

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555825	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER San Marino Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099 Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained or enhanced a resident's dignity and respect for two (2) of 15 sampled residents (Resident 37 and 42) by failing to ensure facility staff did not stand over and above resident's eye level while assisting the resident during meal. This deficient practice had the potential to affect Resident 37 and 42's self-esteem and self-worth. Findings: 1. During a review of Resident 37's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included generalized muscle weakness and polyneuropathy (conditions affecting nerve function in various parts of the body, leading to symptoms such as weakness, numbness, and burning pain). During a review of Resident 37's Minimum Data Set (MDS, a federally mandated assessment tool), dated 10/7/2024, the MDS indicated Resident 37 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 37 was dependent (helper does all the effort) with toileting hygiene, shower, upper and lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 35 required substantial assistance (helper does more than half the effort) with oral and personal hygiene and partial assistance (helper does less than half the effort) with eating. During a meal observation on 11/12/2024 at 12:22 PM in Resident 37's room, Resident 37 was observed seated on a wheelchair while being assisted with eating by Certified Nursing Assistant 1 (CNA 1) placed a towel on top of the resident's chest area to protect clothes. CNA 1 was observed standing over Resident 37 and was not within eye level of the resident. CNA1 was heard stating, Yummy, yummy to Resident 37. 2. During a review of Resident 42's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and dementia (loss of cognitive functioning such as thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities). (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
FORM CMS-2567 (02/99) Previous Versions Obsolete		Event ID: 555825
Facility ID: 555825		If continuation sheet Page 1 of 23

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 42's MDS dated [DATE], the MDS indicated Resident 42 had severe impairment in cognitive skills for daily decision making. The MDS also indicated Resident 42 was dependent with toileting hygiene, shower, lower body dressing, and putting on/taking off footwear and required substantial assistance with oral and personal hygiene, and upper body dressing. The MDS further indicated Resident 42 required partial assistance with eating. During a concurrent observation and interview on 11/12/2024 12:33 PM in Resident 42's room, Resident 42 was observed seated at the side of the bed while CNA 1 was standing over feeding the resident. CNA 1 stated it was easier for her to feed the residents while standing up. During an interview on 11/12/2024 at 3:22 PM, Licensed Vocational Nurse 2 (LVN 2) stated staff should be seated so can be within eye level when feeding the resident for dignity and respect. During an interview on 11/13/2024 at 4:35 PM, the Director of Nursing (DON) stated the staff should be seated so can be within eye level when feeding the resident so staff can observe the resident in case of choking. The DON stated this will also ensure comfort and dignity of the residents. During a review of the facility's Policy and Procedure (P&P) titled, Assistance with Meals, revised July 2017, P&P indicated that residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity such as not standing over the residents while assisting them with meals and avoiding use of bibs or clothing protectors instead of napkins, unless requested by the resident.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47362 Based on observation, interview, and record review, the facility licensed staff failed to obtain an informed consent (a process in which a resident and his/her medical provider communicate about medical procedure or treatment, including its possible risks and benefits, and the resident agrees to it) from the resident's responsible party before administering Quetiapine Fumarate (an antipsychotic medication, a drug used to treat serious mental health conditions), for one (1) of 15 sampled residents (Resident 19) in accordance with the facility policy. This deficient practice violated the resident's right to be fully informed and consent to receive psychoactive medications. Findings: During a review of Resident 19's Admission Record, the Admission Record indicated the facility admitted Resident 19 on 9/18/2024 and was readmitted on [DATE] with diagnoses which included schizophrenia (a serious mental health condition that affects how people think, feel, and behave), anxiety (a feeling of fear, dread, and uneasiness), dementia (a term for several diseases that affect memory, thinking, and the ability to perform daily activities). During a review of Resident 19's MDS, a federally mandated resident assessment tool, dated 10/29/2024, the MDS indicated Resident 19 was severely impaired (never/rarely made decisions) with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 19 needs supervision or touching assistance (helper provides verbal cues and touching steadying as resident complete activity) on eating, oral hygiene. Partial moderate assistance (helper does less than half the effort, helper lift, holds or supports trunk or limb but provides less than half the effort) on upper and lower body dressing, personal hygiene. During a review of Resident 19's Order Summary Report, dated 11/13/2024, the Order summary report indicated an order date of 11/5/2024 for Quetiapine Fumarate oral tablet 25 milligrams (mg, unit of measurement) two times a day for schizophrenia manifested by disorganized thoughts as evidenced by talking and mumbling. During a concurrent interview and record review of Resident 19's chart on 11/13/2024 at 11:56 AM with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated there was no informed consent for Resident 19's use of Quetiapine Fumarate. LVN 3 also stated if there was no consent that means the resident or responsible party did not give authorization to take the medication. LVN 3 added, the informed consent should be available at the chart all the time. During a concurrent review of Resident 19's Medication Administration Record (MAR) for the month of 11/2024 and interview on 11/13/2024 at 12:28 PM with Registered Nurse 1 (RN 1), RN1 stated Resident 19 has been taking Quetiapine Fumarate 25mg for nine (9) days, from 11/5/2024 to 11/13/2024, without a consent. (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent review of the facility's Policy and Procedure (P&P) titled, Informing Residents of Health, Medical Condition and Treatment Options, date revised 12/2016, and interview with the Director of Nursing (DON) on 11/13/2024 at 4:07 PM, the DON stated the P&P indicated, The residents will be informed of their health, medical condition and options for treatment and /or care. During the same concurrent review of the facility's P&P titled, Resident Rights, revised date 2/2021, and interview on 11/13/2024 at 4:07PM with the DON indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: o. be informed of his or her medical condition and of any change in his or her condition. p. be informed of and participate in, his or her care planning and treatment. During a concurrent review of Resident 19's MAR for the month of 11/2024 and interview with the DON on 11/13/2024 at 4:10 PM the DON stated Resident 19 received Quetiapine Fumarate 25mg without an no informed consent from 11/5/2024 to 11/13/2024. The DON also stated an informed consent should be obtained prior to giving any medication or treatment.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099 Based on observation, interview, and record review, the facility failed to provide reasonable accommodation to meet the resident's needs for three (3) of 15 sampled residents (Residents 37, 45, and 208) in accordance with the facility policy when: 1. Resident 37 with limited range of motion (ROM, extent of movement of a joint) of bilateral hands was not provided with an appropriate call device (a device used by residents to call staff). 2. and 3. Resident 45 and 208's call lights was observed not within arm's reach. These failures had the potential to result in a delay in or in an inability for Residents 37, 45, and 208 to obtain necessary care and services especially during an emergency, which could result in injury and harm. Findings: 1. During a review of Resident 37's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included generalized muscle weakness and polyneuropathy (conditions affecting nerve function in various parts of the body, leading to symptoms such as weakness, numbness, and burning pain). During a review of Resident 37's Minimum Data Set (MDS, a federally mandated assessment tool), dated 10/7/2024, the MDS indicated Resident 37 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 37 was dependent (helper does all the effort) with toileting hygiene, shower, upper and lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 35 required substantial assistance (helper does more than half the effort) with oral and personal hygiene and partial assistance (helper does less than half the effort) with eating. During an observation on 11/11/2024 at 10:43 AM, Resident 37 was observed lying in bed with limited range of motion of both hands. Resident 37's call light cord was observed on top of the resident's bed. During a concurrent observation and interview on 11/12/2024 at 8:39 AM, Resident 37 tried to pull the call light cord with his hands but struggled. Resident 37 stated it was frustrating for him not to be able to pull the call light cord. Resident 37 also stated he usually just yell for help when he needs the staff's assistance. During an interview on 11/14/2024 at 9:12 AM, Registered Nurse 1 (RN 1) stated Resident 37 would not be able to pull the cord of the call light with the resident's hands being contracted (abnormal shortening of muscle tissue). RN 1 also stated Resident 37 should have a type of call light where he could just touch it when he needed help or assistance. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 45's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included muscle wasting and atrophy (loss of muscle tissue) and metabolic encephalopathy (metabolic encephalopathy (a chemical imbalance of the blood in the brain). During a review of Resident 45's MDS, dated [DATE], the MDS indicated Resident 45 had moderate impairment in cognitive skills for daily decision making. The MDS also indicated Resident 45 required partial assistance with oral, toileting, and personal hygiene, shower, upper and lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 45 required setup assistance (helper sets up; resident completes activity) with eating. During an observation on 11/11/2024 at 9:49 AM, Resident 45 was lying in bed. The base of the call light of Resident 45 was observed mounted to the wall. The cord of the call light was wrapped around the base which was about seven (7) feet from the resident. The call light was not within Resident 45's reach. During an interview on 11/14/2024 at 9:16 AM, RN 1 stated Resident 45 would not be able to reach the call light to call for help or assistance if the call light was out of reach. 3. During a review of Resident 208's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included muscle wasting and atrophy and lack of coordination (poor muscle control and clumsy movements which can affect a person's ability to walk). During a review of Resident 208's MDS dated [DATE], the MDS indicated Resident 208 had moderate impairment in cognitive skills for daily decision making. The MDS also indicated Resident 208 required substantial assistance (helper does more than half the effort) with toileting, shower, upper and lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 208 required partial assistance with personal hygiene and supervision (helper provides verbal cues) with eating and oral hygiene. During a concurrent observation in Resident 208's room and interview on 11/11/2024 at 10:58 AM, Resident 208 was observed awake and was sitting on his bed. Resident 208's call light was observed attached to the wall which was approximately seven (7) feet from the resident. The call light was observed to only have a short metal string attached to it which was approximately 3 to four (4) inches in length. Resident 208 stated, There was no way I could reach the call light so I can request for help. During an interview on 11/14/2024 at 9:16 AM, RN 1 stated Resident 208 would not be able for reach the call light to ask for help if there was no string/ cord attached to it. During a review of the facility's Policy and Procedure (P&P) titled, Call System, Resident, dated September 2022, the P&P indicated that residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. The policy also indicated that if the resident has a disability that prevents him/her from making use of the call system, an alternate means of communication that is usable for the resident is provided and documented in the care plan.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099 Based on interview and record review, the facility failed to follow its Advance Directive (a written instruction, such as a living will or durable power of attorney for health care, recognized under State law relating to the provision of health care when the resident is incapacitated [clinical state in which a resident is unable to participate in a meaningful way in medical decisions]) policy for one (1) of four (4) sampled residents (Resident 208) by failing to inform and provide the resident a written information on the option to formulate an advance directive. This deficient practice had the potential for Residents 208 to not be informed of his right to formulate an advance directive and for the staff not to carry out the resident's wishes regarding health care decisions during an emergency. Findings: During a review of Resident 208's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] and was with diagnoses that included muscle wasting and atrophy (loss of muscle tissue) and lack of coordination (poor muscle control and clumsy movements which can affect a person's ability to walk). During a review of Resident 208's Minimum Data Set (MDS, a federally mandated assessment tool), dated 11/4/2024, the MDS indicated Resident 208 had moderate cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 208 required substantial assistance (helper does more than half the effort) with toileting, shower, upper and lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 208 required partial assistance (helper does less than half the effort) with personal hygiene and supervision (helper provides verbal cues) with eating and oral hygiene. During a review of the Advance Directive Acknowledgement Form, the advance directive acknowledgement form indicated to initial and acknowledge one of the following statements: 1. I have been given written materials and informed about my right to accept or refuse medical treatment. 2. I have been informed of my rights to formulate an advance directive. 3. I understand that I am not required to have an advance directive in order to receive medical treatment at this healthcare facility. 4. I understand that the terms of any advance directive that I executed will be followed by the health care facility and my care givers to the extent permitted by law. The Advance Directive Acknowledgement Form further indicated to check one of the following statements: (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. I have executed an advance directive. 2. I have not executed an advance directive. a. I decline to execute an advance directive. b. I wish to execute an advance directive. During a concurrent interview and review on 11/11/2024 at 2:48 PM, Licensed Vocational Nurse 1 (LVN 1) confirmed Resident 208 did not have an advance directive. LVN 1 stated Resident 208's Advance Directives Acknowledgement form in the resident's chart was blank. LVN 1 stated the Advanced Directives Acknowledgement form should be filled out. During an interview on 11/13/2024 at 9:30 AM, the Social Services Director (SSD) stated the facility fills out the Advance Directives Acknowledgement form upon admission and as soon as possible. SSD also stated the Advance Directives Acknowledgement form should be completed so the residents will know that they have the right to formulate an advance directive. SSD stated the advance directive will assist the staff in carrying out the resident's wishes in case of emergency.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099 Based on observation, interview, and record review, the facility failed to provide a safe, clean, and homelike environment for two (2) of six (6) sampled residents (Residents 45 and 208) as indicated on the facility's policy when: - Residents 45's overhead lights in the resident's room did not have a bulb. - Resident 208's wheelchair had multiple holes and ripped edges on its seat. Resident 208's overhead lights in Resident 28's room did not have a cord to turn the lights on and off. These deficient practices have the potential to negatively affect Resident 45 and 208's safety and quality of life. Findings: - During a review of Resident 45's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included muscle wasting and atrophy (loss of muscle tissue) and metabolic encephalopathy (metabolic encephalopathy (a chemical imbalance of the blood in the brain). During a review of Resident 45's Minimum Data Set (MDS, a federally mandated assessment tool), dated 11/4/2024, the MDS indicated Resident 45 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 45 required partial assistance (helper does less than half the effort) with lying to sitting on side of bed, sit to stand, chair/bed to chair transfer, oral, toileting, and personal hygiene, shower, upper and lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 45 required setup assistance (helper sets up; resident completes activity) with eating. During an observation in Resident 45's room on 11/11/2024 at 9:49 AM, Resident 45 was awake and lying in bed. Resident 45's overhead light which was attached to the wall on top of the head part of the bed did not have a bulb. During an interview on 11/13/2024 at 4:48 PM, the Director of Nursing (DON) stated Resident 45 would be at risk for fall and injury if there was no overhead light in the resident's room in case resident gets up and the room is dark. - During a review of Resident 208's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included muscle wasting and atrophy and lack of coordination (poor muscle control and clumsy movements which can affect a person's ability to walk). (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 208's MDS dated [DATE], the MDS indicated Resident 208 had moderate impairment in cognitive skills for daily decision making. The MDS also indicated Resident 208 required substantial assistance (helper does more than half the effort) with toileting, shower, upper and lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 208 required partial assistance with personal hygiene and supervision (helper provides verbal cues) with eating and oral hygiene. The MDS indicated Resident 208 normally use wheelchair in the last seven (7) days. During a concurrent observation in Resident 208's room and interview on 11/11/2024 at 10:58 AM, Resident 208's wheelchair was observed with multiple holes and ripped edges on the wheelchair seats. Resident 208 stated, The wheelchair is disgusting and not fit for anyone to use. During a concurrent observation in Resident 208's room and interview on 11/11/2024 at 11 AM, Resident 208 was awake and sitting on the bed, Resident 208's overhead light was observed to be approximately seven (7) feet away from the resident. The overhead light had a short metal string which was approximately three (3) to four (4) inches in length. Resident 208 stated he was not able to reach the overhead light to turn it on. During an interview on 11/13/2024 at 4:48 PM, the DON stated the holes and ripped edges of the wheelchair that Resident 208 was using could potentially cause injury to the resident's skin. The DON also stated Resident 208's wheelchair should have been replaced. The DON stated Resident 208 was at risk for fall and injury at night if he could not reach the light to turn it on. During an interview on 11/14/2024 at 9:16 AM, Registered Nurse 1 (RN 1) stated holes and ripped edges on Resident 208's wheelchair seats would not be comfortable to sit on and could scratch the resident's skin. RN 1 also stated Residents 45 and 208's rooms would be dark on their respective side at night and the residents could potentially trip and fall. During a review of the facility's Policy and Procedure (P&P) titled, Quality of Life-Homelike Environment, revised May 2017, the P&P indicated that Residents are provided with a safe, clean, comfortable, and homelike environment. The policy also indicated that the Staff shall provide person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. The policy further indicated that comfortable lighting and adequate lighting is provided in all areas of the facility to promote safe, comfortable, and homelike environment which included emphasis on night lighting to promote safety and independence. During a review of the facility's P&P titled, Maintenance Service, revised December 2009, the P&P indicated that maintenance service shall be provided to all areas of the building, grounds, and equipment. The policy also indicated that maintenance personnel shall follow established safety regulations to ensure the safety and well-being of the concerned. During a review of the facility's P&P titled, Therapy Rooms, Equipment, and Supplies, revised December 2009, the P&P indicated that therapeutic equipment, supplies, and space are available to meet the therapeutic needs of the residents. The policy also indicated that therapists are responsible for maintaining assigned equipment in a safe, clean, and usable manner.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099 Based on observation, interview, and record review, the facility failed to ensure resident with Language barrier was provided a communication board (pre-printed board that has pictures, numbers, and user defined images that allows a resident to point or indicate on the board what he/she wants communicated) with the language that the resident was able to understand for two of three sample residents (Resident 24 and 28) in accordance with the facility policy and procedure. This deficient practice prevented the residents from communicating with the staff and had a potential to delay receiving appropriate care/treatment the residents needed. Findings: 1. During a review of Resident 24's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it harder to breath) and dementia (loss of cognitive functioning such as thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities). During a review of Resident 24's Care Plan which, re-evaluated on 12/2024, the Care Plan indicated a concern/problem related to language barrier (Language #2) with an approach/plan for translator /communication devices as indicated. During a review of Resident 24's Minimum Data Set (MDS, a federally mandated assessment tool), dated 9/18/2024, the MDS indicated Resident 24 had severe impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 24 required supervision (helper provides verbal cues) with shower, upper and lower body dressing, and putting on/taking off footwear and personal hygiene. The MDS further indicated Resident 24 required setup assistance (helper sets up; resident completes activity) with oral and toileting hygiene and was independent with eating. The MDS indicated Resident 24's preferred languages were Language 2 and Language 3. The MDS also indicated Resident 24 needed or wanted an interpreter to communicate with a doctor or health care staff. During a concurrent observation in Resident 24's room and interview on 11/11/2024 at 9:23 AM, Resident 24 was seen sitting on the side of the bed and did not have a communication board at bedside. During a concurrent observation in Resident 24's room and interview on 11/12/2024 at 9:18 AM, Certified Nursing Assistant 1 (CNA 1) was unable to communicate with Resident 24. Resident 24 did not reply to CNA 1 when she tried to communicate with her in English. During an interview on 11/13/24 at 4:32 PM, the Director of Nursing (DON) stated there should be a communication board at Resident 24's bedside for the staff to understand what the resident's needs are with regards to her care. (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/14/2024 at 9:09 AM, Registered Nurse 1 (RN 1) stated Resident 24 should have a communication board so the resident would understand and know how to communicate with the staff. RN 1 also stated their communication board are usually located in the nurse's station. During a concurrent observation and interview on 11/14/24 at 11:30 AM, RN 1 was unable to find the communication board in both Nurses Station 1 and 2. 45523 2. During a review of Resident 28's Admission Record, the Admission Record indicated Resident 28 was initially admitted to the facility on [DATE] and re admitted on [DATE] with a diagnosis that included but not limited to polyneuropathies (can affect multiple movements in different parts of the body like weakness in the arms or legs), COPD, type 2 diabetes (a chronic disease caused by high levels of sugar in the blood), schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), bipolar (a mental illness that causes extreme shifts in mood, energy, and activity levels) and primary language is English. During a review of the MDS, dated [DATE], the MDS indicated Resident 28's preferred language is Language 1 and requested an interpreter to communicate with a doctor or health care staff. Resident 28 was severely impaired in cognitive skills (ability to think, learn, remember, solve problems, and make decisions) for daily decision making and needed substantial assistance (helper does more than half the effort) from the staff for the activities of daily living such as toileting hygiene, shower, upper and lower body dressing and putting on/taking off footwear. The MDS also indicated, Resident 28 requires partial/moderate assistance (helper does less than half the effort) for toilet transfers, chair/bed to chair transfers, lying to sitting on side of bed and sit to stand. During a review of Resident 28's care plan initiated on 10/18/2024, the care plan indicated resident was found in the hallway in lying prone position because Resident 28 fell while ambulating and the outcome of the fall was a laceration (skin tear) on the right jawline. The care plan indicated interventions for Resident 28 is for staff to encourage Resident 28 to use verbal calling when assistance is needed at all times. During an observation at the facility hallway and interview on 11/11/2024 at 9:35 AM, Resident 28 seen walking in the hallway, using mobile telephone as interpreting device Resident 28 stated in Language 1 that resident speaks very little English. Surveyor and Resident 28 went in Resident 28's room ad there was no communication board (a sheet of symbols, pictures, or photos that a someone will learn to point to, to communicate with those around them) or communication aid at bedside. Observed Resident 28 using hand gestures to try to communicate with CNA 3 who was standing outside the room in the hallway. CNA 3 stated Resident 28 was asking for a pull up (a type of disposable training pant that are designed to look and feel like underwear) with hand gestures and confirmed he really did not know for sure what Resident 28 was saying and that he did not understand the language Resident 28 was speaking. (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 11/11/2024 at 9:42 AM, Resident 28 was still trying to communicate with CNA 3 using Language 1. Observed CNA 3 shaking his head and stated, he was not understanding, Resident 28. CNA3 stated he communicated with the resident by hand gestures only. CNA 3 confirmed there were no communication boards or communication aids at resident's bedside, and he did not have a way to communicate clearly with Resident 28 to know what the resident wanted or needed. Observed Resident 28 to start pacing back and forth in the hallway and waving arms up and down getting agitated because he could not communicate or be understood by CNA 3. During a concurrent interview with Resident 28 on 11/11/2024 at 9:43 AM using translating phone as communication device, surveyor asked Resident 28 to say what he needed. Resident 28 stated in Language 1 that he was hungry and wanted a snack. During an observation and interview on 11/11/24 at 9:45 AM, CNA 3 came back with AD who went inside Resident 28's room and began to speak to Resident 28 in Language 1. AD stated Resident 28 did not need anything in particular but was only asking for snack time. AD stated, When I am here I can communicate with him (Resident 28), when I am not, the staff can do hand gestures to try to communicate with him (Resident 28). We also have pictures for them to see so they can tell us what they need. We have them in Director of Staffing (DSD) office or in the medication room. AD also stated the pictures to aid residents to communicate with facility staff if their primary language is not English should also be available at the resident's bedside so they can communicate with staff and staff can communicate with the resident and understand what the resident needs. AD stated in case of an emergency, it would be hard for the staff to understand what the resident is saying. During an observation of the DSD office and in both medication rooms on 11/11/2024 at 10:00 AM, there was no communication board or translating aid available. During an interview with Minimum Data Set Staff (MDSS) on 11/14/2024 at 8:12 AM, MDSS confirmed Resident 28's admission record should have Language 1 as residents language and stated she did not know how the language of English was added to the residents admission record. During an observation of the Social Service Director (SSD) office on 11/14/2024 at 8:20 AM, there was no communication board or translating aid available in the SSD's office. During an interview with the Director of Nursing (DON) on 11/14/2024 at 8:30 AM, the DON stated it was important to provide interpreter services (a verbal form of translation that help people who speak different languages communicate with each other) and tools such as communication board for residents that spoke a different language that is not English. Per DON there was a staff that could speak in Language 1 that could translate for Resident 28 but that the staff was not in the facility all the time. The DON further stated the staff had not been in serviced on communication board and translation services and there would be potential harm to the residents in case of an emergency if the staff could not communicate with them in their own language. During an interview with Administrator on 11/14/2024 at 9:00 AM, Administrator stated there were communication boards at resident's bedside, however, the residents would sometimes walk away with them and lose them. Administrator also stated regardless, there should be other options and communication/translation devices for all staff to use to properly communicate with the residents. (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Translation and/or interpretation of Facility Services, revised 11/2020, the P&P indicated, This facility's language access program will ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information and services provided by the facility. It is understood that in order to provide meaningful access to services provided by the facility, translation and/or interpretation must be provided in a way that is culturally relevant and appropriate to the LEP individual. Staff shall be trained upon hire and at least annually on how to provide language access services to LEP residents. During a review of the facility's P&P titled, Accommodation of Needs, revised 1/2020, the P&P indicated, Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and well-being. The P&P also indicated staff will interact with the residents in a way that accommodates the physical or sensory limitations of the residents, promotes communication, and maintains dignity.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47362 Based on observation, interview and record review, the facility failed to ensure a resident who is unable to carry out activities of daily living (ADL) receives services to maintain good hygiene/ grooming for one (1) of two (2) sampled residents (Resident 8) by failing to clip Resident 8's long and dirty fingernails. This deficient practice resulted in Resident 8 not receiving fingernail care and had the potential to negatively impact Resident 8's self-esteem. Findings: During a review of Resident 8's Admission Record, the Admission Record indicated the facility admitted Resident 8 on 6/23/2014 with diagnoses which included depressive disorder (a common mental disorder. It involves a depressed mood or loss of pleasure or interest in activities for long periods of time), presbyopia (the gradual loss of your eyes' ability to focus on nearby objects), anxiety (a feeling of fear, dread, and uneasiness). During a review of Resident 8's H&P, dated 6/27/2024, the H&P indicated Resident 8 have the capacity to understand and make decisions. During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8's cognition (processes of thinking and reasoning) was intact. The MDS indicated independent on eating, substantial maximal assistance on toileting hygiene, personal hygiene. During a concurrent observation and interview on 11/11/2024 at 9:56 AM in Resident 8's room, Resident 8's fingernails on both hands were long and the fingernails on the right hand were dirty (with soil like- brownish to blackish in color debris under the nails). Resident 8 stated her fingernails were dirty, and nobody comes to cut them. Resident 8 also stated her nails are filthy, and she has been asking facility staff for clippers for a long time (unable to recall since when). During a concurrent observation, interview and record review on 11/12/2024 at 12:32 PM with License Vocational Nurse (LVN 3), LVN 3 stated Resident 8's fingernails were dirty, it has black, brown, and yellowish substance on and under the fingernails on the right hand. LVN 3 stated resident's fingernails on both hands needs to be kept trimmed and clean all the time. LVN 3 stated, it was important to keep the resident's fingernails short and clean, so the resident do not harm themselves by accidentally scratching themselves, and it was a potential to harbor bacteria (very small organisms that are found everywhere and are the cause of many diseases). LVN 3 also stated there was no care plan on Resident 8's chart indicating resident was refusing fingernails trimming. During a concurrent observation in Resident 8's room and interview on 11/12/2024 at 2:02 PM with LVN 4, LVN 4 stated Resident 8's fingernails are long, and there is thick discoloration with blackish brown and yellowish substance under the resident's fingernails. LVN 4 also stated the resident's fingernails are not supposed to be long, it might scratch the resident's skin, possible harbor bacteria that can cause sickness like diarrhea or stomachache. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same interview and record review on 11/12/2024 at 2:02 PM with LVN 4, Resident 8's care plan titled ADL Self-Care Deficit dated 3/4/2024 was reviewed. The care plan indicated the goal for resident will be clean, dry, and well-groomed daily. The care plan also indicated to assist resident with grooming and trimming of fingernails. During interview on 11/13/2024 at 4:22 PM with the Director of Nursing (DON), the DON stated all residents should have good hygiene, to prevent infection specially when eating. The DON stated fingernails should be trimmed to prevent the resident from scratching self. During a record review of facility's Policies and Procedures (P&P) titled Activities of Daily Living (ADL), Supporting date revised 3/2018 indicated, residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL's). The P&P indicated, residents who are unable to carryout ADL's independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming and oral care.		

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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. 47362 Based on observation, interview, and record review, the facility did not maintain an accident-free environment for one of 15 sampled resident (Resident 8) by failing to ensure there were no open A&D ointment (medication used as a moisturizer to treat or prevent dry, rough, scaly, itchy skin and minor skin irritations ,such as diaper rash, skin burns from radiation therapy) at Resident 8's bed side table. This failure had the potential to cause injury and harm in the event the medication was ingested by residents here in La Union. Findings: During a review of Resident 8's Admission Record, the Admission Record indicated the facility admitted Resident 8 on 6/23/2014 with diagnoses which included depressive disorder (a common mental disorder. It involves a depressed mood or loss of pleasure or interest in activities for long periods of time), Presbyopia (the gradual loss of your eyes' ability to focus on nearby objects), anxiety (a feeling of fear, dread, and uneasiness). During a review of Resident 8's History and Physical Examination (H&P), dated 6/27/2024, the H&P indicated Resident 8 does have capacity to understand and make decisions. During a review of Resident 8's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/3/2024, the MDS indicated Resident 8's cognitive (processes of thinking and reasoning) skills for daily decision making was intact. The MDS indicated Resident 8 was independent with eating, and required substantial maximal assistance (helper does more than half the effort) with toileting hygiene, personal hygiene. During an observation in Resident 8's room on 11/11/2024 at 9:56 AM, Resident 8 was in bed awake. There was an unattended opened A&D ointment was seen on Resident 8's bedside table. During a concurrent observation in Resident 8's room and interview on 11/11/2024 at 10:02 AM with Certified Nursing Assistant 1 (CNA1), CNA 1 stated that an unattended opened A&D ointment was left on Resident 8's bed side table. During a concurrent review of Resident 8's chart and interview with Licensed Vocational Nurse 3 (LVN 3) on 11/12/2024 at 2:12 PM, LVN 3 stated the facility staff should not leave an A&D ointment by Resident 8's bedside table because if ingested accidentally, it can cause harm for those residents that are wandering. LVN 3 stated no order on Resident 8's chart indicating Resident 8 can self-administer medication. During interview on 11/13/2024 at 4:24 PM with the Director of Nursing (DON), the DON stated open medication left at bedside was not acceptable. The DON stated the residents might consume or eat the medication, especially if have psych patients people with serious mental illness are living in nursing. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's Policy and Procedure (P&P) titled, Safety and Supervision of Residents date revised 7/2017, indicated Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accident are facility- wide priorities. During a review of facility's P&P, titled Homelike Environment, date revised 2/2021 indicated The residents are provided with safe, clean comfortable and homelike environment.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 45099 Based on observation, interview, and record review, the facility failed to ensure the Daily Staffing Report (Nurse Staffing Information) posted was accurate and complete in accordance with the facility's policy and procedure by failing to: 1. Ensure the Daily Staffing Report on 11/11/2024 was posted. 2. Reflect the correct total number and actual hours of certified nursing assistants directly responsible for resident care for 11/8/2024, 11/11/2024, 11/12/2024, and 11/13/2024. These deficient practices had the potential for residents and visitors not being informed of the census and staffing for the facility. Findings: 1. During an observation on 11/11/2024 at 7:42 AM, the Daily Staffing Report located at the front lobby area was dated 11/8/2024. During an interview on 11/13/2024 at 12:50 PM, the Director of Staff Development (DSD) stated posted Daily Staffing Report had to be accurate so the nurses, visitors and family members would know the facility had enough staff coverage for the 24-hour period. During an interview on 11/13/2024 at 4:55 PM, the Director of Nursing (DON) stated the posted Daily Staffing Report should be accurate and updated to make sure the facility was not short staffed and are following Nursing Hours Per Patient Day (NHPPD - a tool that measures the number of hours of direct patient care provided by the nurses and other staff per patient day) staffing regulation. The DON also stated the DSD was responsible in posting the Daily Staffing Report from Monday to Friday and the Registered Nurse (RN) supervisors would post the Daily Staffing Report on weekends. 2. During a review of the Daily Staffing Report, the Daily Staffing Report posted for 11/8/2024 indicated a census of 57 and a total number of seven (7) Certified Nursing Assistants (CNAs) for day shift. During a concurrent review of the Daily Staffing Report, Facility Staffing Assignment, and Sign-In Sheet on 11/14/2024 at 9:44 AM, the following were reviewed and verified by the DSD: a. On 11/8/2024, the Daily Staffing Report indicated a census of 57 and a total number of 7 CNAs for day shift. Facility Nurse Staffing Assignment and Sign-In indicated the facility had a total of eight (8) CNAs (as opposed to 7 CNAs listed on the Daily Staffing Report) for day shift. b. On 11/11/2024, the Daily Staffing Report indicated a census of 56 and a total number of 7 CNAs for day shift. The Facility Staffing Assignment and Sign-In Sheet, indicated the facility had a total of six (6) CNAs (as opposed to 7 CNAs listed on the Daily Staffing Report) for day shift. (continued on next page)		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	c. On 11/12/24, the Daily Staffing Report posted indicated a census of 57 and a total number of 8 CNAs for evening shift. The Facility Staffing Assignment and Sign-In Sheet indicated the facility had a total of 7 CNAs (as opposed to 8 CNAs listed on the Daily Staffing Report) for evening shift. d. On 11/13/2024, the Daily Staffing Report posted indicated a census of 56 and a total number of five (5) CNAs for night shift. The Facility Staffing Assignment and Sign-In Sheet indicated the facility had a total of four (4) CNAs (as opposed to 5 CNAs listed on the Daily Staffing Report) for night shift. During an interview on 11/14/2024 at 10:08 AM, the DSD stated that Posted Daily Staffing Report should be accurate. The DSD also stated inaccurate Posted Daily Staffing Report could affect the quality of care provided to the residents if the facility had less CNA's so the facility should maintain the right ratio for CNAs. During a review of the facility's Policy and Procedure (P&P) titled, Posting Direct Care Daily Staffing Numbers, revised August 2022, the P&P indicated that the facility will post on a daily basis for each shift nurse staffing data, including the numbers of Nursing personnel responsible for providing direct care to the residents. The policy also indicated that within two (2) hours of the beginning of each shift, the number of licensed (RNs and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for residents' care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523 Based on observation, interview, and record review, the facility failed to ensure the storage, preparation and distribution of food was done under sanitary conditions (clean and healthy) in accordance with the facility policy by failing to ensure : - Food items inside kitchen produce refrigerator and dry storage (a method of conserving temperature and humidity without the need for refrigeration) were labeled with a received date and/ or expiration date, and expired food items were discarded and not mixed with other non-expired foods. - Chlorine Test Paper strips (to measure the concentration of free available chlorine in sanitizing solutions [diluted mixture of chemical agent, most commonly a bleach solution, used to kill bacteria on surfaces like countertops, cutting boards, utensils after they have been cleaned, effectively reducing the number of germs to a safe level]) were not expired to make sure the dishwasher was sanitized (made clean, hygienic, disinfected) properly. These deficient practices had the potential to result in pathogen (germ) exposure to 57 of 57 residents and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever and can lead hospitalization . Findings: - During a concurrent initial observation of the kitchen produce refrigerator and dry storage area and interview with the Dietary [NAME] on [DATE] at 7:46 AM, [NAME] confirmed some of the food items inside the kitchen produce refrigerator were not labeled and did not have date opened or expiration date. [NAME] further stated today's date was [DATE] and some of the food had passed the use by date and was expired. [NAME] stated the following food observed in the produce refrigerator and dry storage area were as follows: - Parmesan cheese with best by (use by) date of [DATE]. - Ground pork with a date of [DATE] written on the package. The date did not indicate if this was a best buy or received date - Cups filled with red liquid placed on a tray with no serve by date. - Cups filled with milk placed on a tray with a label indicating milk - juice for breakfast [DATE] no serve by date. During the same interview with [NAME] on [DATE] at 7:53 AM, [NAME] stated it was important to label the food as soon as food container is opened or first used, to prevent confusion. [NAME] stated, this places the residents with the risk of eating expired food that can cause sickness like stomachache, diarrhea. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent observation and interview with the Dietary Staff Supervisor (DSS) on [DATE] at 8:13 AM at the dish washing station, DSS stated the staff wash the dishes by hand first then run them through the dishwasher to sanitize them. During a concurrent observation and interview with the Dishwashing Staff on [DATE] at 8:17 AM, Dishwashing staff stated she uses a chlorine test paper to make sure the dishwasher machine is properly sanitized. Observed chlorine test paper strip bottle to be empty and with expiration date of ,d+[DATE]. Dishwasher staff stated she used the last strip inside the bottle today. Observed [NAME] who brought in a different bottle of test strips. The other chlorine test paper bottle had an expiration date of ,d+[DATE]. Dishwashing staff and cook confirmed both bottles of test strips were expired. Dishwashing staff stated if she was using the expired test strips then the information and test results were not correct, and she was not doing the job correctly. I do use the strips inside the bottle, I didn't check the expiration date. It is important to check for expiration date because if I use the strips and they are expired, then the results are wrong, and it can cause the residents harm by serving their food on plates that have not been sanitized and cleaned properly. During concurrent observation at the dishwashing station and interview with the DSS on [DATE] at 8:25 AM, DSS confirmed both bottles of test paper strips were expired. DSS stated, the bottles of the chlorine test paper strips that were expired were the testing strips the staff had been using. DSS further stated the importance for the dishwasher machine to be properly sanitized was to prevent cross contamination (occurs when microorganisms [bacteria, parasites, viruses] are transferred from a food where they occur naturally to one where they do not naturally occur such as a cutting board or utensils). DSS stated, if the test strips are expired, I would not trust the results and it should not have been used. DSS also stated that it might not show if the machine is sanitized the and the facility might not get the right readings. During a review of the facility's undated Policies and Procedures (P&P) titled, Storage of Food and Supplies, the P&P not dated, indicated, 8. Labels should be visible All food will be dated-month, day, year. No food will be kept longer than the expiration date on the product. 11. Liquid foods which have been opened will be labeled and dated. During a review of the facility's undated P&P titled, Dishwashing, not dated, indicated, All dishes will be properly sanitized through the dishwasher. The dishwasher will be kept clean and in good working order. 4. The dish machine is to be serviced on a regular basis by a technician to ensure accurate measurements of sanitizing agents.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555825	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER San Marino Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 45099 Based on interview and record review, the facility failed to maintain facility staff documentation of the current Coronavirus disease 2019 (COVID-19, a disease caused by a virus named SARS-CoV-2 which stands for severe acute respiratory syndrome coronavirus 2) vaccination status for four (4) of 73 facility staff as indicated in the facility's policy. This deficient practice had the potential to not accurately reflect which facility staff were at risk from contracting the COVID-19 disease which could potentially spread to other staff and the residents. Findings: During a concurrent interview and record review on 11/13/2024 at 3:50PM, the Infection Prevention Nurse (IPN) confirmed the Employee COVID-19 Vaccination log was not updated to reflect the 4 staff vaccinated with the current COVID-19 vaccine. The IPN stated the 4 staff vaccinated with the current COVID vaccine included herself, the Director of Staff Development (DSD), the Dietician and one of the Activity Assistant. The IPN also stated the Employee COVID-19 Vaccination log did not have an accurate list of staff that received the current COVID-19 vaccine. During an interview on 11/13/2024 at 4:13 PM, the IPN stated the Employee COVID-19 Vaccination log should be updated so that the facility would know who among the staff are at risk of contracting COVID-19 disease. During an interview on 11/13/2024 at 4:50 PM, the Director of Nursing (DON) stated the facility should have a current list of staff with COVID-19 Vaccine to identify who are high risk of getting the COVID-19 disease and who among the staff had any co-morbidities that pose a much higher risk for contracting COVID-19 disease. The DON also stated that Employee COVID-19 Vaccination log must be up to date for accurate reporting to National Healthcare Safety Network (NHSN, is a national healthcare -associated infection [HAI] reporting system developed and maintained by Centers of Disease Control and Prevention) and California Immunization Registry (CAIR, a secure, confidential, and computerized system that tracks immunization records for California residents). The DON further stated the residents could catch the COVID-19 disease from unprotected staff who could be asymptomatic (no symptoms). During a review of the facility's undated Policy and Procedure titled, Coronavirus Disease (COVID-19) - Vaccination of Staff, indicated that the IP maintains a tracking worksheet of staff members and their vaccination status. The policy also indicated that the tracking worksheet provides the most current vaccination status of all staff who provide any care, treatment, or other services for the facility and/or its residents.		