

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 11/24/2025
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 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 concise, and accurate documentation on Minimum Data Set (MDS, a resident assessment tool) for one (1) of two (2) sampled residents (Resident 1) that was completed on 7/28/2025 and 10/23/2025 respectively. 1. Resident 1's admission MDS dated [DATE] did not indicate the resident's mobility device included wheelchair only and not walker. 2. Resident 1's Quarterly MDS dated [DATE] did not indicate the resident's history of fall that occurred on 10/7/2025. This deficient practice had the potential to result in inaccurate care plans, inaccurate representation of a resident's acuity, which affects residents' treatment progress and plan of care. Findings: During a review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included malignant neoplasm of liver not specified as primary or secondary (a cancerous tumor in the liver where the origin is not specified), alcohol use unspecified uncomplicated (a pattern of alcohol consumption that does not meet the full diagnostic criteria for alcohol use disorder, but still poses potential health risks), and altered mental status (a change in a person's level of consciousness, alertness, and cognitive function). During a review of Resident 1's admission MDS dated [DATE], MDS indicated Resident 1 had moderate cognitive impairment, (resident likely need cues and supervision with some daily activities and their cognition is not intact, and resident make poor decisions). The MDS also indicated, Resident 1 is independent, (resident completes the activity by themselves with no assistance from a helper) with eating and oral hygiene and needs partial, moderate assistants (helper does less than half of the effort) for toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on or taking off footwear and personal hygiene. The MDS also indicated Resident 1 had a walker and wheelchair as his mobility devices since admission to the facility. During a review of Resident 1's admission Assessment (AA) dated 7/21/2025, it indicated Resident 1 had wheelchair. During an interview on 10/30/2025 at 10:56 AM with MDS Nurse 1 (MDSN 1), MDSN 1 stated MDSN 1 did his assessment on Resident 1 on 7/28/2025, and he accidentally checked in the MDS section that Resident 1 has walker and wheelchair as Resident 1's mobility devices. MDSN 1 stated he should have carefully reviewed his assessment to make sure the resident's MDS reflects the correct assessment for Resident 1's functional ability and mobility device that Resident 1 uses to have correct plan of care for this resident. During an interview on 10/30/2025 at 11:40 AM with Assistant Director of Nursing (ADON), ADON stated he never observed Resident 1 using other ambulatory devices besides the resident's wheelchair since the resident's admission to the facility. ADON stated it is important to have accurate MDS assessment and documentation to make sure nurses can create individualized care plans, identify health problems, and monitors quality of care for each resident. During a review of the Interdisciplinary Team (IDT- a group of healthcare or other professionals with different backgrounds who collaborate to achieve common goals for patient care) Post Event Review (IDT) dated 10/8/2025 indicated Resident 1 had an unwitnessed fall at bedside on 10/7/2025. During a review of Resident 1's Quarterly MDS dated [DATE], the MDS indicated Resident 1 has no fall since admission, entry or reentry or prior assessment. During an interview on 10/30/2025 at 10:59 AM with MDSN 1, MDSN 1 stated he was aware of Resident 1's fall (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055293	Facility ID: 055293
		If continuation sheet Page 1 of 2

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	episode on 10/7/2025 but he forgot to include Resident 1 episode of fall the Resident 1's MDS assessment and documentation dated 10/23/2025. MDSN 1 stated he should have included Resident 1 fall episode on 10/7/2025 to reflect Resident 1 updated health condition to identify health problems and Individualized plan of care. During an interview on 10/30/2025 at 11:13 AM with MDS supervisor, the MDS supervisor stated it is very important to document the correct information into the resident's MDS to make sure there is accurate patient care planning, determining reimbursement rates, ensuring regulatory compliance, and measuring quality of care. During a review of the facility's Policy and Procedure (P&P) titled Resident Assessment Instrument (RAI - a guide for nursing homes to create individualized care plans for residents) Process , revised date 10/1/2019, indicated the purpose if the P&P is to ensure that the RAI is used, in accordance with specified format and timeframes, 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.		