

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2025
NAME OF PROVIDER OR SUPPLIER Santa Anita Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 5522 Gracewood Ave. Temple City, CA 91780	

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 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to return the resident's personal belongings for two (2) of 2 sampled residents (Resident 1 and Resident 2) upon discharge from the facility as indicated in facility's policy and procedures (P&P) This deficient practice resulted in the violation of Resident 1 and Resident 2's right to have their personal belongings. 1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included dementia (a progressive state of decline in mental abilities), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), and psychosis s (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 4/21/2025, the MDS indicated Resident 1's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with eating, oral hygiene, toileting hygiene, upper and lower body dressing, and personal hygiene. The MDS indicated Resident 1 was dependent (helper does all the effort) with eating and putting on/taking off footwear. During a review of Resident 1's discharge order, dated 5/21/2025, the discharge order indicated Resident 1 may transfer to General Acute Care Hospital for gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) tube placement. During a review of Resident 1's clinical census, the clinical census indicated that on 5/21/2025, Resident 1's status was hospital paid leave (transferred out to General Acute Care Hospital). During a review of Resident 1's Inventory List, the inventory list indicated: a. IL 1 form signed and dated 1/22/2025, indicated the following items: 2 shirts and four (4) slacks b. IL 2 form signed and dated 1/28/2025, indicated three (3) pants c. IL 3 form signed and dated 3/11/2025, indicated the following items: 1 grey Jacket, 3 shirts (1 red stripe and 2 grey shirts), and 1 pair of tan slippers. During a review of Resident 1's IL form, signed and dated on resident's discharge date of 5/21/2025, the IL form indicated the following items: 4 panties, 1 shirt, and 1 T-shirt. During an interview on 7/17/2025 at 2:15 PM, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated that on 5/21/2025, she prepared Resident 1 for GACH transfer. LVN 1 stated she signed Resident 1's IL 2 form on 5/21/2025 but did not check whether all of Resident 1's listed personal belongings were given to Resident 1. LVN 1 stated IL 2 was completed by Certified Nurse Assistant 1 (CNA1) at the time Resident 1 was about to be transferred to GACH. During an interview on 7/16/2025 at 2:45 PM with Social Service Staff 1 (SS 1), SS 1 stated when residents are transferred to GACH, the facility keeps the resident's belongings. SS1 stated the facility does not have a policy for the staff to call the family right after resident is transferred to GACH to retrieve the resident's belongings. SS 1 stated the facility returns the resident's belongings whenever the family member calls them. SS1 stated if the resident is not readmitted to the facility, one of the Social Service staff would call the resident or family to pick up the resident's belongings. During a concurrent observation of Resident 1's belongings, review of Resident 1's IL forms and interview on 7/17/2025 at 8:18 AM, with SS 2, SS 2 stated Resident 1's belongings were in the facility storage. SS 2 stated she collected Resident 1's belongings from the unit's storage on 5/21/2025 when resident was transferred to GACH. SS 2 stated she has not called Resident 1's responsible party or family to pick up the belongings left in the facility. SS 2 stated the following items were inside the plastic bag: 1 white shirt 1 white striped shirt 1 dark grey sweater 1 light gray long sleeves 1 blue zipper jacket 1 pajama pants 1 pair of socks SS 2 stated some of Resident 1's as listed on the IL forms are still missing, like the pair of slippers, some pants and slacks, and some shirts. 2. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses included depression (a serious mental health condition characterized by persistent sadness, loss of interest, and changes in how one thinks, sleeps, eats, and acts), osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D), and difficulty in walking. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 1's cognitive skill for daily decision making was moderately impaired (decisions poor; cues/supervision required). The MDS indicated Resident 2 was independent with eating, oral hygiene and personal hygiene. The MDS indicated Resident 2 required supervision with upper body dressing. The MDS indicated Resident 2 required partial/moderate assistance (helper does less than half the effort) with lower body dressing. The MDS</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain accurate resident medical records for one (1) of two (2) sampled Residents (Resident 1) by failing to ensure Resident 1's inventory list (IL, a record of personal possessions brought into a healthcare facility upon admission) had the correct resident belongings and that the IL was signed and dated. This deficient practice had potential for all resident belongings not to be returned to Resident 1 upon discharge and potential for increased risk of loss or confusion. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included dementia (a progressive state of decline in mental abilities), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 4/21/2025, the MDS indicated Resident 1's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with eating, oral hygiene, toileting hygiene, upper and lower body dressing, and personal hygiene. The MDS indicated Resident 1 was dependent (helper does all the effort) with eating and putting on/taking off footwear. During a review of Resident 1's discharge order, dated 5/21/2025, the discharge order indicated Resident 1 may transfer to General Acute Care Hospital for gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) tube placement. During a review of Resident 1's clinical census, the clinical census indicated that on 5/21/2025, Resident 1's status was hospital paid leave (transferred out to General Acute Care Hospital). During a review of Resident 1's IL 1, the IL 1's At Admission box, signed and dated 1/22/2025, indicated the following: 2 shirts 4 pairs of slacks/pants During a review of Resident 1's IL 2, the IL 2's At Admission box, signed and dated 1/28/2025, indicated three (3) pants. During a review of Resident 1's IL 3, the IL 3's At Admission box, signed and dated 3/11/2025, indicated the following items: 1 grey Jacket 3 shirts: 1 red strip and 2 grey shirts 1 pair of tan slippers. During a review of Resident 1's IL 2, the IL 2's At Discharge box, signed and dated 5/21/2025, indicated the following items: Four (4) panties 1 shirt 1 T-shirt During a review of Resident 1's IL 3, the IL 3 indicated the At Discharge box was not signed and dated, but it indicated the following items: 3 shirts: 1 red strip and 2 grey shirts 1 grey jacket During a concurrent record review of Resident 1's IL 1, 2 and 3, and interview on 7/16/2025 at 4:30 PM, with Social Service Staff 2 (SS 2), SS 2 stated the IL form is completed upon admission and updated when resident has new belongings brought in by family members. SS2 stated IL form is completed upon discharge. SS2 stated Resident 1's IL form with a documentation of 4 panties was inaccurate because Resident 1 does not use panty. SS 2 stated IL 3 has missing signature and date on the At Discharge box, SS 2 verified that there were items documented on the At Discharge box, but it did not have a signature and date. During an interview on 7/17/2025 at 2:15 PM, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated that on 5/21/2025, she prepared Resident 1 for GACH transfer. LVN 1 stated she signed Resident 1's IL 2 form on 5/21/2025 but did not check whether all of Resident 1's listed personal belongings were given to Resident 1. LVN 1 stated IL 2 was completed by Certified Nurse Assistant 1 (CNA1) at the time Resident 1 was about to be transferred to GACH. During a concurrent record review of Resident 1's IL 1, 2 and 3 forms, and interview on 7/17/2025 at 2:40 PM, with SS 1, SS 1 stated a documentation of 4 panties was inaccurate because Resident 1 does not use panties. SS 1 stated the nurse must have mistakenly marked the panties for pants in the list. SS 1 stated Resident 1's IL 3 has missing signatures and date on the part where items were listed as At Discharge. SS 1 stated to avoid confusion, the nurse should have placed a one line for error, with his/her initials. During a concurrent record review of Resident 1's IL 1, 2 and 3, and interview on 7/17/2025 at 3:10 PM with the Director of Nursing (DON), the DON verified Resident 1's IL 2 and 3 were inaccurate because of wrong items documentation and missing date and signature in the forms. The DON stated wrong documentation can lead to confusion. The DON also added that the assigned LVN and CNA are responsible in completing resident's inventory list. During a review of Facility's Policy and Procedure (P&P) titled, Theft Prevention, revised on 11/1/2017, the P&P indicated, At the time of admission and discharge, Facility staff complete the resident Inventory. Items brought into the Facility after admission are added to the Resident Inventory at the request</p>		