STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555825	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Marino Healthcare Center	6812 N. Oak Avenue San Gabriel, CA 91775

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor every, one (1) to two (2) hours the whereabouts of 1 of 2 sampled residents (Resident 2) who wander (to move around different places usually without having a particular purpose or direction) in accordance with the facility's policy and procedure. This deficient practice had the potential to result in Resident 2 wandering into another resident's room, which placed the resident at risk for another injury and potential serious harm.Findings:1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included paranoid schizophrenia (a mental illness that is characterized by disturbances in thought) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 3/23/2026, the MDS indicated Resident 1 had an intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 1 required supervision (helper provides cues) with oral, toileting, and personal hygiene, shower, upper and lower body dressing, and putting on /taking off footwear. The MDS further indicated Resident 1 required setup assistance (helper sets up; resident completes activity) with eating. During an interview on 5/8/2026 at 12:16 PM in Resident 1's room, Resident 1 stated the night of 4/23/2026 he was sleeping looking and facing towards the wall hugging his radio when he felt the blanket come off him, he woke up and saw Resident 2 standing beside his bed and grabbed the radio he was holding and Resident 2 started walking towards the door. Resident 1 also stated he went after Resident 2 and grabbed his (Resident 2) shirt in the hallway to stop Resident 2. Resident 1 further stated Resident 2 stopped in front of Room A after he felt the tugging of his shirt then Resident 2 turned towards Room A and went inside. Resident 1 stated both (Resident 1 and 2) were tugging on the radio and then Resident 1 fell on the floor on top of Resident 2 who had hit his (Resident 2) head on the floor. Resident 1 denied hitting Resident 2 and stated the radio he had was borrowed from someone, so he felt responsible for it. 2. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included paranoid schizophrenia and major depressive disorder. During a review of Resident 2's Elopement (a resident leaving a care facility or hospital unit without authorization or notifying the staff. It typically involves vulnerable individuals such as those with mental health conditions) Evaluation (a tool used to determine if an individual requires an alarmed, delayed exit door as a necessary safety intervention), dated 1/27/2026, the Elopement Evaluation indicated Resident 2 wanders and was at risk for elopement. During a review of Resident 2's Care Plan initiated on 1/27/2026, the Care Plan indicated the resident was at risk for injuries secondary to wandering behavior with an approach plan to monitor resident's location with visual checks every 2 hours. During a review of Resident 2's Minimum Data Set, dated [DATE], the MDS indicated Resident 2 had moderate impairment in cognitive skills for daily decision making. The MDS also indicated Resident 2 required supervision with toileting, shower, and personal hygiene and (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	required setup assistance with oral hygiene, upper and lower body dressing. The MDS further indicated Resident 2 was independent with eating and putting on/taking off footwear. During a review of Resident 2's Care Plan initiated on 4/26/2026, the Care Plan indicated the resident was at risk for injuries secondary to wandering behavior with an approach plan to monitor resident's location with visual checks every 2 hours. During a review of the facility's Head Count and Call Light Check for Resident 2 dated 5/4/2026 to 5/8/2026, the head count and call light check were not signed (not done) on the following dates and shift: 5/4/2026 - day, evening and night shifts (7-3 PM, 3-11 PM, and 11-7 PM).5/5/2026 - night shift (11-7 PM)5/6/2026 - evening shift (3-11 PM)5/7/2026 - evening shift (3-11 PM)5/8/2026 - day and evening shift (7-3 PM and 3-11 PM) During an interview on 5/8/2026 at 12:53 PM, Certified Nursing Assistant 1 (CNA 1) stated he was working the night of 4/23/2026 and heard a commotion in Room A, went to the room and saw both Residents 1 and 2 on the floor. During an interview on 5/8/2026 at 1:33 PM, Resident 3 who was in Room A stated, on 4/23/2026, Resident 2 went to his room and was followed by Resident 1, Resident 1 grabbed Resident 2's shirt and took out the radio from him (Resident 2). Resident 3 also stated both Resident 1 and 2 fell towards the bed of his roommate and one of the CNA tried to get Resident 2 off the floor while Resident 1 left his room. During an interview on 5/8/2026 at 3:21 PM, Licensed Vocational Nurse 1 (LVN 1) stated, on the night of 4/23/2026 she was in the medication room when she heard a commotion in Room A and saw both Residents 1 and 2 struggle on something. LVN 1 also stated both Residents 1 and 2 lost their balance while Resident 1 was trying to get the radio from Resident 2. LVN 1 further stated Resident 1 fell on top of Resident 2 and caused Resident 2 to hit his head on the bottom part metal frame of Resident 3's roommate's bed. During a concurrent interview and record review on 5/8/2026 at 4:18 PM, CNA 2 stated the facility had a head count and call light check to log the resident's whereabouts which needed to be filled out once done by the staff to ensure we are aware of the resident's location or whereabouts. CNA 2 also stated there was no valid proof or documented evidence that Resident 2 was being supervised and monitored for the resident's whereabouts every hour on 5/4/2026 to 5/8/2026. CNA 2 further stated Resident 2 walks around and goes to other residents' rooms and the resident should have been monitored. During an interview on 5/8/2026 at 4:48 PM, LVN 2 stated Resident 2 wanders and walks a lot and there are multiple occasions the resident goes to other residents' rooms. LVN 2 also stated the staff are supposed to do head counts and check the residents' location or whereabouts every 1 to 2 hours and as needed to ensure the staff know where the residents are and for the residents' safety. LVN 2 added, if it was done it should have been documented in the resident's head count and call light check. LVN 2 further stated the incident with Resident 1 and 2 would have been prevented if the staff knew where Resident 2 was at that time and they could have prevented Resident 2 wandering into another resident's room. During an interview on 5/8/2026 at 5:16 PM, the Director of Staff Development (DSD) stated Resident 2's Care Plan for wandering behavior dated 4/26/2026 did not indicate any new approach for Resident 2's wandering behavior. DSD also stated the facility had to ensure new interventions were added since the previous intervention (care plan for wandering behavior dates 1/27/2026) was not effective to prevent same incident of Resident 2 wandering into another resident's room from happening again. DSD further stated Care Plan help guide the staff on how to take care of the residents. During a concurrent interview and record review on 5/8/2026 at 5:23 PM, Resident 2's Care Plan for the wandering behavior dated 4/26/2026 and head count and call light check dated from 5/4/2026 to 5/8/2026 were reviewed. The Director of Nursing (DON) stated Resident 2's Care Plan should have been revised and updated after the wandering incident on 4/23/2026 to add new interventions to prevent the same problem of Resident 2 wandering into another resident's room from happening again. The DON also stated monitoring of Resident 2's location or whereabouts was not done from 5/4/2026 to 5/8/2026 every 1 to 2 hours. The DON further stated there is a tendency that Resident 2 could wander into another resident's room again and have another incident and altercation with another resident. The DON also stated the head count and call light check was used to check all the residents' (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	location/whereabouts every hour including those who wander around. During a review of the facility's Policy and Procedure (P&P) titled, Wandering & Elopements, revised 3/2019, the P&P indicated the facility would identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. During a review of the facility's P&P policy titled, Safety and Supervision of Residents, revised on 7/2017, the P&P indicated that residents' safety and supervision and assistance to prevent accidents are facility wide priorities. The P&P also indicated an individualized, resident-centered approach to safety by ensuring that the interventions are implemented correctly and consistently. The P&P further indicated resident risks and environmental hazards included unsafe wandering.