

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 04/30/2026
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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow its policy and procedure to ensure an allegation of physical abuse (willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) was reported to state survey agency (CDPH, California Department of Public Health), local law enforcement (Police Department), and state ombudsman (advocates for residents of nursing homes) within two (2) hours for one (1) of five (5) sampled residents (Resident 1). This deficient practice had the potential to compromise the protection of Resident 1 from further abuse, which could affect the resident's physical, emotional and mental wellbeing. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses including but not limited to metabolic encephalopathy (brain disease, damage, or malfunction that results in an altered mental state), dementia (progressive brain disorder that slowly destroys memory and thinking skills), and Alzheimer's disease (a brain disorder that destroys memory and other important mental functions). During a record review of Resident 1's Minimum Data Set (MDS, a resident assessment and tool), dated 1/20/2026, the MDS indicated the resident was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching/steading and/or contact guard assistance as resident completes activity) for lying to sitting on side of bed, sitting to standing, and walking 10 feet. During an interview on 4/29/2026 at 2:39 PM with Resident 1's Responsible Party (RP), RP stated sometime in January 2026, she was informed by a visitor (caregiver of another unknown resident) that a staff member (unknown) had forcibly pushed Resident 1 into the wheelchair when Resident 1 tried to get up from it. RP stated she informed Registered Nurse (RN) Supervisor about the allegation. During an interview on 4/29/2026 at 3:01 PM with RN Supervisor, RN Supervisor stated on 2/10/2026 during Resident 1's readmission to the facility, RP asked her if Resident 1 was pushed down into his wheelchair or rough handled about a week ago. RN Supervisor stated according to Licensed Vocational Nurse (LVN, not identified), there was an allegation of rough handling and/or pushing Resident 1 into the wheelchair. RN Supervisor stated rough handling and pushing were possible physical abuse allegations. RN Supervisor stated she did not report the allegation to the Administrator (ADM) and should have reported it to the ADM so an investigation could have been conducted. RN Supervisor stated reporting should have been done to ensure the safety of Resident 1 and to determine if the allegation was true or not. RN Supervisor stated failure to report could lead to possible exposure to abuse and compromise the resident's safety. During an interview on 4/29/2026 at 4:39 PM with the Director of Nursing (DON), the DON stated when a family member reports to staff that a resident was pushed into a wheelchair, an investigation is required. The DON stated staff did not inform him of the allegation. The DON stated the staff are required to report when there is a suspicion of abuse. The DON stated staff must report the allegation of abuse to the Administrator (ADM) and to state survey agency, Ombudsman, and local (continued on next page)</p>

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>law enforcement within 2 hours. The DON stated it is important for staff to report so that allegations could be thoroughly investigated to prevent abuse, and incidents do not go unnoticed. During an interview on 4/30/2026 at 12:06 PM with the Assistant Administrator (AADM), the AADM stated that rough handling and pushing a resident could cause bodily harm and constitutes physical abuse. The AADM stated based on the facility's abuse policy, an allegation of abuse should be reported to the three required entities (state survey agency, Ombudsman, and local law enforcement) as soon as possible, but no later than 2 hours. During a record review of the facility's Policy and Procedure (P&P) titled, Abuse Prevention and Prohibition Program, revised 8/1/2023, the P&P indicated the facility will report allegations of abuse, neglect, mistreatment, injuries of unknown source, misappropriation of resident property, or other incidents that qualify as a crime immediately, but no later than two hours after forming the suspicion - if the alleged violation involves abuse or results in serious bodily injury to the state survey agency, law enforcement, and the Ombudsman.</p>		