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	06/09/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to be free from sexual abuse and follow its policy and procedure (P&P) titled Abuse & Mistreatment of Resident, for one of three sampled residents (Resident 1) when on 6/8/2026, Resident 1 reported Certified Nursing Assistant 1 (CNA 1) sexually abused Resident 1. This failure resulted in Resident 1 subjected to sexual abuse by CNA 1 while under the care of the facility. Resident 1 refused to eat breakfast and lunch on 6/8/2026 and Resident 1 cried and did not want CNA 1 to be assigned to Resident 1. Resident 1 was transferred to General Acute Care Hospital 1 (GACH 1) for a sexual assault response team (SART, a group of trained professionals who comes together to support people after a report of sexual harm) assessment. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 11/28/2016 and readmitted on [DATE] with diagnoses including cerebral infarction (brain damage), psychotic disorder (when the resident lost touch with reality), major depressive disorder (longˆlasting sadness and a loss of interest in normal activities) and anxiety disorder (a mental health condition where a person experienced intense, ongoing fear and worry about everyday situations). During a review of Resident 1's History and Physical (H&P) dated 10/26/2025, 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 4/19/2026, the MDS indicated Resident 1 had intact cognition (ability to think and reason). The MDS indicated Resident 1 had severely impaired vision (no vision, eyes did not appear to follow objects). The MDS indicated Resident 1 required supervision from staff with eating and oral hygiene. The MDS indicated Resident 1 required moderate assistance (helper did less than half the effort) from staff with bed-to-chair transferring. The MDS indicated Resident 1 required maximal assistance (helper did more than half the effort) from staff with toileting hygiene, showering/ bathing, and personal hygiene. During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR, a communication tool used by healthcare workers when there was a change of condition among the residents) form, dated 6/8/2026, the SBAR indicated on 6/8/2026 at 8:06 a.m., Resident 1 alleged CNA 1 got on top of Resident 1, kissed Resident 1's mouth, touched Resident 1's right breast, masturbated, and finished masturbation on top of Resident 1 on 6/8/2026. The SBAR indicated Resident 1 was crying and refused to eat breakfast and lunch. The SBAR indicated the facility transferred Resident 1 to GACH 1 for a SART assessment. During a review of Resident 1's Physician Order (PO) dated 6/8/2026, the PO indicated Resident 1 had an active order to transfer to GACH 1 related to alleged sexual abuse. During a review of Resident 1's GACH 1 H&P dated 6/8/2026, the GACH 1 H&P indicated Resident 1 arrived at GACH 1 following a report of sexual assault (any unwanted sexual contact or activity that happened without clear, voluntary consent) on 6/8/2026. The GACH 1 H&P indicated Resident 1 stated CNA 1 masturbated on Resident 1 while changing Resident 1's adult brief on 6/8/2026. During an interview on 6/8/2026 at 11:45 a.m. with Resident 1, Resident 1 stated, on 6/8/2026 after 12 a.m., Resident 1 used the call light to call CNA 1 for adult brief change. Resident 1 stated CNA 1 closed the door and started kissing Resident 1 on the lips. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1 stated CNA 1 tried to put CNA 1's tongue into Resident 1's mouth, and Resident 1 kept Resident 1's mouth shut. Resident 1 stated Resident 1 felt CNA 1's hand squeezing on Resident 1's right breast. Resident 1 stated Resident 1 was blind, and all Resident 1 could see was black. Resident 1 stated Resident 1 could hear and feel without any sensational impairment. Resident 1 stated CNA 1 touched Resident 1's right groin and tried to put fingers inside Resident 1's vaginal area. Resident 1 stated Resident 1 kept Resident 1's legs closed. Resident 1 stated CNA 1 kissed Resident 1's groin area. Resident 1 stated CNA 1 was standing next to Resident 1's bedside. Resident 1 stated CNA 1 grabbed Resident 1's left hand to touch CNA 1's penis and buttock area. Resident 1 stated Resident 1 felt CNA 1's chest on Resident 1. Resident 1 stated Resident 1 was frozen and unable to move or say anything when CNA 1 was on top of Resident 1. Resident 1 stated CNA 1 used a towel to clean up the warm and wet stuff on Resident 1's groin area. Resident 1 stated it was approximately 15 minutes that CNA 1 stayed in Resident 1's room. Resident 1 stated CNA 1 stated I am done. I see you in the morning. Resident 1 stated CNA 1 did not return to Resident 1's room for the rest of the shift. Resident 1 stated Resident 1 did not want adult brief change at 5:30 a.m. by CNA 1 so Resident 1 did not call for diaper (adult brief) change. Resident 1 stated Resident 1 did not tell the night shift staff because Resident 1 wanted to wait for the morning social workers. Resident 1 stated Resident 1 did not eat breakfast the morning after the incident on 6/8/2026. During an interview on 6/8/2026 at 1:07 p.m. with CNA 4, CNA 4 stated Resident 1 told CNA 4 that CNA 1 got on top of Resident 1 on 6/8/2026. CNA 4 stated Resident 1 said Resident 1 felt semen on Resident 1's upper body and abdomen. CNA 4 stated Resident 1's allegation was considered as sexual abuse/assault. During an interview on 6/8/2026 at 1:17 p.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated, on 6/8/2026 around 8 a.m., Resident 1 was crying inside Resident 1's room and stated Resident 1 did not want the charge nurse to assign CNA 1 to Resident 1 again. LVN 1 stated Resident 1 told LVN 1 that CNA 1 touched Resident 1. During an attempted telephone interview with CNA 1 on 6/8/2026 at 1:20 p.m. CNA 1 did not pick up the phone call from Surveyor 1. Surveyor 1 left a voice message to CNA 1 on 6/8/2026 at 1:20 p.m. During a concurrent interview and surveillance video review on 6/8/2026 at 1:34 p.m. with the administrator (ADM), the ADM stated the video indicated CNA 1 entered Resident 1's room with the door open on 6/8/2026 at 1:14 a.m. The ADM stated the video indicated CNA 1 helped Resident 1 to locate the television remote control. The video indicated CNA 1 entered Resident 1's room and placed clean linen on Resident 1's bedside table on 6/8/2026 at 1:16:22 a.m. and closed Resident 1's door on 6/8/2026 at 1:17:11 a.m. The video indicated CNA 3 walked past by Resident 1's closed door on 6/8/2026 at 1:28:53 a.m. The video indicated CNA 1 left Resident 1's room and closed the door on 6/8/2026 at 1:31:32 a.m. The ADM stated CNA 1 left Resident 1's room carrying dirty linen. The ADM stated the facility suspended CNA 1 during the investigation. During a review of CNA 1's text message to Surveyor 1 on 6/8/2026 at 2:20 p.m., the text message indicated CNA 1 did not want to talk to anyone and refused to talk on the phone. During an interview on 6/9/2026 at 11:09 a.m. with the Director of Nursing (DON), the DON stated on 6/8/2026, Registered Nurse 1 (RN 1) called the DON and informed the DON that Resident 1 stated CNA 1 masturbated on top of Resident 1 on 6/8/2026. The DON stated Resident 1 was seen by the SART team in GACH 1 on 6/8/2026. The DON stated the DON was unable to interview CNA 1. During a review of the facility's undated P&P titled, Abuse & Mistreatment of Resident, undated, the P&P indicated the facility should uphold a resident's right to be free from sexual abuse. The P&P indicated that sexual abuse included assault and battery (the touching of another person's intimate parts without their consent, or against their will).