

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056477	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/20/2025
NAME OF PROVIDER OR SUPPLIER  Eastland Subacute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3825 Durfee Ave El Monte, CA 91732	

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 0573  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records.  (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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<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to provide a copy of the medical records upon written request for one of three sampled residents (Resident 1). This deficient practice violated Resident 1's right to obtain a copy and Resident 1's representative to obtain a copy of Resident 1's medical records. Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness in the arm, leg, and face on one side of the body) following cerebral infarction (damage to tissues in the brain which occurs because of disrupted blood flow to the brain). During a review of Resident 1's Discharge summary, dated [DATE], the summary indicated Resident 1 was discharged on 6/16/23 to Facility #2 at the request of Resident 1's family, so Resident would be closer to home. The summary indicated the final diagnoses during the stay were altered level of consciousness (ALOC- a change in a person's mental state, affecting their awareness, alertness, and responsiveness to their environment), hypertension (high blood pressure), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and stroke (damage to the brain from interruption of its blood supply). During a review of the e-mail from the complainant, dated 8/19/25, the complainant stated the Medical Records Director (MRD) was personally served a medical records request for Resident 1's medical records on 7/31/25. During an interview on 8/19/25 at 9:38 a.m. with the Medical Records Director (MRD), the MRD stated once the requester completes the medical records request form, the facility has 24 to 48 hours to provide records. During an interview on 8/19/25 at 2:52 p.m. with the MRD, the MRD stated the medical records log sheet only tracked the resident and family medical records requests. MRD stated hospital requests for records are faxed to the facility and do not appear on the log. MRD stated attorney letters requesting medical records are sent to the facility's attorney's office for review before the release of information. MRD stated the facility has a week to process the request. MRD stated once the facility's attorney gives the approval to release the information, then the facility also checks with the Director of Nursing (DON) before the final release of the information. During an interview on 8/20/25 at 4:26 p.m. with the MRD, the MRD stated the MRD received the medical records request for Resident 1's medical records from [name of legal services] on 7/31/25 and the MRD sent the medical records request the MRD received from [name of legal services company] to the facility's attorney for review on 8/5/25. During an interview on 8/20/25 at 4:50 p.m. with the complainant, the complainant stated as of 8/20/25, the complainant has not received any of Resident 1's records from the facility. During a review of the facility's current Policy &amp; Procedure (P&amp;P) titled, Release of Information, revised November 2009, the P&amp;P indicated All information contained in the resident's medical record is confidential and may only be released by the written consent of the resident or his/her legal representative (sponsor), consistent with state laws and regulations; A resident may obtain photocopies of his or her records by providing the facility with at least a forty-eight (48) hour (excluding weekends and holidays) advance notice of such request. During a review of the facility's current Policy &amp; Procedure (P&amp;P) titled, Resident Rights, revised February 2021, the P&amp;P indicated Policy Interpretation and Implementation: Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to appoint a legal representative, in accordance with state law; access to personal and medical records pertaining to him or herself.</p>		