| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555825 | A. Building<br>B. Wing | 06/25/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| San Marino Healthcare Center | 6812 N. Oak Avenue<br>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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from physical abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) for one of two sampled residents (Resident 1) when Certified Nursing Assistant 2 (CNA 2) grabbed and pulled Resident 1's hair on 6/10/2026 in accordance with the facility's policy and procedure (P&P). This deficient practice had the potential to affect Resident 1's psychosocial (combined influence of psychological factors and the surrounding social environment on physical, emotional, and/or mental wellness) well-being. Findings: During a review of Resident 1's admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including but not limited to metabolic encephalopathy (abnormalities of water, electrolytes, vitamins, and other chemicals that adversely affect the brain function), cognitive (mental action or process of acquiring knowledge and understanding) communication deficit, and dementia (progressive brain disorder that slowly destroys memory and thinking skills). During a record review of Resident 1's Minimum Data Set (MDS, a resident assessment and tool), dated 4/29/2026, the MDS indicated the resident had severe impairment with cognitive skills for daily decision making. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) for toileting hygiene, upper and lower body dressing, and sit to stand. The MDS also indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching/steading and/or contact guard assistance as resident completes activity) for sit to lying and lying to sitting on side of bed. During a record review of Resident 1's Situation-Background-Assessment-Recommendation (SBAR) Communication Form (a technique used to provide a framework for communication between members of the health care team), dated 6/10/2026, the SBAR Communication Form indicated at approximately 9:24 PM, Licensed Vocational Nurse 1 (LVN 1) received a call from Director of Staff Development (DSD) stated CNA 1 called her and reported and witnessed an alleged abuse toward a resident, from another staff. During a record review of Resident 1's Interdisciplinary Team (IDT, group of healthcare professionals from diverse fields who work in a coordinated manner toward a common goal for the resident) Conference Record, dated 6/12/2026, the record indicated CNA 1 stated I was walking in the hallway, I heard a loud noise as I was passing by near Resident 1's room. I saw Resident 1 on the floor with her pants pulled down and saw CNA 2 grabbed Resident 1's hair. Resident 1 said ouch. I asked CNA 2 if she needs help, but she just ignored me. The record also indicated CNA 2 stated she was trying to change Resident 1. Resident 1 was combative and almost fell out of bed. CNA 2 tried to hold Resident 1's head and shoulder so she could not get hurt but Resident 1 was pushing CNA 1 back. CNA 1 was on the left side of Resident 1's back so she accidentally grabbed Resident 1's head and hair. During a record review of the facility's Five-Day Letter, dated 6/14/2026, the letter indicated CNA 1 reported while walking past Resident 1's room, he heard a loud noise and observed CNA 2 holding what appeared to be Resident 1's hair. CNA 1 further reported that he assisted CNA 2 in returning the resident to bed and subsequently reported his concerns to the DSD. During an interview (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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | on 6/25/2026 at 12:03 PM with CNA 2, CNA 2 stated while changing Resident 1's brief (protective underwear to prevent leakage), Resident 1 was sitting at the edge of the bed and started kicking as she slid onto the floor from the bed. CNA 2 stated she held Resident 1 with her leg as Resident 1 was sliding down. CNA 2 stated she used her left hand to hold Resident 1's head and her right hand was trying to cut the brief to easily tear off Resident 1's brief. CNA 2 stated that CNA 1 passed by twice offering help, but she declined both times. CNA 2 stated when CNA1 passed by the second time, Resident 1 was sitting on the floor and then stood up on her own. During an interview on 6/25/2026 at 12:26 PM with CNA 1, CNA 1 stated he heard some commotion in Resident 1's room and as CNA 1 walked by, he saw Resident 1 lying on the floor between the two beds. CNA 1 stated Resident 1 was lying down and propping her head higher than the rest of her body. CNA 1 stated he saw CNA 2 walk towards Resident 1 from behind the curtain and reached down and grabbed Resident 1's hair in a fist against her scalp. CNA 1 stated he saw Resident 1's head tilt back from CNA 2 grabbing Resident 1's hair. CNA 1 stated Resident 1 said ouch and her face was scrunched up and expressed pain. CNA 1 stated CNA 2 then noticed CNA 1 looking into the room and CNA 2 immediately stopped what she was doing. CNA 1 stated he put on gloves and went inside the room and asked CNA 2 if she needed help, but CNA 2 did not respond. CNA 1 stated when he went inside Resident 1's room and Resident 1 said that CNA 2 was rough. CNA 1 stated he remained with Resident 1 while CNA 2 changed Resident 1's bed. CNA 1 stated he was shocked after witnessing CNA 2 grab Resident 1's hair and therefore felt it was safer for him to remain with Resident 1 while CNA 2 was in the room. CNA 1 stated he then spoke with the DSD and LVN 1 to report CNA 2 pulling Resident 1's hair since he was a mandated reporter. During an interview on 6/25/2026 at 12:54 PM with LVN 1, LVN 1 stated CNA 1 reported that as he was passing by Resident 1's room and saw Resident 1 on the floor, CNA 1 saw CNA 2 holding Resident 1's hair in her hand. LVN 1 stated CNA 2 said that she helped Resident 1 not to hit herself when falling and ended up grabbing Resident 1's hair. During an interview on 6/25/2026 at 2:28 PM with DSD, DSD stated CNA 1 called her on 6/10/2026 before 9:30 PM. DSD stated CNA 1 stated he witnessed an abuse and saw CNA 2 grabbing Resident 1's hair. During an interview on 6/25/2026 at 4:41 PM with DSD, DSD stated that when a resident falls, staff are expected to use proper body mechanics, such as bending their knees and lifting residents by supporting them under the arms. DSD stated that staff should not hold a resident's head during a fall, as this could result in pulling the resident's hair or causing a head injury. DSD further stated that if a resident is already on the ground after a fall, the CNA should not assist the resident to get up. Instead, the CNA must call the licensed nurse first so the licensed nurse can assess the resident for injuries before the resident is assisted to stand. During a concurrent interview and record review on 6/25/2026 at 5:12 PM with the Director of Nursing (DON) of the facility's P&P titled, Preventing Resident Abuse, revised 01/2011, the P&P indicated the facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc., to assist in preventing resident abuse and the facility's goal is to achieve and maintain an abuse-free environment. The DON stated Resident 1 was on the floor and CNA 2 was trying to pull Resident 1's hair. The DON stated that when CNA pulled Resident 1's hair, it was a failure to ensure the resident's right to be free from abuse. |