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	05/27/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain accurate (being completely free from mistakes, errors, or defects) resident medical records for two (2) of 2 sampled residents (Resident 1 and 2) by failing to ensure:Resident 1's Fall risk evaluation (a simple, straightforward check-up used to determine how likely you are to fall and get hurt) dated 3/29/2026 and 5/24/2026 were accurate.Resident 2's Fall risk evaluation dated 4/13/2026 and 4/21/2026 were accurate. This deficient practice had the potential for Resident 1 and 2 not to identify and address fall risk factors and interventions to minimize and prevent future falls.Findings: 1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included depression (a serious mood disorder that causes a persistent feeling of sadness and a loss of interest in activities you usually enjoy), atrial fibrillation (AFib, is an irregular and often very rapid heart rhythm), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 3/23/2026, the MDS indicated Resident 1's cognitive skill (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching assistance) with eating. It also indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with upper body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with oral hygiene and lower body dressing. In addition, it indicated Resident 1 was dependent (helper does all of the effort) with toileting hygiene, shower, and personal hygiene. The MDS indicated Resident 1 is taking antipsychotic (prescription medications used to treat mental health conditions), antianxiety (prescription drugs designed to calm the nervous system), antidepressant (medications that treat mental health conditions), anticoagulant (blood thinners), diuretic (drugs that cause your kidneys to make more urine), hypoglycemic (drug used to lower and control high blood sugar levels) and anticonvulsant (drugs used to calm abnormal electrical activity in the brain) medications. During a review of Resident 1's Fall Risk Evaluation, dated 3/29/2026, the Fall Risk Evaluation indicated Resident 1 requires use of assistive devices (cane, wheelchair, walker, and furniture) for gait/balance assessment. The Fall Risk Evaluation indicated to respond based on the following types of medications:Anesthetics (medication used by doctors to temporarily block pain and sensation).Antihistamines (medication that stops or reduces allergy symptoms).Antihypertensives (medication designed to prevent or treat high blood pressure).Antiseizures (anticonvulsant, medication used to calm abnormal electrical activity in the brain).Benzodiazepines (medication that slows down activity in your brain).Cathartics (medication used to empty the bowels).DiureticsHypoglycemicsNarcotics (substance that dulls the senses, relieves pain, and induces sleep).Psychotropics (drugs that alter brain chemistry, affecting how you think, feel, and behave).Sedatives/Hypnotics (medications that slow down your brain and nervous system (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	activity).The Fall Risk Evaluation indicated Resident 1 takes one (1) to 2 of these medications and/or within the last seven days. During a review of Resident 1's Fall Risk Evaluation, dated 5/24/2026, the Fall Risk Evaluation indicated Resident 1 requires use of assistive devices (cane, wheelchair, walker, and furniture) for gait/balance assessment. The Fall Risk Evaluation indicated to respond based on the following types of medications:Anesthetics.Antihistamines.Antihypertensives.Antiseizures.Benzodiazepines.Cathartics.Diureticsł Fall Risk Evaluation indicated Resident 1 takes one (1) to 2 of these medications and/or within the last seven days. During a concurrent record review and interview on 5/27/2026 at 1:48 PM with Licensed Vocational Nurse1 (LVN 1), Resident 1's Fall Risk Evaluation dated 3/29/2026 and 5/24/2026, and active medication orders were reviewed. LVN 1 stated Resident 1's Fall Risk |Evaluation dated 3/29/2026 and 5/24/2026 are exactly similar. LVN 1 stated, Resident 1 had a fall incident on 5/24/2026, that is why Fall Risk Evaluation was done for that day. LVN 1 stated when a resident had a fall incident, the Fall Risk Evaluation should already indicate a history of fall and the form completed on 5/24/2026 did not indicate resident has a history of fall. LVN 1 stated the Fall Risk Evaluation has inaccurate documentation for Resident 1's gait/balance assessment. LVN 1 stated the box indicating Resident 1 requires assistive device is not enough, there should be a check mark on the boxes indicating that Resident 1 has balance problem while standing and walking. LVN 1 also, stated Resident 1 is currently taking Ativan (medication for anxiety) which is a type of benzodiazepine and narcotic medication, Cymbalta which is psychotropic, Lasix which is a diuretic, metoprolol which is an antihypertensive. LVN 1 stated Resident 1 takes 3 to 4 medications under the types of medications that was indicated in the Fall Risk Evaluation. LVN 1 stated the assessment answer indicating Resident 1 takes 1 to2 of the medications under the listed types of medications was a wrong documentation because it did not reflect that Resident 1 is taking 3 to 4 medications. LVN 1 stated maintaining accurate medical records, including Fall Risk Evaluations, is important to avoid confusion. During a concurrent record review and interview on 5/27/2026 at 3:15 PM with MDS nurse (MDSN), Resident 1's Fall Risk Evaluation dated 3/29/2026 and 5/24/2026, and nurse progress notes dated 5/24/2026, timed 10:30 PM were reviewed. MDSN stated Resident 1's Fall Risk Evaluation dated 3/29/2026 and 5/24/2026 were documented similar to each other, with the same inaccurate documentation. MDSN stated Resident 1's Fall Risk Evaluation, dated 3/29/2026, was done for Resident 1's quarterly assessment, and the licensed nurse who was taking care of Resident 1 on 5/24/2026 copied the Fall Risk Evaluation dated 3/29/2026. MDSN also stated the documentation for the Fall Risk Evaluation on 5/24/2026 should reflect Resident 1's fall incident and 1 history of fall should have been documented because Reisdent 1 had a fall in the facility. MDSN stated Resident 1 had a fall on 5/24/2026 around 8:30 PM, where in Resident 1 was observed crawling on the floor near the foot of the bed as indicated in nurse progress notes dated 5/25/2026, timed 10:30 PM. 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 readmitted on [DATE]. Resident 2's diagnoses included seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D) with current fracture (a broken or cracked bone), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had modified independence (some difficulty in new situations only) cognitive skills for daily decision making. The MDS indicated Resident 2 required supervision or touching assistance with eating, oral and toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. It also indicated Resident 2 was independent (resident completes the activity by themselves with no assistance from a helper) with walking and Resident 2 is taking antipsychotic, antidepressant, diuretic, and anticonvulsant medications. During a review of Resident 2's Fall Risk Evaluation, dated 4/13/2026, the Fall Risk Evaluation indicated Resident 2 had a 1 to 2 history of (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	falls from the past three (3) months. The Fall Risk Evaluation indicated Resident 2 was chairbound (being unable to walk and relying on a chair or wheelchair) and has incontinent elimination status (lacks voluntary control over their bladder or bowels, resulting in involuntary leakage or accidental loss of urine or stool). The Fall Risk Evaluation indicated Resident 2 has balance problem while standing and walking, has decreased muscular coordination, has change in gait pattern when walking through doorway, has jerking or unstable when making turns, and requires use of assistive devices (cane, wheelchair, walker, and furniture) for gait/balance assessment. The Fall Risk Evaluation indicated to respond based on the following types of medications:AnestheticsAntihistamines.Antihypertensives.Antiseizures.Benzodiazepines.Cathartics.DiureticsH- Fall Risk Evaluation indicated Resident 2 takes 3 to four (4) of these medications and/or within the last seven days. During a review of Resident 2's Fall Risk Evaluation, dated 4/21/2026, the Fall Risk Evaluation indicated Resident 2 had no history of falls from the past 3 months. The Fall Risk Evaluation indicated Resident 2 was ambulatory (able to walk or move around instead of being confined to a bed or chair) and has incontinent elimination status. The Fall Risk Evaluation indicated to respond based on the following predisposing (suffer from a specific condition) conditions:Seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness).Osteoporosis (a condition that weakens your bones).Fractures (broken bone).The Fall Risk Evaluation indicated Resident 2 has decreased muscular coordination and requires use of assistive devices for gait/balance assessment. The Fall Risk Evaluation indicated to respond based on the following types of medications:AnestheticsAntihistamines.Antihypertensives.Antiseizures.Benzodiazepines.Cathartics.DiureticsH- Fall Risk Evaluation indicated Resident 2 takes 1 to 2 of these medications and/or within the last seven days. During a concurrent record review and interview on 5/27/2026 at 2 PM with LVN 1, Resident 2's Fall Risk Evaluation dated 4/13/2026 and 4/21/2026, and active medication orders were reviewed. LVN 1 stated Fall Risk |Evaluation dated 4/13/2026 and 4/21/2026 documentations were different. LVN 1 stated that Resident 2 had a fall incident on 4/13/2026, that is why Fall Risk Evaluation was done for that date. LVN 1 stated the Fall Risk Evaluation dated 4/21/2026 has inaccurate documentation since it was documented that Resident 2 has no history of falls for the past 3 months. LVN 1 stated the Fall Risk Evaluation dated 4/13/2026 has inaccurate documentation for Resident 2's ambulation and elimination status, since Resident 2 was ambulatory and not chairbound. During the same concurrent review and interview on 5/27/2026 at 2 PM, Resident 2's Fall Risk Evaluation dated 4/21/2026 was reviewed. LVN 1 stated the Fall Risk Evaluation dated 4/21/2026 has inaccurate documentation for Resident 2's gait/balance assessment, the checked off boxes indicating Resident 1 has decreased muscular coordination and requires assistive device is not enough, there should be check marks on the boxes indicating that Resident 1 has balance problem while standing and walking. LVN 1 stated Resident 2 has multiple medications that are categorized as psychotropics, diuretics, narcotics, cathartics, sedatives, and antiseizures. LVN 1 stated Resident 2's Fall Risk Evaluation dated 4/21/2026 was a wrong documentation since it indicated Resident 2 takes 1 to 2 medications instead of 3 to 4 medications under the types of medications. During a concurrent record review and interview on 5/27/2026 at 3:20 PM with MDSN, Resident 2's Fall Risk Evaluation dated 4/13/2026 and 4/21/2026, and medical records were reviewed. MDSN stated Resident 2's Fall Risk Evaluation, dated 4/13/2026, was done because Resident 2 had a fall incident. MDSN stated Resident 2's Fall Risk Evaluation, dated 4/13/2026 has inaccurate documentation when the licensed nurse documented that Resident 2 was chairbound, because Resident 2 was ambulatory. MDSN stated Resident 2's Fall Risk Evaluation, dated 4/21/2026 has inaccurate documentation because it was documented that Resident 2 has no history of fall, but Resident 2 just had a fall incident 1 week prior to the evaluation. MDSN also stated Resident 2's Fall Risk Evaluation, dated 4/21/2026 indicated Resident 2 has only 1 to 2 predisposing diseases, but Resident 2 has 3 or more predisposing diseases such as seizures, osteoporosis, and fracture. MDSN stated that inaccurate documentation might lead (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to confusion in the delivery of care. MDSN added it is very important to maintain accurate documentation with residents' Fall Risk Evaluation because it is used as part of the assessment process to ensure residents' safety. During a review of Facility's Policy and Procedure (P&P) titled, Charting Errors and/or Omissions (leaving something out), revised in December 2006, the P&P indicated accurate medical records shall be maintained by the facility. During a review of Facility's P&P titled, Charting and Documentation, revised in July 2017, the P&P indicated documentation in the medical record will be objective (not opinionated), compete and accurate.