STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555055	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baldwin Gardens Nursing Center	10786 Live Oak Avenue 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687 Based on interview and record review, the facility Administrator (ADM) and Director of Nursing (DON) failed to report an injury of unknown origin (IUO- injury in which the cause cannot be determined due to lack of witnesses and resident injured unable to express how the injury occurred) to officials including the State Survey Agency (SSA) and adult protective services (APS), immediately, but no later than 24 hours, and according to the facility ' s policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating for one of two sampled residents (Resident 1). This failure had the potential for IUO to occur to other residents without appropriate reporting and investigation. Findings: During a review of Resident 1 ' s Admission Record (AR), the AR indicated the facility initially admitted Resident 1 on 3/7/2024 and was readmitted on [DATE] with diagnoses that included unspecified intellectual disabilities (a condition that limits intelligence and disrupts abilities necessary for living independently) and generalized muscle weakness (weakness of muscles caused by lack of exercise, ageing, injury, or disease). During a review of Resident 1 ' s Minimum Data Set (MDS- a resident assessment tool) dated 3/6/2025, the MDS indicated Resident 1 had severely impaired cognition (ability to think, remember, and function). The MDS indicated Resident 1 was dependent (helper does ALL the effort. Resident does none of the effort to completely the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene, showering/bathing self, lower body dressing, putting on/taking off footwear, and tub/shower transfers. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort and lifts or holds trunk or limbs, but provides less than half the effort) with upper body dressing, personal hygiene, rolling left and right (in bed), sitting to lying, sitting to standing, chair/bed-to-chair transfers, and walking 10 feet. During a review of Resident 1 ' s Resident Incident Investigation Report Form (RIIRM) dated 2/21/2025, the RIIRM indicated Resident 1 was, Suddenly noted a small skin discoloration under right lower eye. The RIIRM indicated Resident 1 was unable to communicate what happened. The RIIRM indicated the Resident 1 ' s right lower eye discoloration was, More than likely, self-inflicted by Resident 1. (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
	555055	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baldwin Gardens Nursing Center	10786 Live Oak Avenue Temple City, CA 91780

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s situation-background-assessment-recommendation (SBAR- a written communication tool that helps provide essential, concise information, usually during crucial situations) Communication (SBAR) Form, dated 2/21/2025, timed at 1:03 pm, the SBAR form indicated licensed vocational nurse (LVN) 2 wrote Resident 1 was noted to have a self-inflicted small discoloration to right lower eye possibly upon striking (attempting to hit) out at staff. During an interview on 3/11/2025, timed at 3:25 pm, with LVN 2, LVN 2 stated 2/21/2025 between 9 am and 10 am, Resident 1 was agitated and trying to hit an unknown certified nurse assistant (CNA). LVN 2 stated Resident 1 attempted to hit and kick LVN 2 as well. LVN 2 stated Resident 1 was crying and rubbing Resident 1 ' s eyes, Aggressively. LVN 2 stated LVN 2 did not noticed any redness to Resident 1 ' s right eye that morning. LVN 2 stated Resident 1 stopped crying at some point after 12 pm, before LVN 2 ' s shift was over at 3 pm. LVN 2 stated the unknown CNA came up to LVN 2 and informed LVN 2 Resident 1 had redness under Resident 1 ' s right eye. LVN 2 stated LVN 2 did not know what caused the discoloration. LVN 2 stated LVN 2 did not actually know what happened to Resident 1 ' s right undereye because LVN 2 did not witness Resident 1 fall or hit anything. LVN 2 thought Resident 1 ' s right under eye discoloration happened due to rubbing Resident 1 ' s eyes, and was making an educated guess using LVN 2 ' s critical thinking skills. LVN 2 stated LVN 2 reported the incident to Resident 1 ' s sister and the DON. During a telephone interview on 3/11/2025, timed at 3:53 pm, with CNA 1, CNA 1 stated on 2/21/2025, Resident 1 was crying and rubbing Resident 1 ' s eyes a lot. CNA 1 stated around 11 am or 12 pm, CNA 1 went into to Resident 1 ' s room and noticed Resident 1 ' s right eye was red. CNA 1 stated CNA 1 did not witness Resident 1 fall or hit anything. CNA 1 stated CNA 1 report Resident 1 ' s right eye redness to LVN 2. During an interview on 3/11/2025, timed at 5:11 pm, with the DON, the DON stated on 2/21/2025, LVN 2 informed the DON Resident 1 had discoloration around the right eye. The DON stated the DON attempted to find out what happened when Resident 1 ' s sister visited Resident 1 that afternoon but Resident 1 could not answer. The DON stated they (the facility) did not know what happened to Resident 1 to cause the right eye discoloration unless it was caused by rubbing Resident 1 ' s eyes. The DON stated what happened to Resident 1 was an IUO. The DON stated IUO was supposed to be reported to the department of public health so it could be investigated for resident safety. The DON stated at the time of the interview, the DON was going to report the incident to the SSA, now, as well as local law enforcement, and the ombudsman. During an interview on 3/11/2025, timed at 5:40 pm, with the ADM, the ADM stated if staff identified a resident injury that was undetermined, it was supposed to be reported because it could be abuse. The ADM stated what happened to Resident 1 was an IUO, and should be reported to the ombudsman, department of public health, and local law enforcement. During a review of the P&P titled, Abuse Investigation and Reporting, revised 11/2024, the P&P indicated the facility promptly reports all resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. The P&P indicated an alleged violations of abuse, neglect, exploitation or mistreatment (including injuries of unknown source [.] will be reported immediately but not more than 24 hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury.