

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 07/25/2025
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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure call lights/pad sensors (a communication device used by residents in healthcare facilities to signal for assistance from nursing staff) were within reach for two of two sampled residents (Residents 46 and 32). These failures had the potential for Residents 46 and 32 not to receive necessary care or receive delayed services. Findings:</p> <p>a. During a review of Resident 46's admission Record (AR), the AR indicated Resident 46 was readmitted to the facility on [DATE] with diagnoses including contracture (a stiffening/shortening at any point, that reduces the joint's range of motion) of the right hand and elbow, quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), and history of falling.</p> <p>During a review of Resident 46's Minimum Data Set (MDS, a resident assessment tool), dated 5/15/2025, the MDS indicated Resident 46 had severely impaired cognition (ability to understand and process information) and was dependent (helper did all the effort, resident did none of the effort to complete the activity) on staff with oral hygiene, toileting, shower, upper and lower body dressing and personal hygiene.</p> <p>During a review of Resident 46's Care Plan (CP), dated 5/14/2025, the CP indicated Resident 46 was at risk for falls / injury related to generalized weakness, impaired cognition, impaired vision, poor balance and safety awareness / judgement. The CP interventions included keeping the pad / call light within easy reach and close to the resident.</p> <p>During an observation, inside Resident 46's room on 7/22/2025 at 8:40 a.m., with the Infection Prevention Nurse (IPN), Resident 46 was in bed, and on her back with the pad sensor above and on the right upper part of the bed, next to Resident 46's pillow. Resident 46 could move Resident 46's left arm and hand up and down. Resident 46's right arm and hand were contracted. During a concurrent interview, the IPN stated Resident 46 could not move her right arm and hand and could not reach the pad sensor call light. The IPN stated the pad sensor call light should be placed close or next to Resident 46's left arm and hand for Resident 46 to use when needed.</p> <p>During an interview on 7/24/2025 at 10:36 a.m., the Director of Nursing (DON) stated all pad sensors and call lights should be placed on the strong arm / hand of the resident to call for assistance and for staff to address the resident's needs timely.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 056477	If continuation sheet Page 1 of 17

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NAME OF PROVIDER OR SUPPLIER Eastland Subacute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3825 Durfee Ave El Monte, CA 91732	
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedures (P&P) titled, "Call System, Resident," dated March 2023, the P&P indicated, "Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. Call system communication may be audible or visual. The system may be wired or wireless. If the resident has a disability that prevents him/her from making use of the call system, an alternative means of communication that is usable for the resident is provided and documented in the care plan."</p> <p>b. During a review of Resident 32's admission Record, the admission Record indicated Resident 32 was admitted to the facility on [DATE] with diagnoses including respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in the body), gastro-esophageal reflux disease(GERD- stomach acids flow back up into esophagus and causes heartburn), and dysphagia (difficulty swallowing).</p> <p>During a review of Resident 32's History and Physical (H&P), dated 2/6/2025, the H&P indicated Resident 32 was able to make decisions for activities of daily living.</p> <p>During a review of Resident 32's Minimum Data Set (MDS- a resident assessment tool), dated 5/12/2025, the MDS indicated Resident 32 rarely had the ability to understand and was dependent (helper does all of the effort and the resident does one of the efforts to complete the activity) on staff for personal hygiene, showering, and dressing.</p> <p>During an observation on 7/22/2025 at 12:22 p.m., in Resident 32's room, Resident 32 was lying in the bed. The call light was in the bedside table drawer, and not within reach of Resident 32.</p> <p>During an observation on 7/22/2025 at 1:49 p.m., in Resident 32's room, Resident 32 was lying in the bed, the call light was in the bedside table drawer, and not within reach of Resident 32.</p> <p>During a concurrent interview and record review on 7/23/2025 at 1 p.m. with Certified Nursing Assistant (CNA) 2, a picture of Resident 32's call light taken on 7/22/2025 at 12:22 p.m. was reviewed. CNA 2 stated the call light should be within reach next to Resident 32. CNA 2 stated if Resident 32 needed to call for help she would not be able to call and could fall.</p> <p>During a concurrent interview and record review on 7/23/2025 at 1:30 p.m. with Licensed Vocational Nurse (LVN) 3, the same picture was reviewed. LVN 3 stated Resident 32's call light was not within reach so the resident could have access if she wanted to be changed or needed assistance.</p> <p>During a review of the facility's policy and procedure (P&P) titled, "Answering the Call Light," dated 3/2023, the P&P indicated the purpose was to ensure timely responses to the resident's requests and needs. The P&P indicated to ensure the call light was accessible to the resident when in bed or wheelchair in room.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 40's) right to a clean homelike environment. Resident 40's room had peeling paint on the walls and closet. This deficient practice caused an increased risk for Resident 40's psychosocial environment and comfort in accordance with resident preferences. Findings: During a review of Resident 40's admission Record, the admission Record indicated Resident 40 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), schizoaffective disorder (a chronic mental illness that affects a person's thinking, behavior, and perception of reality), and gastro-esophageal reflux disease([GERD]- stomach acids flow back up into esophagus and causes heartburn). During a review of Resident 40's Minimum Data Set (MDS - a resident assessment tool), dated 4/15/2025, the MDS indicated Resident 40 had severe cognitive impairment (ability to reason, remember, and make decisions), and required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs but provides more than half the effort) from staff for showering, toileting hygiene, and dressing. During a review of Resident 40's History and Physical (H&P), dated 7/8/2024, the H&P indicated Resident 40 did not have the capacity to understand and make decisions. During an observation on 7/22/2025 at 11:39 a.m., in Resident 40's room, there was paint chipping off the wall and closet door. During a concurrent interview, Resident 40 stated he had been in the facility for four months and the paint had been like this ever since. Resident 40 stated, Yes, I would want my room to be neat and clean. During a concurrent observation and interview on 7/23/2025 at 1:05 p.m. with Certified Nursing Assistant (CNA) 2, in Resident 40's room, there was chip paint on the walls and the closet. CNA 2 stated Resident 40's room should look nice. CNA 2 stated the room that did not look nice could make the resident feel sad, looking at the chip paint daily. During a concurrent observation and interview on 7/23/2025 at 1:20 p.m. with Maintenance Assistant 1, in Resident 40's room, there was chip paint on the walls and the closet. Maintenance Assistant 1 stated, I check the rooms daily and this room is not a homelike environment for Resident 40. Maintenance Assistant 1 stated Resident 40's room should be prioritized to have the room area painted and that looking at the chip paint could make Resident 40 and visitors feel mad. During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, dated 2/2021, the P&P indicated residents were provided with a safe, clean, comfortable, and homelike environment. The P&P indicated the facility staff and management maximize the characteristics of the facility that reflect a personalized, homelike setting. The P&P indicated homelike setting includes clean, sanitary, orderly environment, and inviting colors and decor.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one of six sampled residents (Resident 28) was free from physical abuse when Resident 78 had become anxious (experiencing worry, unease, or nervousness) and failed to monitor Resident 78's whereabouts. This deficient practice of not monitoring Resident 78's whereabouts after he felt anxious caused Resident 28 to be physically abused by Resident 78. Findings: a. During a review of Resident 28's admission Record, the admission Record indicated Resident 28 was admitted to the facility on [DATE] with diagnoses of fracture of fourth lumbar vertebra (a break in the bone in the lower back), syncope (a temporary loss of consciousness), and osteoporosis (a weak and brittle bones due to lack of calcium and Vitamin D). During a review of Resident 28's History and Physical (H&P), dated 9/8/2024 the H&P indicated, Resident 28 had the capacity to understand and make decisions. During a review of Resident 28's Minimum Data Sheet ([MDS]- a resident assessment tool), dated 6/4/2025, the MDS indicated Resident 28's cognition (ability to learn, reason, remember, understand, and make decisions) was moderately impaired. The MDS indicated Resident 28 required partial/moderate assistance (helper does less than half the effort. Helper lifts or hold trunk or limbs and provides more than half the effort) for toileting hygiene, showers, and dressing. During an interview on 7/24/2025 at 1:25 p.m. with family member for Resident 28, the family member stated, I took her home (Resident 28) on 7/22/2025 for a therapeutic leave (a temporary absence of a resident from the facility), because she was crying and stressed about being hit by Resident 78. During review of Resident 28's Change of Condition (COC) Assessment, dated 7/21/2025, the COC indicated Licensed Vocational Nurse (LVN) 4, heard a noise from Resident 28's room. The COC indicated LVN 4 had observed Resident 78 had tap Resident 28 on her right shoulder and she was upset. The COC indicated a translator was paged to speak with Resident 28. During an interview on 7/24/2025 at 2:19 p.m. with Social Service Assistant/Interpreter (SSA) 1, SSA 1 stated Resident 28 spoke Mandarin, and she had translated what had happened to Resident 28. SSA 1 stated Resident 78 went into her room, he hit her right shoulder four to five times, and she yelled for the nurse. SSA 1 stated Resident 28 was upset and scared. During an interview on 7/24/2025 at 2:39 p.m. with Director of Nursing (DON), the DON stated Resident 28 was hit by Resident 78. The DON stated Resident 28 had a startled reaction when Resident 78 entered her room, she was emotional and upset. b. During a review of Resident 78's admission Record, the admission Record indicated Resident 78 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 78's diagnoses bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs), schizophrenia (a mental illness that can affect thoughts, mood, and behavior), dementia (a progress state of decline in mental abilities), and anxiety (a state emotional state characterized by feelings of unease, worry, or apprehension). During a review of Resident 78's H&P, dated 7/5/2025 the H&P indicated, Resident 78 had the capacity to make needs known but could not make medical decisions. During a review of Resident 78's MDS, dated [DATE], the MDS indicated Resident 78 cognition (ability to learn, reason, remember, understand, and make decisions) was moderately impaired. The MDS indicated Resident 78 required supervision or touching assistance (helper provides verbal cues for touching/steadying, contact guard assistance as resident completes activity) for toileting hygiene, personal hygiene, and dressing. The MDS indicated Resident 78 had psychiatric mood disorders of anxiety, depression (persistent feelings of sadness and a loss of interest in activities), bipolar disorder, and schizophrenia. During a concurrent observation and interview on 7/22/2025 at 4:15 p.m. with the Administrator (ADM), the facility's video footage dated 7/21/2025 at 1:53 p.m., was reviewed. The ADM stated Resident 78 walked out of his room (Room A), crossed the hallway and entered Resident 28's room (Room B) on 7/21/2025 at 1:53 p.m.,. The ADM stated Resident 78 was no longer visible after he entered Room B. The ADM stated LVN 4 walked Resident 78 back to his room at 1:54 p.m. During a review of Resident 78's COC, dated 6/24/2025, the COC indicated Resident 78 had exhibited increased anxiety and restlessness. The COC indicated Resident 78 stated I feel like I can't relax, and was pacing in the hallway and in his room. During a review of Resident 78's Medication Administration Record (MAR), dated 7/4/2025, the MAR indicated to monitor episodes of anxiety manifested by verbalization of feeling anxious and tally by hashmarks for Ativan use every shift. During a review of Resident 78's Order Summary Report, dated 7/4/2025, the Order Summary Report indicated to monitor for anxiety manifested by verbalization of feeling anxious and tally by hashmarks. During a review of Resident 78's Order Summary Report, dated 7/21/2025</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to transmit the Minimum Data Set (MDS - a resident assessment tool) to the Centers for Medicare and Medicaid Services (CMS) system for two of four sampled residents (Resident 39, and Resident 85). This deficient practice resulted in CMS not having accurate information for Resident 39 and Resident 85. Findings: a. During a review of Resident 39's Face Sheet, the Face Sheet indicated Resident 39 was originally admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (characterized by a progressive decline in mental abilities), arthritis (a disease characterized by joint pain and inflammation), and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 39's MDS, dated [DATE], the MDS indicated Resident 39 had severe cognitive impairment (problems with ability to reason, understand, or remember) and did not have limitations in movement of the upper and lower extremities (related to the arms and legs). During a review of Resident 39's History and Physical (H&P) dated 5/23/2025, the H&P indicated Resident 39 did not have the ability to understand and make medical decisions. During a review of the CMS MDS 3.0 Nursing Home (NH) Validation Report, the CMS MDS 3.0 NH Validation Report indicated Resident 39's MDS assessment was submitted late on 9/13/2024, which was more than 14 days after the completion date. b. During a review of Resident 85's Face Sheet, the Face Sheet indicated Resident 85 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), sepsis (a life-threatening blood infection), and pneumonia (an infection / inflammation in the lungs leads to the accumulation of fluid and pus in the lungs, making it difficult to breathe). During a review of Resident 85's MDS, dated [DATE], the MDS indicated Resident 85 had severe cognitive impairment, and had limitations in movement to the upper and lower extremities. During a review of Resident 85's History and Physical (H&P) dated 7/11/2025, the H&P indicated Resident 85 had the capacity to understand and make medical decisions. During a review of the CMS MDS 3.0 NH Validation Report, the CMS MDS 3.0 NH Validation Report indicated Resident 85's MDS assessment was submitted late on 3/25/2025, more than 14 days after the completion date of 2/25/2025. During an interview on 7/25/2025 at 1:38 p.m., the Minimum Data Set Coordinator (MDSC) stated the facility had 14 days after completion of the assessment to submit the MDS to CMS. The MDSC stated Resident 39 and Resident 132 was submitted late, and it was important to submit the MDS assessment to CMS in a timely manner to ensure CMS had the most up to date information for each resident. During a review of the facility's policy & procedures (P&P) titled, Resident Assessments, dated 3/2022, the P&P indicated the Resident Assessment Instrument (RAI) User's Manual, Chapter 2 provided detailed information on timing and submission of assessments, including 14 days after completion of the assessment.</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 44) received necessary care and services to ensure resident's abilities to perform activities of daily living (ADL -routine tasks to perform daily care for themselves) do not diminish. Resident 44 was observed in bed for three days during the day shift and was not out of bed per physician's order. This deficient practice caused an increased risk in Resident 44's mental and physical abilities. Findings:During a review of Resident 44's admission Record, the admission Record indicated Resident 44 was admitted to the facility on [DATE] with diagnoses including peripheral vascular disease (a group of conditions affecting the circulatory system that can impair blood flow), chronic kidney disease (damaged kidneys cannot filter blood as needed causes risks of high blood pressure and heart disease), and diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of the Physician's Order Summary Report dated 3/17/2025, the Order Summary Report indicated Resident 40 may be out of bed per schedule. During a review of Resident 44's Minimum Data Set (MDS- a resident assessment tool), dated 6/23/2025, the MDS indicated Resident 44's rarely had the ability to understand others. The MDS indicated Resident 44's activity preferences were participating in favorite activities and spending time outdoors. The MDS indicated Resident 44 was dependent (helper does all the effort and the resident does none of the effort to complete the activity) on staff for personal hygiene, showering, and dressing.During an observation 7/22 and 7/23/2025, Resident 40 was lying in bed from 8 a.m. to 4:30 p.m. During a telephone interview on 7/23/2025 at 1:46 p.m., Case Worker 1 stated when he visited Resident 40 (at least three times a month) she (Resident 40) was in bed. During an observation on 7/24/2025 Resident 40 continued to lie in bed from 8 a.m.-4:30 p. m. During a concurrent interview and record review on 7/24/2025 at 10 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 40's Order Summary Report dated 3/17/2025 was reviewed. The Order Summary Report indicated Resident 40 may be out of bed per schedule. LVN 3 stated Resident 40 had not been taken out of the bed on 7/22, 7/23, or 7/24/2025, and that there was no specific schedule to take the resident out of the bed. LVN 3 stated not taking Resident 40 out of the bed could cause the resident to feel isolated, decrease body movement, and decrease circulation for the resident. During a review of facility's policy and procedure (P&P) titled, Activities of Daily Living (ADLs), Supporting, dated 3/2023, the P&P indicated residents would be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out of ADLs. The P&P indicated care, and services would be provided for residents who were unable to carry out ADLs independently to prevent or minimize functional decline.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 32), who had a shoulder injury, received care and equipment assistance. Resident 32's splints (a medical device used to stabilize and support a body part), were not applied per physician's order. This deficient practice caused an increased risk in contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) for Resident 32. Findings: During a review of Resident 32's admission Record, the admission Record indicated Resident 32 was admitted to the facility on [DATE] with diagnoses including respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in the body) and a dislocated right shoulder (injury in which the upper arm bone popped out that's part of the shoulder blade). During a review of Resident 32's History and Physical (H&P), dated 2/6/2025, the H&P indicated Resident 32 was able to make decisions for activities of daily living. During a review of Resident 32's Minimum Data Set (MDS- a resident assessment tool), dated 5/12/2025, the MDS indicated Resident 32 was dependent (helper does all the effort and the resident does one of the efforts to complete the activity) on staff personal hygiene, showering, and dressing. The MDS indicated Resident 32 had limited range of motion (a joint or body part cannot move as far) to the upper and lower extremities. During a review of the Physician's Order Summary Report dated 5/14/2025, the Order Summary Report indicated for Resident 32 the Restorative Nurse Assistant (RNA) was to apply bilateral hand splint, right elbow splint, and bilateral ankle-foot orthosis (AFO) boots daily, six days a week. During an observation on 7/22/2025 at 10 a.m.-4 p.m., Resident 32 did not have splints on as ordered by physician. During a concurrent observation and interview on 7/23/2025 at 12 p.m. with RNA 1, in Resident 32's room, Resident 32 did not have a full set of splints on her extremities as ordered by physician. RNA 1 stated my role was to place the splints on Resident 32's extremities daily. RNA 1 stated Resident 32 was missing her left-hand splint and right elbow splint. RNA 1 stated, I did not place all the splints on the resident. RNA 1 stated not being consistent with placing the full set of splints daily could cause Resident 32 to have a decline or develop contractures. During a concurrent observation and interview on 7/23/2025 at 1:38 p.m., Licensed Vocational Nurse (LVN) 3 stated Resident 32 did not have the full set of splints on, and she was missing the left hand and the right elbow splint. LVN 3 stated the RNAs were to report when the resident when there were missing devices. LVN 3 stated Resident 32 should be wearing the full set of splints to prevent contractures. During a review of facility's policy and procedures (P&P) titled, Assistive Devices and Equipment, date unknown, the P&P indicated the facility maintains and supervises the use of assistive devices and equipment for residents. The P&P indicated devices and equipment that assist with resident mobility, safety, and independence were provided for residents. During a review of facility's P&P titled, Restorative Nursing [NAME], dated 7/2017, the P&P indicated residents would receive restorative nursing care as needed to help promote optimal safety and independence. The P&P indicated restorative goals included supporting and assisting the resident to adjusting, adapting to changing abilities.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 101), who had history of falls, had a fall mat at the bedside per the physician's order to prevent injury. This deficient practice caused an increased risk in Resident 101 being injured. During a review of Resident 101's admission Record, the admission Record indicated Resident 101 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including lack of coordination, history of falling, and schizophrenia (a mental illness that is characterized by disturbances in thought).During a review of the Physician's Order Summary, dated 6/9/2025, the summary indicated Resident 101 was ordered for the bed at lowest position and a floor mat to prevent injury.During a review of Resident 101's History and Physical (H&P), dated 6/10/2025, the H&P indicated Resident 101 did not have the capacity to understand and make decisions. During a review of Resident 101's Minimum Data Set (MDS - a resident assessment tool), dated 6/13/2025, the MDS indicated Resident 101 was not able to stand, transfer to toilet, or walk 10 feet.During a review of Resident 101's Fall Risk Evaluation, dated 7/5/2025, the evaluation indicated Resident 101 was at risk for falls due to an actual fall.During a review of Resident 101's High Risk for Falls care plan, dated 7/17/2025, the care plan indicated the facility would keep the bed at the lowest position and use a floor mat to prevent injury.During a concurrent observation and interview on 7/23/2025 at 1:45 p.m. with Certified Nursing Assistant (CNA) 3 at the bedside of Resident 101, there was no floor mat observed. CNA3 stated Resident 101 was supposed to have a floor mat because the resident climbed out of bed. CNA3 stated Resident 101 has fallen before and because there was no floor mat if Resident 101 fell, she may be injured.During a review of the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, dated March 2018, the P&P indicated staff would identify interventions related to the resident's specific risks and try to minimize complications from falling.</p>

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NAME OF PROVIDER OR SUPPLIER Eastland Subacute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3825 Durfee Ave El Monte, CA 91732	
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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to label the nasal cannula (NC, a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) tubing of a resident on oxygen therapy (treatment that provides supplemental oxygen, or extra oxygen) consistent with the facility's policy and procedure (P&P) for one of two sampled residents (Resident 75). This failure caused an increased risk for infection to Resident 75. Findings:During a review of Resident 75's admission Record (AR), the AR indicated Resident 75 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic respiratory failure (CRF, a condition where the lungs could not adequately exchange oxygen and carbon dioxide over an extended period), tracheostomy (a surgical procedure that creates an opening in the front of the neck, known as the trachea, or windpipe), acute embolism (the blockage of a blood vessel by a substance that has traveled through the bloodstream from another part of the body) and thrombosis (formation of a blood clot inside a blood vessel, obstructing the flow of blood). During a review of the Physician's Order Summary Report (OSR), dated 4/1/2025, the OSR indicated to place Resident 75 on oxygen through the NC at 2 liters per minute (LPM, the volume of oxygen delivered per minute).During a review of Resident 75's Minimum Data Set (MDS, a resident assessment tool), dated 7/11/2025, the MDS indicated Resident 75 had severely impaired cognition (ability to understand and process information) and was dependent (helper did all the effort, resident did none of the effort to complete the activity) on staff with oral hygiene, toileting, shower, upper and lower body dressing and personal hygiene. The MDS indicated Resident 75 was on oxygen therapy.During an observation, inside Resident 75's room, on 7/22/2025 at 8:23 a.m., with the infection prevention nurse (IPN), Resident 75 was in bed, on his back with oxygen through the NC at 2 LPM. During a concurrent interview, the IPN stated the NC was not labeled with the date when it was changed, nor initialed with the name of the staff who changed the oxygen tubing. The IPN stated nasal cannula and other oxygen therapy equipment should be changed every week and dated when it was changed to determine when the last time the oxygen tubing was changed for infection control purposes. During an interview on 7/24/2025 at 10:30 a.m., the Director of Nursing (DON) stated oxygen tubing and other respiratory supplies should be labeled with a date when the oxygen tubing was changed to prevent the spread of infection. During a review of the facility's undated policy and procedure (P&P) titled, Oxygen Administration, the P&P indicated The date, time, and initials should be noted on oxygen equipment when it is initially used and when changed.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>Based on observation, interview and record review, the facility failed to ensure the shift nurse staffing information was completed and posted in accordance with the facility's policy and procedures (P&P) for three of three recertification days inspected (7/22, 7/23, and 7/24/2025) by failing to:-Ensure to post the actual nurse staffing information for the skilled nursing and sub-acute stations at the beginning of each shift in a prominent location readily accessible to residents, visitors, and staff for viewing.-Ensure the nurse staffing information for the three to eleven post meridiem (PM, indicate hours from 12 noon to 11:59 pm at night) shifts indicated the number of licensed and unlicensed staff working for the skilled nursing (SNF, referred as nursing home) and sub-acute (level of medical care less intensive but more specialized than typical skilled nursing care) stations.These failures had the potential to mislead the residents, visitors, and staff of the actual staffing in the facility that may affect the quality of nursing care provided to the residents.</p> <p>Findings:During an observation in the skilled nursing stations 1, 2, and 3 and concurrent interview on 7/22/2025 at 10:20 am with the Director of Staff Development (DSD), there was no staffing information posted in nursing stations 1, 2, and 3. The DSD stated staff information was posted only in the sub-acute station and for the SNF station, it was on the side wall of the hallway close to the front office.During a review on of the facility's daily shift nurse staffing information for the skilled nursing (stations 1, 2, and 3) and sub-acute stations, dated 7/22, 7/23, and 7/24/2025, the daily shift nurse staffing information for the 3-11 pm shifts did not indicate the number of working licensed and unlicensed nursing staff directly responsible for the care of the residents.During an interview on 7/25/2025 at 11:46 pm, the DSD stated the current location of the staffing information was not visible and not accessible (can be easily reached or obtained without effort) to the visitors, residents and staff. The DSD stated the staffing information should be filled out within two hours of the beginning of the shift and posted in a prominent and visible location for the visitors, residents, and staff to know the facility had enough staffing to provide appropriate care to the residents. During an interview on 7/25/2025 at 11:56 am, the Director of Nursing (DON) stated staffing information should be posted on a prominent, visible and accessible location like the nursing stations and the lobby for the visitors, residents, and staff and staffing information should be updated to reflect the actual hours of the licensed and unlicensed staff working within two hours after a shift began, for accurate reporting to the Centers for Medicare and Medicaid Services (CMS, a federal agency responsible for administering the Medicare and Medicaid programs) and to know the facility had sufficient staff to care for the residents in the facility. During a review of the facility's policy and procedures (P&P) titled, Posting Direct Crae Daily Staffing Numbers, revised August 2022, the P&P indicated Within two hours of the beginning of each shift, the number of licensed nurses (RNs, LPNs, and LVNs) and unlicensed nursing personnel (CNAs and NAs) directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in clear a clear and readable format.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure three of three sampled residents (Resident 2, Resident 38 and Resident 83) medications were properly labeled and stored in accordance with the current accepted professional standards of practice. a. Resident 2's bottle of Gabapentin (an anticonvulsant medication used for nerve pain and seizures) stored in the refrigerator was not labeled with the residents' identifying information, drug information, or drug instructions. b. Resident 38's package of Sinemet (Carbidopa- Levodopa, used to treat tremors, stiffness and slow movement) medication was not removed from the medication cart once it had expired; and c. Resident 83's package of carvedilol (Coreg, used to manage heart conditions) medication was not removed from the medication cart once it had expired. These deficient practices caused an increased risk in residents receiving the wrong medication or ineffective medications leading to health complications, hospitalization or death. Findings: a. During a review of Resident 2's Face Sheet, the Face Sheet indicated Resident 2 was readmitted to the facility on [DATE] with diagnoses including neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 2's History and Physical (H&P) dated [DATE], the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated [DATE], the MDS indicated Resident 2 had problems with short-term and long-term memory. The MDS indicated Resident 2 had limitations in movement on both sides of the upper and lower extremities (pertaining to the arms and legs). During a review of the Physician's Order Summary Report dated [DATE], the Order Summary Report indicated for Resident 2 to receive Gabapentin 2 milliliters (ml., unit of measurement) every eight hours for neuropathy. During an observation [DATE] at 7:30 a.m., inside the Station 3 medication room refrigerator, an orange clear bottle was seen with a medication label that had Resident 2's name on it, Gabapentin 250mg, and an open date of [DATE]. During a concurrent observation and interview on [DATE] at 7:50 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the medication label should have the expiration date on it, medication information including instructions, and the expiration date on it. LVN 1 stated Resident 2's bottle of Gabapentin was missing information on it because it was faded. LVN 1 stated you could not see the instructions for taking the medication, the concentration of the medication, or the expiration date. LVN 1 stated it was important to have all the information on the medication label because a nurse would not know all the information regarding the medication. b. During a review of Resident 38's Face Sheet, the Face Sheet indicated Resident 38 was admitted to the facility on [DATE] with diagnoses including Parkinsonism (a progressive disease of the nervous system marked by tremors, muscular rigidity, and slow, imprecise movements), and dementia (a progressive state of decline in mental abilities). During a review of Resident 38's H&P dated [DATE], the H&P indicated Resident 38 did not have the capacity to understand and make decisions. During a review of Resident 38's MDS dated [DATE], the MDS indicated Resident 38 had short-term and long-term memory problems and had impairments in movement on both sides of the upper and lower extremities. During a review of the Physician's Order Summary Report, the Order Summary Report indicated Resident 38 was prescribed carbidopa-levodopa 25-100mg to be given one tablet a day for Parkinson's disease. c. During a review of Resident 83's Face Sheet, the Face Sheet indicated Resident 83 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses including hypertension (high blood pressure). During a review of Resident 83's H&P dated [DATE], the H&P indicated Resident 83 did not have the capacity to understand and make decisions. During a review of Resident 83's MDS dated [DATE], the MDS indicated Resident 83 had short-term and long-term memory problems and had impairments in movement on both sides of the upper and lower extremities. During a review of the Physician's Order Summary Report, the Order Summary Report indicated Resident 83 was prescribed carvedilol 12.5mg three times a day and was discontinued on [DATE]. During a concurrent observation and interview on [DATE] at 1:11 p.m. with LVN 5, the bottom of medication cart 1, in hallway 2, there was a package of carbidopa-levodopa with an expiration date of [DATE] for Resident 38 and a package of carvedilol was seen with an expiration date of [DATE] for Resident 83. LVN 5 stated Resident 38's package of carbidopa-levodopa was expired and the package of carvedilol for Resident 83 was discontinued and expired. LVN 5 stated expired and discontinued medications need to be removed from the medication cart</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Resident 25 had a Total T3 level (a lab test that measures the amount of thyroid hormone in the blood) completed every two weeks per physician's order for 4/2025. This deficient practice resulted in a lack of monitoring of Resident 25's thyroid function (crucial for regulating metabolism, growth and development in the body). During a review of Resident 25's admission Record, the admission Record indicated Resident 25 was admitted to the facility on [DATE] with diagnoses including thyrotoxicosis (excess of thyroid hormones in the blood) and hypertension (HTN - high blood pressure). During a review of Resident 25's Hyperthyroidism care plan, dated 2/20/2025, the care plan goal indicated Resident 25 would not experience avoidable symptoms of hyperthyroidism and the care plan interventions indicated the facility would complete labs if ordered by the physician. During a review of Resident 25's History and Physical (H&P), dated 3/14/2025, the H&P indicated Resident 25 had the capacity to understand and make decisions. During a review of the Physician's Order Summary, dated 3/17/2025, the summary indicated Resident 25 was to receive a routine Total T3 level every two weeks due to abnormal results of thyroid function studies. During a review of Resident 25's Minimum Data Set (MDS - a resident assessment tool), dated 5/23/2025, the MDS indicated Resident 25 had a diagnosis of thyrotoxicosis. During a concurrent interview and record review on 7/24/2025 at 2:45 p.m. with Licensed Vocational Nurse (LVN) 3, Resident 25's lab results were reviewed. The results indicated the Total T3 level was completed on 3/24/2025 and there was no further testing for 4/2025. LVN 3 stated the T3 level was not completed every two weeks, and the purpose of the lab test was to monitor Resident 25's thyroid levels. LVN 3 stated, because the test was not completed as ordered, the resident could have had a change of condition. During a review of the facility's policy and procedure (P&P) titled, Lab and Diagnostic Test Results - Clinical Protocol, dated March 2023 the P&P indicated staff would process test requisitions and arrange for tests.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed ensure proper sanitation and safe handling practices in the kitchen in accordance with professional standards for food service safety. The site glass tube (transparent area that allows you to check the level of a liquid) on the coffee maker and the ice machine were both observed with brown substances. This deficient practice caused an increased risk in mold and bacteria, leading to contamination and residents having foodborne illness. Findings: a. During a concurrent observation and interview on 7/22/2025 at 8:27 a.m. with the Dietary Supervisor (DS) in the kitchen, the coffee machine site glass tube was noted to have thick, brown build-up. The DS stated the build-up could contain bacteria which could make you sick. The DS stated she did not know when the coffee machine was last cleaned and that the machine should be deep cleaned every week. b. During a concurrent observation and interview on 7/22/2025 at 8:29 a.m. with DS in the kitchen, the ice machine was noted to contain a light brown slimy substance when it was wiped with a clean towel. The DS could not state what the substance was. The DS stated the light brown slimy substance should not be there. The DS further stated the substance can contaminate the ice and make someone sick. During a review of the Dietary Supervisor's Job Description, dated January 2022, the description indicated the dietary supervisor would make sure food service equipment was clean at all times.</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident 63) had a bottle of opened prune juice refrigerated as indicated on the product label. This deficient practice had the potential for Resident 63 to experience foodborne illness (diseases caused by contamination of food and occur at any stage in food production, delivery and consumption). Findings: During an observation on 7/22/2025 at 11:03 a.m., a bottle of opened and half consumed prune juice was seen on Resident 63's nightstand. The label on the bottle indicated to refrigerate after opening. During an observation on 7/22/2025 at 2:33 p.m., the bottle of the opened prune juice remained on Resident 63's nightstand. During a review of Resident 63's Face Sheet, the Face Sheet indicated Resident 63 was readmitted to the facility on [DATE] with diagnoses including diverticulosis (a condition where small pouches form in the lining of the colon and push outward through weak spots in the intestinal wall), and paraplegia (loss of movement and/or sensation, to some degree, of the legs). During a review of Resident 63's History and Physical (H&P) dated 4/16/2025, the H&P indicated Resident 63 did not have the ability to understand and make decisions. During a review of Resident 63's Minimum Data Set (MDS - a resident assessment tool) dated 6/4/2025, the MDS indicated Resident 63 was cognitively intact (ability to understand, remember, and learn) and did not have impaired movement of the upper and lower body (related to the arms and legs). During an interview on 7/24/2025 at 3:23 p.m., the Activities Director (AD) stated the facility had a refrigerator to store residents' food. The AD stated the nursing and activities staff provided education on storing personal food items in the refrigerator because sometimes the residents did not want their food items to be stored in the refrigerator or did not want their perishable food items to be thrown away. The AD stated it was important to store perishable food items in the refrigerator for the residents to avoid residents from getting sick. During a concurrent observation and interview on 7/24/2025 at 3:40 p.m. with the AD and Resident 63, the AD looked at the bottle of prune juice on Resident 63's nightstand and stated the label on it indicated to refrigerate the bottle after opening. Resident 63 stated his family brought that in for him and the bottle had been there for almost two weeks now. The AD stated it was important to store the bottle as labeled by the manufacturer to avoid illness caused by the food going bad. During a review of the facility's policy and procedure (P&P) titled, Foods Brought by Family/Visitors, dated 3/2022, the P&P indicated perishable foods were stored in re-sealable containers with tightly fitting lids in a refrigerator and potentially hazardous foods that were left out for the resident without a source of heat or refrigeration longer than two hours were thrown away.</p>		

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>Based on observation, interview, and record review, the facility failed to ensure seven of 63 resident rooms (Rooms 114, 115, 116, 117, 119, 121, and 123) met the square footage requirement of 80 square feet (sq. ft. - unit of measurement) per resident in multiple resident rooms. This deficient practice had the potential for the residents not have enough space for activities of daily living (ADL- routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves) and hinder staff from providing nursing care to the residents. Findings: During an observation on 7/22-7/25/2025, during the Recertification Survey, Rooms 114, 115, 116, 117, 119, 121, and 123 had adequate space, nursing, care, comfort, and privacy for the residents. The residents were observed to have enough space to move freely inside the rooms and staff had adequate space to provide care for the residents. During an interview with the facility Administrator (ADM) on 7/22/2025 at 2 p.m., the ADM stated the facility requested a room wavier this year for Rooms 114, 115, 116, 117, 119, 121, and 123. The ADM stated nothing had changed, including the number of bed occupancy to the rooms. During a review of the facility's letter to request a room wavier dated 7/22/2025, the letter indicated there was reasonable privacy, closet and storage space provided in each room. The letter indicated there was sufficient room to provide nursing care and resident equipment. The letter indicated the rooms were in accordance with the special needs of all the residents as necessary. The letter indicated that all rooms had windows, and no rooms were below ground level. The letter indicated that the health and safety of each resident would not be jeopardized by the waiver. The letter indicated the room waiver would not adversely affect the resident's health and safety. The room waiver letter dated 7/22/2025 and Client Accommodation Analysis dated 7/22/2025 indicated the following: Room Sq. ft. Beds 114 300 4115 300 4116 300 4117 300 4 119 300 4121 300 4123 300 2.</p>