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	11/05/2025

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 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. (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 0689 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 observation, interview, and record review, the facility failed to supervise and ensure the safety of one (1) of 2 sampled residents (Resident 1) in accordance with the facility's Wandering and Elopement (leaving the facility without the staff's knowledge and/or supervision) Policy and Procedure (P&P).This failure resulted in Resident 1 eloping from the facility on 11/1/2025 around 4:15 PM which placed the resident at risk for exposure to extreme weather, medical complications, injury, serious harm, and/or death. Resident 1 was not found until approximately eight (8) hours later, on 11/2/2025, at 11:45 PM at the general acute care hospital (GACH).Findings:During a review of Resident 1's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of chronic (long term) chronic obstructive pulmonary disease (CODP; a group of lung diseases that block airflow and make it difficult to breathe) and chronic pulmonary edema (a condition where fluid builds up in the lungs causing persistent shortness of breath [SOB]). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 9/24/2025, the MDS indicated the resident was moderately impaired with cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 1 was dependent (helper does all of the effort; resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with toilet transfer (the ability to get on and off a toilet or commode), lower body dressing (the ability to dress and undress below the waist). Resident 1 needed substantial/maximal assistance (helper does more than half the effort) with chair/bed-to-chair transfers (the ability to transfer to and from bed to a chair or wheelchair), going from lying to sitting on the side of the bed, and needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating. During a review of Resident 1's Situation, Background, Assessment and Recommendation (SBAR) documentation, dated 11/1/2025 at 9 PM, the SBAR documentation indicated during shift change, Resident 1 was not in his room and the morning shift nurse reported that Resident 1 went to the patio after lunch. The SBAR further indicated Resident 1 did not return to his room at the usual time later in the evening. Registered Nurse 1 (RN 1) was notified and facility staff looked for Resident 1 in every unit and around 12 AM on 11/2/202,5 Resident 1 was confirmed to be admitted at GACH.During a review of Resident 1's RN (Registered Nurse) Note, dated 11/2/2025 at 12:20 AM, Resident 1's RN Note indicated the following:> At approximately 9 PM on 11/1/2025, Resident 1 was noted to be missing and facility staff began searching for the resident.> Resident 1 was last seen on 11/1/2025 around 4:09 PM leaving the patio area of the facility and going towards the facility's 200 and 300 units, as seen by Activities Director (AD). > At approximately 10 PM on 11/1/2025 when the footage from the facility security camera was reviewed, it showed that on 11/1/2025 around 4:15 PM, Resident 1 was sitting by the facility's parking lot gate wearing a black hat, grey torso shirt with black short sleeves and an unknown pedestrian wearing a hat and light-colored clothing was seen approaching the resident. The pedestrian pressed on the button to open the parking lot gate and Resident 1 wheeled himself out of the facility. The pedestrian was then seen walking away but then turned around to help Resident 1 push his wheelchair towards the sidewalk.> Local authorities arrived at the facility approximately at 11:32 PM on 11/1/2025. > On 11/2/2025 at 12:11 AM, it was confirmed by the local authorities that Resident 1 was found at GACH. During a review of Resident 1's GACH Consult Cardiology (a branch of medicine that deals with the diagnosis, treatment, and prevention of disease of the heart and blood vessels) Note dated 11/1/2025, the GACH Consult Cardiology Note indicated Resident 1 was found by a neighbor who called the ambulance after finding the resident roaming on a wheelchair for a substantial period of time. Resident 1's chest x-ray (a test that uses radiation [energy that travels in the form of waves or particles] to create an image of the organs and structures in the chest used to help diagnose) showed Resident 1 had cardiomegaly (enlarged heart) with bilateral opacities (an area that appears whiter than the surrounding tissue indicating it is blocked or absorbed more of the x-rays) suggesting decompensated congestive heart failure (a sudden worsening of heart failure symptoms, occurring when the heart cannot pump enough blood to meet the body's needs) and pleural effusion (an abnormal buildup of excess fluid in the space between the lungs and the chest cavity). Resident 1 was then admitted to the GACH telemetry (a device used for the automatic, remote [far away in distance] measurement and transmission of data from various sources to a central monitoring station for analysis) unit. During an interview on 11/4/2025 at 11:18 AM with Quality Assurance Nurse (QAN), QAN