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	06/15/2026

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 maintain accurate clinical records as required by professional standard and practice, when Licensed Vocational Nurse 2 (LVN 2) added lorazepam (Ativan-a central nervous system depressant, a medication used to treat anxiety disorder [a group of mental health conditions characterized by persistent, excessive, and uncontrollable fear, worry, or dread that interferes with daily life]) to the medication list for one (1) of two (2) sampled residents (Resident 1) without obtaining an order from Resident 1's physician. This deficient practice had the potential for Resident 1 to receive Ativan, resulting in medication error and lead to adverse reactions (any unexpected reactions to a drug) and the accidents that are associated with adverse reactions.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that including but not limited to cerebral infarction (stroke- a type of tissue death in the brain when blood flow to a part of the brain is reduced or completely blocked), hemiplegia and hemiparesis following cerebral infarction affecting right non-dominate side (paralysis or significant weakness on the entire right side of the body), and unspecified cirrhosis of liver (permanent scarring of the liver caused by chronic, long-term liver disease and injuries). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 5/29/2026, the MDS indicated Resident 1 was assessed having intact memory and 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 with eating, oral hygiene, and personal hygiene. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with upper body dressing, rolling left and right, sitting to lying, and toilet transfer. The MDS further indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self, sit to stand, and walk 10 feet (ft.- unit of measurement). During an interview on 6/12/2026, at 12:03 PM, with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated Resident 1 did not display any behaviors or verbal aggression towards staff or residents during his stay in the facility. During a concurrent interview and record review on 6/12/2026, at 12:34 PM, with the Assistant Administrator (AADM), Resident 1's physician's orders dated 5/29/2026, 4:57 PM were reviewed. AADM stated Resident 1 had a onetime order for lorazepam injection solution 2 milligrams (mg- unit of measurement for weight)/1 milliliter (ml- unit of measurement for liquid) inject 0.5 ml intramuscularly (inject into a muscle) for anxiety manifested by verbal aggression until 5/29/2026 11:59 PM, give 1mg/0.5ml. During the same concurrent interview and record review on 6/12/2026, at 12:34 PM, with the Assistant Administrator (AADM), Resident 1's progress notes and Medication Administration Record (MAR) were reviewed. AADM stated Resident 1 did not have any progress notes on or before 5/29/2026 indicating Resident 1 had anxiety as manifested by verbal aggression. AADM also stated Resident 1's Ativan order was charted as Code 13 (no dose required) in Resident 1's MAR on 8:55 PM. During an interview on 6/12/2026, at 1:29 PM, with LVN 1, LVN 1 stated Resident 1 was not anxious or verbally aggressive towards her or other residents on 5/29/2026. LVN 1 stated there was also no (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	report from the previous shift that Resident 1 had anxiety or verbally aggressive behavior. LVN 1 stated she did not know who ordered the Ativan or why Ativan was ordered for Resident 1 on 5/29/2026 because he did not have aggressive behavior that day. During an interview on 6/12/2026, at 4 PM, with LVN 2, LVN 2 stated she entered the Ativan order under Resident 1's name on 5/29/2026. LVN 2 stated Resident 1 was never ordered to take Ativan by his physician for anxiety or verbally aggressive behavior. LVN 2 stated she placed the Ativan order under Resident 1's name only to show the new unnamed LVN she was training how to put in new medication orders. LVN 2 stated she forgot to delete the Ativan order after she was done teaching the new LVN how to do it. LVN 2 stated she should not have entered the Ativan order under Resident 1's name even if it was for teaching purposes. LVN 2 stated entering a medication that was not ordered for Resident 1 could have caused a medication error and cause Resident 1 to receive an unnecessary medication. LVN 2 stated Ativan was a form of chemical restraint and should not be administered to a resident without an order or consent from the physician. During an interview on 6/12/2026, at 4:15 PM, with the Director of Nursing (DON), the DON stated Resident 1 was not ordered by his physician to receive Ativan for anxiety or verbal aggression on 5/29/2026. The DON stated the Ativan order was for another resident and not for Resident 1. The DON stated LVN 2 entered the Ativan order on 5/29/2026 under Resident 1's name because Resident 1's electronic medical record (eMAR) was open while LVN 2 was teaching a new LVN how to enter medication orders. The DON stated LVN 2 should have entered the order under the resident that was ordered for Ativan. The DON stated entering an order under the wrong resident could cause a medication error and cause the resident to experience side effects and adverse reactions that the resident would not otherwise experience. During a review of the facility's policy and procedure (P&P), titled, Documentation-Nursing, revised 6/1/2017, the P&P indicated, Nursing documentation will be concise, clear, pertinent, and accurate.