 stated the residents could experience further weight loss when RD recommendations are not carried out. During a concurrent interview and record review on 6/17/2025 at 4:24 PM with MDS nurse (MDS nurse) of Resident 6's COC, MDS nurse stated Resident 6 did not and should have had a COC done for Resident 6's weight loss in November 2024. During an interview on 6/17/2025 at 4:45 PM with the Director of Nursing (DON), the DON stated when residents have a significant weight loss, the nurses should do a COC and notify the physician for any orders and follow the recommendations given by the RD. The DON stated nurses needed to implement the orders and recommendations to prevent the residents from losing more weight. During a record review of the facility's policy and procedure titled, Change of Condition Notification, revised 6/1/2017, the policy indicated the Licensed Nurse will notify the resident's Attending Physician when there is a change in weight of five pounds or more within a 30-day period unless a different stipulation has been stated in writing by the patient' physician. The Attending Physician will be notified timely with a resident's change in condition. Notification to the Attending Physician will include a summary of the condition change and an assessment of the resident's vital signs and system review focusing on the condition and/or signs and symptoms for which the notification is required.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer a medication as indicated on the physician's order for one of six sampled residents (Resident 5) by failing to administer Diphenhydramine HCl Cream 2% (a medication used to treat allergic reactions) to Resident 5 from 6/1/2025 to 6/10/2025 (total of ten days). This deficient practice had the potential to result in worsening of Resident 5's skin rashes. Findings: During a record review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including but not limited to pneumonia (lung inflammation caused by bacterial or viral infection), acute respiratory failure (an inability to maintain adequate oxygenation for tissues or adequate removal of carbon dioxide from tissues) with hypoxia (lack of oxygen in the tissues to sustain bodily function), and hemiplegia (a condition caused by brain damage or spinal cord injury that leads to paralysis [loss of motor function in one or more muscles] on one side of the body). During a record review of Resident 5's Minimum Data Set (MDS, a resident assessment and tool), dated 3/25/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were moderately impaired. The MDS indicated Resident 5 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for shower/bathing self, upper and lower body dressing, and personal hygiene. During a record review of Resident 5's Change of Condition (COC, tool used by health care professionals when communicating about critical changes in a resident's status) dated 5/31/2025, the COC indicated Resident 5 was noted with rash on right arm, left chest and left leg. The physician recommendation was for a treatment evaluation to be done. During a record review of Resident 5's Physician Order Summary, dated 5/31/2025, the order indicated may have dermatology (a branch of medicine dealing with the skin, its structure, functions, and diseases) consultation due to rash. During a record review of Resident 5's Physician Order Summary, dated 6/1/2025, the order indicated Diphenhydramine HCl Cream 2% - Apply to affected area topically every eight hours as needed for skin rash. During a record review of Resident 5's Medication Administration Record (MAR, a medical record used by healthcare providers to document the administration of a medication or treatment) for the month of June 2025, the MAR indicated staff did not administer Diphenhydramine HCl Cream 2% to Resident 5 from 6/1/2025 to 6/10/2025 (total of ten days). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 5's Dermatology Note, dated 6/10/2025, the note indicated Resident 5 had atopic dermatitis (a chronic condition that causes dry, itchy, and inflamed skin) on the right upper extremity (shoulder, elbow, wrist, hand) and chest. The plan was to apply Diflorasone (a highly potent steroid that prevents the release of substances in the body that cause inflammation) 0.05 % ointment to chest and right arm twice daily. During an interview on 6/17/2025 at 1:03 PM in Resident 5's room with Resident 5, Resident 5 stated the nurses did not put cream on my arm for a while, but then they started to give it about 6 days ago (6/11/2025) During a concurrent interview and record review on 6/17/2025 at 3:15 PM with Treatment Nurse (TXN), Resident 5's MAR and nurses notes dated from 6/1/2025 to 6/10/2025 were reviewed, TXN stated the nurses did not and should have administered the Diphenhydramine HCl Cream 2% as ordered by the physician from 6/1/2025 to 6/10/2025. TXN stated when TXN saw Resident 5 on 6/8/2025 and 6/10/2025, Resident 5 still had the rashes. TXN stated, since the Diphenhydramine HCl Cream 2% was not applied TXN was unable to determine if the medication was effective or not since it was not given per physician's order. During an interview on 6/17/2025 at 4:45 PM with the Director of Nursing (DON), the DON stated the nurses should be administering the medication ordered by the physician. The DON stated the medication was ordered to treat the condition the doctor had determined needed treating. The DON stated that when medications were not administered as ordered by the physician the condition might not get resolved or can worsen. During a review of the facility's policy and procedure titled, Medication - Administration, revised 6/1/2017, the policy indicated medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner. The P&P also indicated, it will be documented on the MAR. The P&P indicated, the nurse will document the date, time, and reason for giving the medication.