STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056477	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastland Subacute and Rehabilitation Center	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat residents with dignity and respect for three out of three sampled residents (Resident 1, 2, and 3) when: 1. Resident 1 was not notified about not attending adult day care center (a community-based facility providing supervised, structured, and non-residential care for adults with physical or cognitive impairments) and was not given a reason why she did not attend. 2. Resident 2 and Resident 3's bed were temporarily relocated to the hallway and were not provided any privacy. These deficient practices had the potential to cause psychosocial harm, loss of dignity and respect, and feelings of frustration for Resident 1, 2, and 3. Findings:1. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with diagnoses that included systolic congestive heart failure (chronic condition, the heart does not pump blood as well as it should, occurs if the heart cannot pump [systolic] adequately and diabetes mellitus (body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism elevated levels of glucose in the blood and urine). During a review of Resident 1's History and Physical Examination (H&P, physician's clinical evaluation and examination of the resident), dated 12/1/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 3/25/2026, the MDS indicated Resident 1's cognitive skills (reasoning, learning, and problem-solving) for daily decision making was moderately impaired. The MDS indicated Resident 1 required set up assistance for eating. Then MDS indicated Resident 1 required supervision for oral hygiene. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) for upper body dressing and personal hygiene. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) for lower body dressing, shower/bathing, toileting hygiene and putting on/off footwear. During a review of Resident 1's Order Summary Report, dated 4/1/2026, Order Summary Report indicated Resident 1 had an order to attend adult day care center (a community-based facility providing supervised, structured, and non-residential care for adults with physical or cognitive impairments) every Monday and Tuesday. During an interview on 4/8/2026 at 10:29 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 was supposed to be picked up and taken to adult day care center but Resident 1 was never picked up. CNA 1 stated Resident 1 was dressed and ready to go to the adult day care center and no one had notified her that she was not going. CNA 1 stated Resident 1 questioned her if Resident 1 was going to the adult day care center and she told Resident 1 she did not know. CNA 1 stated she asked her charge nurse if Resident 1 was going to the adult day care center and the charge nurse stated she did not know. CNA 1 stated no one had notified Resident 1 about not going to the adult day care center and Resident 1 was looking forward to going to the adult day care center. During an interview on 4/8/2026 at 11:00 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated on 4/7/2026 Resident 1 was not picked up to go to adult day care center. LVN 1 stated resident was not notified why Resident 1 was not picked up because nursing staff did not know why Resident 1 was not picked up. LVN 1 stated she (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was supposed to notify Resident 1 and RP 1 about Resident 1 not attending the adult day care center but she did not. During an interview on 4/8/2026 at 1:45 p.m. with Resident 1, Resident 1 stated Resident 1 did not attend adult day care yesterday (4/7/2026) and nursing staff did not notify Resident 1 why Resident 1 was not picked up. Resident 1 stated Resident 1 was looking forward to attending adult day care. During an interview on 4/8/2026 at 2:05 p.m. with Resident 1's Responsible Party (RP) 1, RP 1 stated Resident 1 informed her Resident 1 was not picked up to go to the adult day care center. RP 1 stated Resident 1 was disappointed because Resident 1 wanted to go to the adult day care center and Resident 1 was looking forward to going. RP 1 stated Resident 1 did not know why Resident 1 did not go to the adult day are center and Resident 1 had asked staff but they did not give Resident 1 a reason why Resident 1 was not picked up. 2. During a review of Resident 2's AR, the AR indicated Resident 2 was admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with diagnoses that included atrial fibrillation heart's upper chambers (atria) beat out of coordination with the lower chambers (ventricles), can lead to blood clots in the heart) and pneumonia (lung inflammation caused by bacterial or viral infection, in which the air sacs fill with pus and may become solid). During a review of Resident 2's H&P, dated 12/6/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making was intact. The MDS indicated Resident 2 required set up assistance for eating. Then MDS indicated Resident 2 required supervision for oral hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 2 required moderate assistance for lower body dressing, shower/bathing, toileting hygiene and putting on/off footwear. 3. During a review of Resident 3's AR, the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnoses that included overactive bladder (a sudden, uncontrollable urge to urinate, often leading to frequent bathroom trips) and dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). During a review of Resident 3's H&P, dated 11/15/2025, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 3 required set up assistance for eating. Then MDS indicated Resident 3 required supervision for oral hygiene and upper body dressing. The MDS indicated Resident 3 required moderate assistance for toileting hygiene, lower body dressing, shower/bathing, toileting hygiene and putting on/off footwear. During an observation on 4/7/2026 at 8:28 a.m. in the hallway, the screen dividers were used to corner off two resident beds. The screen dividers did not prevent visualization of one resident in bed. Resident 3 was in bed. During an observation on 4/7/2026 at 3:35 p.m., in the hallway, staff remove screen dividers and push Resident 3's bed back to Resident 3's room. During an interview on 4/8/2026 at 9:20 a.m. with Maintenance Director (MD), the MD stated Resident 2 and Resident 3 were temporarily relocated to the hallway because Resident 2 and 3's room required repair. The MD stated residents always got relocated to the hallway when their room got repaired. MD stated facility provided screen dividers for privacy for the residents. The MD stated the screen dividers did have a small gap where you can visualize behind the screen divider. During an interview on 4/8/2026 at 10:18 a.m. with CNA 1, CNA 1 stated Resident 2 and Resident 3 were relocated to the hallway, where it was semiprivate and were separated by small curtains. CNA 1 stated when residents got relocated to the hallway, residents did not get a television. CNA 1 stated she did not think placing residents in the hallway offered residents respect and dignity because residents would not feel comfortable being in the hallway and would feel like other residents and staff were watching them. CNA 1 stated Resident 2 refused to take a shower because Resident 2 did not want to get undressed because Resident 2 did not want anyone to see Resident 2 undressed. CNA 1 stated Resident 2 preferred to take a shower when Resident 2 returned to Resident 2's room because there was privacy there and could get undressed there. During an interview on 4/8/2026 at 11:13 a.m. with LVN 1, LVN 1 stated when residents get relocated to the hallway, a curtain divider is (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provided for privacy. LVN 1 stated if residents had a conversation, everyone in the hallway would hear their conversation and that was not providing privacy to residents. LVN 1 stated she did not ask residents how they felt or if they had any concerns about being relocated to the hallway. LVN 1 stated it was important to follow up with residents to see how they are feeling because it was nursing staff's job to make residents comfortable and safe. During an interview on 4/8/2026 at 1:12 p.m. with Registered Nurse (RN) 1, RN 1 stated nursing staff should have checked if there were vacant beds before relocating residents to the hallway. RN 1 stated the relocation area did not provide safety to residents because there were no walls to prevent residents from falling. RN 1stated nursing staff should have received consent from residents prior to relocating residents. During an interview on 4/8/2026 at 1:29 p.m. with Resident 2, Resident 2 stated on 4/7/2026 Resident 2 was relocated to the hallway because Resident 2's room needed to be repaired. Resident 2 stated that morning (4/7/2026) Resident 2 was informed about the move and was not given a choice if Resident 2 wanted to move. Resident 2 stated Resident 2 did not like the relocation area because it had no privacy. Resident 2 stated Resident 2 did not feel safe in that area because Resident 2 wanted Resident 2's bed against the wall. Resident 2 stated Resident 2 did not want to be relocated to that area again because it had no privacy and felt weird that other residents could see Resident 2 get undressed. During an interview on 4/8/2026 at 2:52 p.m. with Director of Nursing (DON) the DON stated relocated residents were given privacy curtains and the area lacked full privacy and the privacy curtains used had gaps. The DON stated she did not know if the privacy curtain provided enough privacy or not. The DON stated she was not aware of who got consent from resident to be relocated to the hallway. The DON stated it was not an acceptable practice to place residents in the hallway because it did not provide dignity or respect to residents. The DON stated residents required dignity and respect for their self-esteem and morale. The DON stated it was important to provide dignity and respect to residents because it was a basic need and a human right. During a review of facility's Policy and Procedure (P&P), titled Resident Rights, dated 2/2021, the P&P indicated employees shall treat all residents with kindness, respect, and dignity. The P&P indicated federal and state laws guarantee certain basic rights to all residents of this facility. The rights include the resident's right to be informed of, and participate in, his or her care planning and treatment. During a review of facility's P&P titled Dignity, dated 2/2021, the P&P indicated each resident would be cared for in a manner that promoted and enhanced his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The P&P indicated staff would inform and orient residents to their environment and procedures would be explained before they are performed and residents will be told in advance if they are going to be taken out of their usual or familiar surroundings.

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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 interview, and record review, the facility failed to develop a care plan (a document that outlines a person's health needs and the care they require) for one of two sampled residents (Resident 1) when: 1. Facility did not ensure Resident 1 had a care plan for attending activities outside the facility. This deficient practice had the potential to negatively affect Resident 1's mental and psychosocial well-being. Findings:During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with diagnoses that included systolic congestive heart failure (chronic condition, the heart does not pump blood as well as it should, occurs if the heart cannot pump [systolic] adequately and diabetes mellitus (body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism elevated levels of glucose in the blood and urine). During a review of Resident 1's History and Physical Examination (H&P, physician's clinical evaluation and examination of the resident), dated 12/1/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 3/25/2026, the MDS indicated Resident 1's cognitive skills (reasoning, learning, and problem-solving) for daily decision making was moderately impaired. The MDS indicated Resident 1 required set up assistance for eating. Then MDS indicated Resident 1 required supervision for oral hygiene. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) for upper body dressing and personal hygiene. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) for lower body dressing, shower/bathing, toileting hygiene and putting on/off footwear. During a review of Resident 1's Order Summary Report, dated 4/1/2026, Order Summary Report indicated Resident 1 had an order to attend adult day care center (a community-based facility providing supervised, structured, and non-residential care for adults with physical or cognitive impairments) every Monday and Tuesday. During a review of Resident 1's electronic medical record, unable to locate Resident 1's care plan indicating Resident 1 was to attend adult day care center on Monday's and Tuesdays. During an interview on 4/8/2026 at 2:52 p.m. with Director of Nursing (DON), the DON stated a care plan was a blueprint of care that would be provided to a resident. The DON stated if something did not get care nursing staff would not know what interventions to follow. The DON stated it was important to develop care plans so all nursing staff have the same approach in care. The DON stated Resident 1 should have a care plan for attending adult day care because that was part of Resident 1's activities. The DON stated the care plan for adult day care should indicate days of attendance, transport arrangements, and assisting resident in preparation. The DON stated if there was no care plan for attending adult day care, it will not be done and it would not be consistent. During a review of facility's Policy and Procedure (P&P) titled Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs would be developed and implemented for each resident. The P&P indicated the comprehensive, person-centered care plan would describe the services that would be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being.