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	06/05/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the facility staff had an accurate and complete progress note in the resident's medical record for one (1) of three sampled residents (Resident 1) per facility's policy and procedure. The progress notes dated 6/4/2026 did not include licensed nurse's post monitoring documentation regarding Resident 1's specific behavior after Ativan oral tablet (Lorazepam, is used to treat anxiety disorders) was given to the resident. This deficient practice had the potential to result in miscommunication and improper delivery of care and inaccurate information of the care provided to the residents which could negatively affect the overall wellbeing of Resident 1.FindingsDuring a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 1's diagnoses included mood affective disorder (a type of mental health condition where there is a disconnect between actual life circumstances and the person's state of mind or feeling), anxiety disorder (mental health condition marked by persistent excessive worry, fear, or nervousness that interferes with daily life), major depressive disorder (or also called clinical depression, it affects how you feel, think and behave and can lead to a variety of emotional and physical problems), psychosis (a mental disorder characterized by a disconnection from reality) and dementia (a progressive state of decline in mental abilities) During a review of Resident 1's Minimum Data Set (MDS, resident assessment tool), dated 5/18/2026, the MDS indicated Resident 1 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 1 needed partial/ moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs but provides less than half the effort) in toileting hygiene, shower/ bathe self, lower body dressing, putting on/ taking off footwear, personal hygiene, sit to lying, lying to sitting on the side of the bed, sit to stand, chair/ bed-to-chair transfer, toilet transfer, tub/ shower transfer, walking 10 feet, and walking 50 feet with two turns. During a review of Resident 1's Physician Order (PO) dated 6/4/2026. The PO indicated,Ativan oral tablet 1 MG. Give 1 tablet by mouth every 6 hours as needed (PRN) for anxiety for 14 days. 1-Music/TV. 2- 1:1 (one to one) Conversation. 3-Activity. 4-Verbal cues/Encouragement. 5-Redireclion/Refocus/Diversion. 6-Reassurance/Orientation. 7-Removal of stimuli. 8- Rest/sleep, Manifested By (m/b) restlessness ordered on 5/26/2026Behavior Monitoring -Anxiolytic (Ativan): Document Number of Episodes per shift of target behavior (m/b restlessness) every shift for Anxiolytic Use, non-pharmacological intervention (NPI, is any treatment, therapy, or lifestyle change that improves health, manages symptoms, or enhances well-being without the use of medications) Codes for psychotropic medication use: 1-Music/TV. 2-1:1 Conversation. 3-Activity. 4-Verbal cues/Encouragement. 5-Redirection/Refocus/Diversion. 6-Reassurance/Orientation. 7-Removal of stimuli. 8-Rest/sleep During a review of Resident 1's Care Plan (CP) for Ativan for anxiety related to adjustment issues, anxiety disorder manifested by getting up from wheelchair and walking out to the unit without assistance. The CP interventions indicated:Administer Antianxiety (a drug used to treat symptoms of anxiety, such as feelings of fear, dread, uneasiness, and muscle tightness, that may occur as a (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reaction to stress) medications as ordered by the physician. Monitor for side effects and effectiveness every shift.Monitor the resident for safety.Monitor/document/report PRN any adverse reactions to antianxiety therapyMonitor/record occurrence of for target behavior symptoms (nervousness without cause, pacing, wandering, inappropriate response to verbal communication, violence/aggression towards staff/others. etc.) and document per facility protocol. During an interview on 6/4/2026 at 4:47 PM with Licensed Vocational Nurse (LVN 1), LVN 1 stated, on 6/4/2026 CNA 1 told LVN 1 on Resident 1 was agitated, so LVN 1 administered Ativan at 2:30AM to Resident 1. LVN 1 added after 1 hour after administering the Ativan, Resident 1 was still agitated and was still trying to get out of bed. During a concurrent interview and record review on 6/5/2026 at 2:05 PM with Quality Assurance Nurse (QAN), Resident 1's Nurses' Progress Notes (NPN) dated 6/4/2026 was reviewed. QAN stated Ativan, was given to Resident 1 on 6/4/2026 at 2:30 AM, and NPN indicated effective. QAN also stated LVN 1 did not describe Resident 1's behavior at the time of reassessment and it was not accurate documentation if LVN 1 was saying Resident 1 was still agitated and was still trying to get out of bed after an hour from giving the Ativan. During a concurrent interview and record review on 6/5/2026 at 2:48 PM with QAN, the facility's policy and procedure (P&P) titled, Documentation - Nursing revised 6/1/2017 was reviewed, the P &P indicated,(a) Describe the resident's condition, include what you see, hear, smell, feel, etc.(b) Use the resident's own words if needed.(c) Describe what you have done in response to what is going on with the resident.(d) Describe how the Resident responded to the actions.QAN stated Resident 1's reassessment documented in NPN should have a description of Resident 1's behavior during the time of LVN 1's reassessment after the Ativan was given. QAN also stated documenting effective is not enough documentation for Resident 1's behavior and LVN 1 should have included the accurate description of what LVN 1 saw and heard. LVN 1 should have documented Resident 1 was still agitated and trying to get up from bed if that's what LVN 1 saw. During a concurrent interview on 6/5/2026 at 3:21 PM with the Administrator (ADM), ADM stated inaccurate and/ or inaccurate documentation of licensed staff may affect the quality of care for the residents. During a record review of the facility's P&P titled, Documentation - Nursing revised 6/1/2017, the P&P indicated nursing documentation will be concise, clear, pertinent, and accurate. The P&P also indicated narrative charting, as outlined in specific policies and procedures, will be used for initial treatments or procedures.