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	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Anita Convalescent Hospital	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 - Few	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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two (2) of four (4) sampled residents (Resident 2 and 3), were treated with dignity and respect when: 1. Certified Nursing Assistant 3 (CNA 3) failed to speak respectfully to Resident 2 during incontinent (involuntary loss of urine or stool) care on 8/24/2025 during the night shift (11 PM through 7 AM). 2. CNA 3 failed to respect Resident 3's request not to receive incontinent care on 8/21/2025 during the night shift. These failures had the potential to negatively affect Residents 2 and 3's overall wellbeing. Findings: 1. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), dementia (a progressive state of decline in mental abilities) and weakness. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 7/30/2025, the MDS indicated Resident 2 had moderately impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS also indicated Resident 2 was substantial/maximal assistance (helper does more than half the effort needed to complete the activity) with eating, oral, personal and toileting hygiene and dependent (helper does all effort needed to complete activity) with shower/bathing and lower body dressing. The MDS also indicated Resident 2 had a urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) and was always incontinent (having no or insufficient voluntary control) of bowel. 2. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness one side of the body), dementia (a progressive state of decline in mental abilities) and dysphagia (difficulty swallowing). During a review of Resident 3's MDS, dated 7/24/2025, the MDS indicated Resident 3 had severely impaired cognitive skills for daily decision making. The MDS also indicated Resident 3 was dependent with toileting hygiene, shower/bathing, partial/moderate assistance (helper does less than half the effort needed to complete the activity) with oral and personal hygiene and supervision or touching assistance (helper provides verbal cues, touching/steadying and/or contact guard assistance during activity) with eating. The MDS also indicated Resident 3 was frequently incontinent with urine and bowel. During an interview on 8/26/2025 at 1:14 PM with CNA 2, CNA 2 also stated staff are to speak and treat to all residents with respect. During an interview on 8/26/2025 at 3:33 PM with CNA 3, CNA 3 stated she was assigned to Resident 2 on 8/24/2025 and went to assist him with his incontinence care and told him No stop scratching, don't do this, come turn over. CNA 3 stated Resident 2 has feces on his left hand and CNA 3 wanted to clean him up. CNA 3 stated sometimes her voice can come across harsh to others but that was not her intention. CNA 3 stated she should have talked to Resident 2 in a way that was respectful. During an interview on 8/26/2025 at 3:50 PM, CNA 3 stated she was assigned to Resident 3 on the night shift of 8/21/2205. CNA 3 stated she told Resident 3 she would be providing her incontinent care, but the resident refused. CNA 3 stated she could not leave Resident 3 wet, so she insisted she needed to be changed and Resident 3 resisted. CNA 3 stated she did not think of leaving Resident 3 alone or calling for another nurse or translator to further understand or explain clearly to Resident 3. CNA3 stated she should not have provided care at that time if Resident 3 said she did not want it. During an interview on 8/27/2025 with LVN 3 at 12:14 PM, LVN 3 stated Resident 3's primary language was Spanish, and she was able to make her needs and wants known. LVN 3 stated according to facility policy, Residents have a right to refuse care and if Resident 3 refused ADL care, the staff should have acknowledged the resident's wants and went back later to offer ADL assistance and should have informed the LVN charge nurse. LVN 3 also stated that not honoring the residents' rights can upset them and can make them distrust staff there to help them. During an interview on 8/27/2025 at 4:03 PM with CNA 4, CNA 4 stated Resident 3 spoke Spanish and able to let staff know if she wanted incontinence care provided at that time. CNA 4 stated during the night shift on 8/22/2025, Resident 3 informed her CNA 3 was rough with care and not listening or trying to understand her while providing incontinent care. During a concurrent interview with the Director of Nursing (DON) and record review on 8/27/2025 at 5:00 PM, the facility's policy & procedure (P&P) titled Resident Rights- Quality of Life, implemented 5/1/2023, the P&P indicated the purpose to ensure all residents are treated with the level of dignity they are entitled to while residing at the facility. The P&P also indicated facility staff speak

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one (1) of four (4) sampled residents (Resident 2), was assessed and monitored for 72 hours after an alleged incident episode of physical abuse (an intentional act causing injury or trauma to another person through bodily contact) as indicated in the facility's policy and procedure (P&P). This failure had the potential for Resident 2 not to be monitored for physical and/or psychosocial changes negatively affecting his overall well-being. Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), dementia (a progressive state of decline in mental abilities) and weakness. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 7/30/2025, the MDS indicated Resident 2 had moderately impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS also indicated Resident 2 was substantial/maximal assistance (helper does more than half the effort needed to complete the activity) with eating, oral, personal and toileting hygiene and dependent (helper does all effort needed to complete activity) with shower/bathing and lower body dressing. During a review of Resident 2's Change in Condition (COC- a significant alteration in a patient's physical, mental, or functional status) Evaluation, dated 8/24/2025, the COC indicated an alleged incident of physical abuse toward Resident 2 by Certified Nurse Assistant 3 (CNA 3). During a review of Resident 2's Risk for Emotional Distress related to Allegations of Abuse care plan (a document that outlines the facility's plan to provide personalized care to a resident based on the resident's needs), initiated 8/24/2025, the care plan indicated interventions to assess emotional status regularly. During an interview on 8/26/2025 at 11:18 AM with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated there was an allegation of abuse towards Resident 2 on 8/24/2025 and nursing monitors his mental and physical health for 72 hours as indicated on the facility's COC policy. During a concurrent interview and record review on 8/26/2025 at 11:26 AM with LVN 2 and Registered Nurse 2 (RN 1), Resident 2's electronic and physical medical chart was reviewed. The medical charts failed to indicate any monitoring of Resident 2's condition on 8/25/2025 during the day shift (7 AM through 3 PM), evening shift (3 PM through 11 PM) and night shift (11 PM through 7 AM). RN 1 stated there is no evidence of monitoring documented for Resident 2 after the COC. RN 1 stated the licensed nurses should have monitored and documented Resident 2's condition for each shift on 8/25/2025. LVN 2 stated it is important to assess and monitor Resident 2 for 72 hours because Resident 2 cannot verbalize changes so staff would not become aware of any new changes without monitoring. During an interview on 8/26/2025 at 1:40 PM with the Director of Staff Development (DSD), the DSD stated 72-hour monitoring is done to monitor changes in condition (improving or worsening), documentation is done in the electronic chart under nurses' notes and is completed every shift. During an interview on 8/27/2025 at 12:14 PM with LVN 3, LVN 3 stated Resident 2 had a change in condition for an alleged instance of abuse and per facility policy, 72-hour monitoring by a nurse each shift should have been done to monitor for bruising, injuries or pain that Resident 2 may develop. LVN 3 stated Resident 2 has confusion and may be unable to verbalize changes, and if monitoring is not done, staff will not be aware of changes which could lead to Resident 2 experiencing neglect (fail to care for properly). During an interview on 8/27/2025 at 5PM with the Director of Nursing (DON), the DON stated that according to the facility policy, staff should have completed the 72-hour monitoring for Resident 2, to ensure he was not in distress, there are no injuries and there are no additional changes in his condition. During a review of the facility's P&P titled Change of Condition Notification, revised 6/1/2017, the P&P indicated the purpose to ensure residents, family, legal representatives and physicians are informed of changes in the resident's condition in a timely manner and a licensed nurse will document each shift for at least 72 hours.