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	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Anita Convalescent Hospital	5522 Gracewood Ave. Temple City, CA 91780

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a safe environment for four of five residents (Residents 187, 228, 275, and 338) in the accidents care area when:1. The facility did not ensure both of Resident 187's siderails were (a bar attached to the bed that is used to prevent patients from accidentally rolling off or falling) padded for seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) precautions as indicated in the facility's policy and procedure (P&P) titled, Seizure Precautions.2. The facility did not post an Oxygen in Use sign on the door frame of Resident 228's room, who was actively using an oxygen machine, as indicated in the facility's P&P titled, Oxygen Administration.3. The facility failed to ensure Certified Nurse Assistant (CNA) 1 verify the resident's need for substantial or maximal assistance (helper does more than half the effort. Helper lifts, or holds trunk or limbs and provides more than half the effort) to request help before attempting to transfer Resident 275 from the toilet seat to the resident's wheelchair and ensure LVN 1 revise the resident's plan of care specific to the resident's physical assistance needs with interventions that included the level of assistance to address the resident's left below knee amputation (LBKA, surgery to remove the lower part of the left leg) to reduce the risk of falls. 4. The facility failed to ensure bed brakes were locked for Resident 338 in accordance with the facility's policy and procedure (P&P) titled Fall Management Program These deficient practices placed Resident 187 at risk of injury in the event of a seizure and placed Resident 228 at risk of injuries from fire hazards and improper handling of oxygen equipment. In addition, it had the potential to create unintended bed movement resulting in potential injury to Resident 338 and resulted in Resident 275's slid down and his LBKA stump (the remaining part of an amputated arm or leg) hit the floor. Findings: 1. During a review of Resident 187's admission Record, the record indicated Resident 187 was admitted to the facility on [DATE] with diagnoses including epilepsy (a long-term brain disorder caused by sudden bursts of electrical activity in the brain that lead to repeated seizures, which can include uncontrollable shaking, staring spells, or brief loss of consciousness) and other disorders of the brain. During a review of Resident 187's Minimum Data Set (MDS- a resident assessment tool) dated 5/6/2026, the MDS indicated Resident 187 had severe cognitive impairment (a profound decline in mental functioning—affecting memory, language, reasoning, and understanding—that significantly impairs daily life and typically necessitates substantial supervision) and was dependent (helper does all the effort) for all cares including turning in bed. During an observation on 5/26/2026 at 10:19 AM, Resident 187 was observed in her bed. Resident (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 - Some	187's left siderail was padded but the right siderail was not. A siderail pad was observed under 187's bed. During a concurrent observation and interview with Licensed Vocational Nurse (LVN) 19 on 10/26/2026 at 10:26 AM, Resident 187's unpadded right siderail was observed. LVN 1 stated both of Resident 187's siderails should have been padded for seizure precautions. LVN 19 stated the pad should not have been left under Resident 187's bed and should have been placed back on the siderail after staff provided care. LVN 19 further stated all staff were responsible for ensuring the pads on the side rails were placed for residents with seizure precautions to ensure the residents did not suffer an injury in the event of a seizure. During an interview with the Director of Nursing (DON) on 5/28/2026 at 9:57 AM, the DON stated Resident 187 could have sustained injuries if the resident had a seizure and the pads were not on Resident 187's siderails. The DON further stated that staff should have ensured proper placement of the siderail pads every time they performed cares for residents on seizure precautions. During a review of the facility's Policy and Procedure (P&P) titled, Seizure Precautions and revised on 6/1/2017, the P&P indicated, The facility will provide preventative measures prior to and during seizure activity to prevent resident injury to the extent possible. The P&P further indicated that residents considered at high risk for seizure activity had seizure precautions initiated including seizure pads placed on the resident's side rails. 2. During a review of Resident 228's admission Record, the record indicated Resident 228 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing) and muscle weakness. During a review of Resident 228's MDS dated [DATE], the MDS indicated Resident 228 was cognitively intact and only required setup or clean-up assistance with most cares such as eating and personal hygiene. During a review of Resident 228's physician orders report dated 5/28/2026, the report indicated the following order, OXYGEN at two (2) liters per minute [lpm- a measure of oxygen flow] via nasal cannula [a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen] as needed for prevention of oxygen saturation [O2 sat- a measurement of how much oxygen the blood is carrying as a percentage] below 92%. During an observation on 5/26/2026 at 9:35 AM, Resident 228 was observed with a nasal cannula on and oxygen machine at the resident's bedside. There was no Oxygen in Use sign posted on the door frame of Resident 228's room. During an interview with LVN 19 on 5/26/26 at 9:40 AM, LVN 19 stated the staff forgot to put an Oxygen in Use sign on the door frame of Resident 228's room. LVN 19 further explained that the oxygen sign was a warning for anyone who entered Resident 228's room not to have an open flame near his oxygen machine in order to prevent a fire or explosion. During an interview with the DON on 5/28/2026 at 4:57 PM, the DON stated oxygen usage signs were supposed to be posted outside the resident's room to notify staff and visitors that oxygen was being used in the room. The DON stated if the sign was not posted, flammables could be brought close to the oxygen which could cause combustion. The DON further explained that not posting the Oxygen in (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Use sign was a safety issue. During a review of the facility's P&P titled, Oxygen Administration and revised 6/1/2017, the P&P indicated, residents using oxygen will have an 'Oxygen in Use' sign placed on the door frame of their room. 3. During a review of Resident 275's admission Record (AR), the AR indicated Resident 275 was admitted on [DATE] and readmitted on [DATE] with diagnosis that included diabetes mellitus (a group of diseases that result in too much sugar in the blood), left eye blindness (the complete or nearly complete loss of sight), and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). The AR indicated on 4/15/2026, Resident 275 had a new diagnosis of acquired absence of LBKA. During a review of Resident 275's care plan (CP) for the resident's risk for falls and/or injuries related to unsteady gait related to DM with foot ulcer (an open sore or wound on the foot that fails to heal properly), revised on 3/28/2026 the CP indicated the resident will reduce risk of falls and/or injury with added new interventions on 4/24/2026 that included to provide assistance with transferring and locomotion (the act or power of moving from one place to another) as needed. During a review of Resident 275's admission summary, dated [DATE], the summary indicated Resident 275 was readmitted to the facility with LBKA. During a review of Resident 275's Fall Risk Assessment, dated 4/15/2026, the assessment indicated Resident 275 was at a moderate risk for falling with weak gait. During a review of Resident 275's Physical Therapy Discharge Summary (PTDS) for the period of 4/16/2026 to 5/8/2026, the PTDS indicated on 4/16/2026, Resident 275 was dependent on chair-to-chair transfer and needed substantial/maximal assistance in sit to stand. During a review of Resident 275's Physician Progress Note (PPN), dated 4/17/2026, the PPN indicated Resident 275 was readmitted to the facility and on therapy services for decline in ADLs (Activities of Daily Living, daily self-care activities), function, mobility after hospitalization with a LBKA procedure on 4/9/2026. During a review of Resident 275's [NAME] Data Set (MDS, a resident assessment tool), dated 4/19/2026, the MDS indicated Resident 275's cognition (the ability to think, remember, and reason) is intact, Resident 275 utilized wheelchair as mobility device. During a review of Resident 275's Change in Condition Evaluation (CIC), dated 4/21/2026, indicated on 4/21/2026, in the afternoon time (not specify when), Resident 275 had an accidental slight impact to LBKA during patient care. The CIC indicated Resident 275 reported to LVN 1 that the resident's LBKA stump accidentally made contact with the floor, upon transfer by the CNA from the toilet back to his chair. During a review of Resident 275's Nurses Progress Notes (NPN) documented by LVN 1 on 4/21/2026, the NPN indicated on 4/21/2026 at around 6:50 PM, Resident 275 reported to LVN 1 that the resident's LBKA stump accidentally made contact with the floor, upon patient transfer by the CNA 1 from the toilet back to the resident's chair due to the CNA trying to put him (Resident 275) back onto the chair by herself. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/26/2026 at 3:35 PM with Resident 275 at the facility's activity area, Resident 275 was sitting on his wheelchair with the LBKA stump covered with wound dressing. Resident 275 stated on 4/21/2026, CNA 1 attempted to transfer him alone by herself even though he normally required two staff members to assist him. Resident 275 stated, when transferring him from the toilet seat to his wheelchair, CNA 1 was unable to hold him up, causing him to slide down and his left stump hit the floor. During an interview on 5/29/2026 at 11:40 AM with LVN 1, LVN 1 stated on 4/21/26, CNA 1 asked for her assistance, and when she entered the room, Resident 275 was not on the floor, but the resident's left stump was touching the floor. LVN 1 stated, Resident 275 reported that CNA 1 was helping Resident 275 transfer from his toilet seat to his wheelchair when the resident slid down because CNA 1 could not hold him up. LVN 1 stated, CNA 1 had attempted to help Resident 275 by herself, but the resident was too heavy for CNA 1 to handle. During an interview on 5/29/2026 at 12:40 PM with CNA 1, CNA 1 stated on 4/21/2026 in the afternoon time (CNA 1 could not remember the exact time), she was helping to transfer Resident 275 from the toilet seat to the resident's wheelchair. CNA 1 stated, the wheelchair handles were facing away from Resident 275, he could not use them to stand up so CNA 1 tried lifting the resident up by holding under the resident armpits. CNA 1 stated Resident 275 was too heavy for her to lift, so he slid down and his left stump landed on the floor. CNA 1 stated Resident 275 was still on the edge of the toilet seat with his left stump on the floor when CNA 1 came out to call for help from LVN 1. CNA 1 stated she had never cared for Resident 275 before, had not received any change of shift report regarding the level of assistance that Resident 275 required, and therefore attempted to transfer the resident alone. During a concurrent interview and record review on 5/29/2026 at 1:43 PMˆwith Rehabilitation Program Manager (RPM), Resident 275's PTDS dated 4/16/2026 and weight summary dated 4/21/2026, were reviewed. RPM stated, the record indicated Resident 275 was dependent on transferring from chair to chair including transferring from his wheelchair to the toilet seat. RPM added that due to Resident 275's new readmission diagnosis of LBKA and recorded weight of 212 pounds (unit of weight) on 4/21/2026, the resident required two-person physical assistance from the nursing staff and this information was communicated verbally to the nursing staff during daily huddle (to gather closely together in a small group) on 4/21/2026. During a concurrent interview and record review on 5/29/2026 at 2:41 PMˆwith the MDS Nurse (MDSN), Resident 275's care plans for the resident's risk for falls were reviewed. MDSN stated when Resident 275 was readmitted on [DATE] after LBKA surgery, the fall risk care plan should be revised to reflect the resident' most current condition of LBKA. MDSN stated the added intervention of provide assistance with transferring on 4/24/2026 was too general and it should be specific on how much assistance and how many person physical assistance that Resident 275 required for transferring. During a concurrent interview and record review on 5/29/2026 at 2:50 PMˆwith the MDS Nurse (MDSN), Resident 275's MDS dated [DATE] and care plan that address the resident's risk for falls and/or injuries related to unsteady gait with added new intervention on 4/24/2026 were reviewed. MDSN stated that the MDS indicated Resident 275 required maximal assistance for toilet hygiene and transfers. MDSN stated based on the resident's condition of 200pound in weight, and new LBKA, the resident required two-person physical assistance, which should have been clearly specified in the care plan for safety. The MDSN added that without adequate and proper assistance, the residents (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	could fall. During an interview on 5/29/2026 at 3:40 PM with the Director of Nursing (DON), the DON stated the resident's care plan should be specific to the resident with the level of assistance needed for the resident to prevent fall.^ During a review of the facility's policy and procedures (P&P) titled Fall Risk Assessment, revised June, 2017, the P&P indicated: A)The Facility will ensure that the resident's environment remains as free of accident hazards as it possible, and that each resident receives adequate supervision and assistance to prevent accidents. B) An episode where a resident lost his/her balance and would have fallen, if not for staff intervention or if the resident caught themselves, is considered a fall. C)Facility Staff, with the support of the Attending Physician, will evaluate any post admission changes in a residents' functional and psychological status (a person's current mental [how a person thinks] and emotional [how a person feels] condition) that may increase fall risk, such as: changes in ambulatory ability, and balance. During a review of the facility's P&P titled, Fall Management Program, revised May 2026, the P&P indicated the program is to prevent resident falls and minimize complications associated with falls. The P&P indicated the facility will provide the highest quality care in the safest environment for the residents residing in the facility and the Fall Management Program is designed to prevent residents falls through meaningful assessments, interventions, education, and re-evaluation. The P&P also indicated the Nursing Staff will develop a plan of care specific to the resident's needs with interventions to reduce the risk of falls and interventions will be implemented or changed based on the resident's condition and response. 4. During a review of Resident 338's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included parkinsonism (a group of brain conditions that caused slowed movements, stiff muscles, tremors, and balance issues), osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D), and adult failure to thrive (a decline caused by chronic disease and functional impairments which could cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 338's Fall Risk (Morse) Assessment (a quick checklist used by healthcare providers to predict how likely a resident was to fall) dated 4/19/2025 at 12:04 PM, the Assessment indicated the resident was high risk for fall. During a review of Resident 338's History and Physical (H&P) dated 12/16/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 338's Physical Therapy Progress Report dated 5/1/2026 to 5/7/2026, the Progress Report indicated the resident was on precautions for falls and the resident's Functional Skills Assessment (evaluated how well a person could perform everyday tasks needed for independent living or work) indicated the resident was dependent (needing someone else for support, help, or survival). The Progress Report indicated the resident's Mobility Function Score was zero (ranged from zero to 12, 12 being the highest function). During a review of Resident 338's Minimum Data Set (MDS, resident assessment tool) dated 5/8/2026, the MDS indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 338's History of Risk for Fall Care Plan dated 5/14/2026, the Care Plan indicated a goal for the resident to reduce the risk of falls or injury through appropriate interventions daily. The Care Plan indicated interventions to include a low bed, wheels locked, and call light within reach. During an observation in Resident 338's room on 5/26/2026 at 2:44 PM, the resident was observed in bed and the bed brake indicator was in the horizontal position with the left side of the indicator being green and the right side of the indicator being red. The indicator was not positioned toward the red marking that indicated the brakes were engaged or locked. During a concurrent observation in Resident 338's room and interview in Resident 338's room on 5/26/2026 at 3:02 PM, Certified Nursing Assistant (CNA) 5 stated the resident's bed was not locked and it should have been locked otherwise the bed could have moved and the resident could have fallen. During an interview on 5/26/2026 at 3:16 PM, Licensed Vocational Nurse (LVN) 18 stated Resident 338's bed was not locked because the bed brake indicator was in a horizontal position. LVN 18 stated the resident's brakes should have always been locked otherwise the resident could have fallen and have an injury or worse. During an interview on 5/28/2026 at 4:35 PM, the Director of Nursing (DON) stated bed safety features included for the bed to be lowered to the ground, and ensuring the beds were locked. The DON stated Resident 338's bed did not seem to be locked but should have been to prevent staff and resident injury. The DON stated if the bed was not locked, Resident 338 could have had a fall or fracture (break in the bone) and the resident could have been scared. During a concurrent interview and record review on 5/28/2026 at 4:49 PM with the DON, the facility's policy and procedure (P&P) titled Fall Management Program dated 6/1/2017 was reviewed. The P&P indicated the purpose of the P&P was to prevent resident falls and minimize complications associated with falls through the development of a Fall Management Program. The P&P also indicated the policy of the facility was to provide the highest quality of care in the safest environment for the residents residing in the facility. The P&P indicated universal fall prevention measured for all residents included placing the residents bed in the lowest position with the brakes locked. The DON stated the facility staff were not following the policy but should have been to prevent fall and injury like a fracture.