| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055293 | A. Building<br>B. Wing | 12/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Santa Anita Convalescent Hospital | 5522 Gracewood Ave.<br>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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>(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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a person-centered care plan for one (1) of two (2) sampled residents (Resident 1), to address Resident 1's need for supervision and assistant during the Activities of Daily Living (ADL's) as indicated on the facility's policy. This deficient practice had the potential of Resident 1 not receiving the necessary supervision and assistance during daily activities, which put Resident 1 at risk for falls and other accidents.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] with diagnosis which including but not limited to lack of coordination, difficulty in walking, dementia (progressive brain disorder that slowly destroys memory and thinking skills), Parkinson's Disease (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 9/8/2025, the MDS indicated Resident 1's cognitive skills (processes of thinking and reasoning) for daily decision making were severely impaired (Severe problems with thinking and memory). The MDS also indicated Resident 1 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on toileting hygiene, shower bath self, lower body dressing, putting on/ taking off footwear. The MDS indicated that Resident 1 needs substantial maximal assistance ( helper does more than half the effort) on sit to lying( the ability to move from sitting on side of bed to lying flat on the bed), sit to stand ( the ability to come to a standing position from sitting in a chair, or on the side of the bed. Chair /bed to chair transfer (the ability to transfer to and from bed to chair or wheelchair. Toilet Transfer (the ability to get on and off a toilet or commode). The MDS indicated Resident 1 was not able to walk 10 feet (ft.-unit of measurement, once standing the ability to walk at least 10 feet in the room, corridor, or similar space) due to medical condition or safety concerns. During a concurrent interview and record review on 12/4/2025 at 12:26 PM with the Registered Nurse (RN 1), of Resident 1's Fall Risk Assessment (checks to see how likely it is that you will fall) dated 9/5/2025, with a score of 95; 10/9/2025 with a score of 75; and 11/18/2025 with a score of 95 was reviewed. RN1 stated the Fall Risk Assessment scores indicate that Resident 1 was at high risk for fall. During an interview on 12/4/2025 at 2:07 PM with the Certified Nursing Assistant (CNA 1), CNA 1 stated that Resident 1 needs supervision while walking and transferring, such as holding Resident 1's hands to assist Resident 1 to prevent falls or accidents. During a concurrent interview and record review of Resident 1's Physical Therapy Discharge Summary with Director of Rehab (DR) on 12/4/2025 at 3:38 PM. DR stated the Physical Therapy Discharge Summary indicated date of service from 9/5/2025 to 11/18/2025, Resident 1 needs supervision or touching assistance on walking 10ft. DR stated the residents can walk around but need some cuing as reminder for safety. During a concurrent interview and record review of Resident 1's care plans on 12/4/2025 at 4:12 PM with License Vocational Nurse (LVN 2). LVN 2 stated No care plan found on Resident 1's medical chart indicating resident needs supervision or touching assistance on ADLs. LVN2 stated the care plan should be specific, and person centered to address the individual needs. LVN 2 stated that not developing and implementing person centered care plan can cause inadequate care and lack of supervision to residents. During a concurrent interview and record review of facility's Policy and Procedures (P&P) titled Care Planning revised date 6/12/2025 on 12/4/2025 at 4:15 PM with LVN 2. LVN 2 stated the P&P indicated the purpose was to ensure that a comprehensive person-centered care plan was developed for each resident based on their individual assessed needs. The P&P also indicated the care plan serves as a course of action where the resident ( resident's family and or guardian or other legal authorized representative), resident attending physician, and the Interdisciplinary Team (IDT, group of healthcare professionals from diverse fields who work in a coordinated manner toward a common goal for the resident) work to help the resident move toward resident specific goals that address the resident's medical, nursing, mental and psychosocial (combined influence of psychological factors and the surrounding social environment on physical, emotional, and/or mental wellness) needs. LVN 2 stated the facility did not develop and implement a specific person-centered care plan for Resident 1. During an interview on 12/4/2025 at 4:45 PM with the Director of Nursing (DON), the DON stated there was no specific care plan developed and implemented for Resident 1 regarding the needs for supervision or touching assistance. The DON stated the care plan is the guideline for the care of residents. Without specific and person-centered care plan this can potentially cause in adequate care supervision |