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	06/12/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an unusual occurrence (events or situations that do not happen daily or that may have had an impact on the residents) for one of two sampled residents (Resident 1) to State Agency (SA) within 2 hours in accordance with the facility's policy and procedure titled Abuse Prevention and Prohibition Program. This deficient practice prevented SA from going to do thorough investigation and had potentially led to ongoing unusual occurrence for Resident 1 or other residents in the facility.Findings:During a review of Resident 1's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with the following but not limited to diagnoses of contracture of both knees, left elbow and right hand, disorders of bone density and structure, and dementia.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/18/2026, the MDS indicated the resident was moderately impaired in cognitive skills for daily decision making. The MDS also indicated the resident required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with eating, oral hygiene, and upper body dressing but was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear and personal hygiene.During a review of Resident 1's Fall Risk Assessment, dated 2/4/2026, the assessment indicated the resident is at high risk for potential falls.During a review of Resident 1's Change of Condition (COC - a significant alteration in an individual's physical, mental, or functional status compared to their established baseline), dated 6/7/2026, the COC indicated the resident was noted with abnormality to the left upper arm. The COC also indicated the resident had pain and was moaning, frightened and tense. The COC further indicated Resident 1 was transferred to a general acute care hospital (GACH).During a review of Resident 1's Skin Observation, dated 6/7/2026 indicated abnormality and swollen on left upper arm and the left upper arm.During a review of Resident 1's Progress Notes (PN), dated 6/7/2026 at 11:05AM, the PN indicated at 10:55am the Licensed Vocational Nurse 1 (LVN 1) informed the Registered Nurse 1 (RN 1) that Resident 1's left upper arm was noted swollen and resident was having facial grimaces.During a review of Resident 1's PN, dated 6/7/2026 at 11:55AM, the progress notes indicated the resident was evaluated by nurse practitioner (NP). The PN also indicated Resident 1 was noted redness on the left arm and like it is fractured (complete or partial break in the bone).During an interview on 6/10/2026 at 12:53PM, the Restorative Nursing Assistant 1 (RNA 1) stated, on 6/7/2026, RNA 1 was about to put the left elbow splint on Resident 1 and that was when RNA 1 noted Resident 1's left inner elbow was purple. RNA 1 further stated as she lifts up Resident 1's sleeve, she observed Resident 1's left upper arm was purple, swollen and had a bump.During an interview on 6/12/2026 at 9:35AM, Licensed Vocational Nurse 1 (LVN 1) stated Resident 1's arm looks swollen and the resident was moaning.During an interview on 6/12/2026 at 9:39AM, Certified Nursing Assistant 1 (CNA 1) stated RNA 1 and himself noted a lot of inflammation on Resident 1's left (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	arm and it was reported to LVN 1 around 7:50AM.During an interview on 6/12/2026 at 10:15AM, Registered Nurse 1 (RN 1) stated she was told by LVN 1 that Resident 1's left arm was abnormal. RN 1 also stated she noted resident left arm was purple, swollen with a bump and the resident was in a lot of pain. RN 1 further stated NP came to assess the resident and gave orders to be transferred to the hospital. RN 1 stated she does not know what happened to the resident and that is considered an injury of unknown origin which needed to be reported within 2 hours, but it was not reported.During an interview on 6/12/2026 at 11:22AM, Quality Assurance (QA) Nurse stated the swelling and bruising of Resident 1's left arm is considered an injury of unknown origin and needed to be reported within 2 hours, but it was not reported.During an interview on 6/12/2026 at 12:02PM, Administrator (ADM) stated Resident 1's left arm bruising and swelling, ADM stated it is an injury of unknown origin which should have been reported within 2 hours, but it was not reported.During a review of the facility's Policy and Procedure (P&P) titled Unusual Occurrence Reporting, revised 10/1/2017, the P&P indicated unusual occurrences are reported to the appropriate agency within 24 hours by telephone and then confirmed in writing.During a review of the facility's P&P titled, Abuse Prevention and Prohibition Program, revised 6/25/2025, the P&P indicated the facility will report allegations of injuries of unknown source, immediately, by phone but not later than 2 hours after forming the suspicion.

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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 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop an individualized resident-centered care plan (a plan that prioritizes the unique health needs and desired outcomes of the resident) with measurable objectives, timeframe, and interventions to meet the resident's oxygen needs for one of two sampled residents (Resident 1).This deficient practice has the potential in delay the necessary care, services, recovery and wellbeing of Resident 1's Activities of Daily Living (ADLs - activities such as bathing, dressing and toileting a person performs daily) and result in injury and/or fall. Findings:During a review of Resident 1's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with the following but not limited to diagnoses of contracture of both knees, left elbow and right hand, disorders of bone density and structure, and dementia.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/18/2026, the MDS indicated the resident was moderately impaired in cognitive skills for daily decision making. The MDS also indicated the resident required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with eating, oral hygiene, and upper body dressing but was dependent (helper does all of the effort. Residents do none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear and personal hygiene.During a review of Resident 1's General Acute Care Hospital (GACH) documents titled Patient Results, dated 2/1/2026, the GACH documents indicated diffuse osteopenia (a widespread reduction in bone mass and density throughout the skeleton, rather than localized bone loss).During a review of Resident 1's Fall Risk Assessment, dated 2/4/2026, the assessment indicated the Resident 1 is at high risk for potential falls.During an interview on 6/12/2026 at 10:15AM, Registered Nurse 1 (RN 1) stated there was supposed to be a care plan for Resident 1's diagnoses of osteopenia but there is not. RN 1 also stated it is important to have an ADL care plan for Resident 1's bone density, so the facility staff can properly care for the Resident 1.During a concurrent interview and record review on 6/12/2026 at 11:15AM, Resident 1's Care plans, dated 4/18/2025 to 6/7/2026, were reviewed. The MDS Coordinator stated Resident 1 does not have an ADL care plan related to bone density and the resident should have had one upon admission on 2/2026 to ensure the Resident 1 is properly cared for and ensure her safety.During an interview on 6/12/2026 at 11:22AM, Quality Assurance (QA) Nurse stated the resident ADL care plan for bone density should have been done on 2/2026 to ensure Resident 1 receives proper care during ADLs like changing and repositioning.During a review of the facility's Policy and Procedure (P&P) titled Care Planning, revised 6/12/2026, the P&P indicated the facility is to ensure that a comprehensive person-centered care plan is developed for each resident based on their individual assessed needs. The P&P also indicated a licensed nurse will initiate the care plan, and the plan will be finalized in accordance with resolution of current problems.