

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

Printed: 07/18/2026
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 01/09/2026
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 - Some	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** Based on observation, interview, and record review, the facility failed to promote dignity and respect for three (3) of three residents (Resident 8, 7, and 39) reviewed under dignity care area when: Certified Nursing Assistant 1 (CNA 1) used labels to address Resident 8 on 1/6/2026. CNA 1 used labels to address Resident 7 and was standing over while assisting the resident during meals on 1/6/2026. Facility staff used labels when addressing Resident 39 on 1/6/2026, 1/7/2026 and 1/8/2026. These deficient practices had the potential to affect Resident 8, 7, and 39's sense of self-worth and self-esteem which could negatively affect the residents' emotional and mental well-being. Findings: 1. During a review of Resident 8's admission Record, the admission Record indicated Resident 8 was admitted to the facility on [DATE]. Resident 8's diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral vascular accident (CVA, or stroke is an interruption in the flow of blood to cells in the brain) of the left non-dominant side, anxiety disorder (a disorder characterized by nervousness characterized by a state of excessive uneasiness and apprehension, typically with compulsive behavior [repetitive, persistent, and often uncontrollable actions that a person feels driven to perform] or panic attacks), and major depressive disorder (or also called clinical depression, it affects how you feel, think and behave and can lead to a variety of emotional and physical problems). During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated 12/3/2025, the MDS indicated Resident 8 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 8 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, roll left and right, sit to lying, and lying to sitting on the side of the bed. During an observation on 1/6/2026 at 12:29 PM in Resident 8's room, Resident 8 stated Did you (referring to CNA 1) get me some ice for my water? CNA 1 stated, Yes, my dear. Resident 8 got upset and screamed at CNA 1 and Resident 8 stated Just put down my ice water in front of me! During an observation on 1/6/2026 at 1:25 PM in Resident 8's room, Resident 8 called CNA 1 to turn on her fan. CNA 1 replied to Resident 8 and stated, Yes, my dear. During an interview on 1/8/2026 at 12:31 PM with CNA 1, CNA 1 stated they were not supposed to address residents using labels such as my dear. CNA1 stated that the staff should address residents by the names they prefer in order to maintain dignity and respect. During a review of the facility's policy and procedure (P&P) titled, Quality of Life - Dignity revised on 2/2020, the P&P indicated Staff shall speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs. 2. During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 7's diagnoses included ataxia (poor muscle control that causes clumsy or awkward movements, having trouble walking or balancing), dementia (a progressive state of decline in mental abilities), and dysphagia (difficulty swallowing) During a review of Resident 7's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily (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:	Facility ID: 555825
		If continuation sheet Page 1 of 31

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	decision making were moderately impaired. The MDS indicated Resident 7 was dependent on eating, oral hygiene, toileting hygiene, shower/bathe self, upper body and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on the side of the bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub shower transfer. During the dining observation on 1/6/2026 at 12:44 PM in Resident 7's Room, Resident 7 was seated in her wheelchair. CNA 1 was observed initially sitting on a chair then observed standing over Resident 7 while feeding the resident. During an interview on 1/6/2026 at 1:33 PM. CNA 1 stated, Sometimes it takes time to assist the feeders. I have two feeders. The other feeder was transferred to the hospital. During an interview on 1/8/2026 at 12:29 PM with CNA 1, CNA 1 stated staff need to be at resident's eye level when assisting residents during meals to promote dignity and respect. CNA 1 stated that she is petite and usually sits on a low folding chair. CNA 1 stated that she kept standing while assisting Resident 7 with her meal because she could not adjust the chair height to be at eye level with Resident 7. During an interview on 1/8/2026 at 2:58 PM with CNA 1, CNA 1 stated staff were not supposed to call the residents who were dependent on staff for eating as feeders because it does not promote respect and dignity. During a review of the facility's P&P titled, Assistance with Meals, revised 7/2017, the P&P indicated Residents requiring full Assistance: residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example:Not standing over residents while assisting them with meals.Avoiding the use of labels when referring to residents (e.g. feeders) 3. During a review of Resident 39's admission Record, the admission Record indicated Resident 39 was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 39's diagnoses included metabolic encephalopathy (ME, occurs when problems with your metabolism cause brain dysfunction), dysphagia, dementia, and history of falling. During a review of Resident 39's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 39 was dependent on oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, toilet transfer and tub/shower transfer. During an observation on 1/6/2026 at 1:27 PM in Resident 39's room, Resident 39 was seated in her wheelchair when CNA 6 entered the room to ask if Resident 39 was ready for activities. CNA 1 stated, Yes, she's finished eating. See, she understood me! Right, girl! Give me two thumbs up. During an observation on 1/7/2026 at 12:37 PM in Resident 39's room, Resident 39 was seated in her wheelchair. CNA 5 stated, Hi sweetie (to Resident 39), she (the surveyor) wants to speak to you. During an observation on 1/7/2026 at 12:44 PM in Resident 39's room, CNA 5 stated, Hold on sweetie (to Res 39). CNA 5 stated, We should not call residents 'sweetie'. We should address them by their names because we need to respect them. We should call them Miss or use their first or last names. During an observation on 1/8/2026 at 12:20 PM in Resident 39's room, Resident 39 was seated in her wheelchair eating her lunch. CNA 4 stated, Mama [NAME] (to Resident 39) are you hungry? Mama, Look.During an interview on 1/8/2026 at 12:25 PM with CNA 4, CNA 4 stated it was not appropriate to call Resident 39 Mama [NAME]. CNA 4 stated that the staff should address residents by their first or last names to maintain dignity. During a review of the facility's undated P&P titled, Quality of Life - Dignity, the P&P indicated Residents are treated with dignity and respect at all times.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review, the facility failed to follow its policy to maintain a safe, clean, comfortable, and homelike environment for three (3) of five (5) sampled residents (Residents 2, 4, and 44) under environment task, when the facility failed to ensure: Resident 2's room was free of trash on the floor, and the wall did not have splattered brownish colored stains. Resident 4's wheelchair was in good condition, with no peeling armrests. Resident 44's wheelchair was in good condition, with no peeling armrests. These deficient practices had the potential to negatively affect Residents 2, 4, and 44 well-being and quality of life. Findings: 1. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE], Resident 2's diagnoses included hydronephrosis (swelling of the kidney) with renal and ureteral calculous (kidney stones) obstruction (preventing urine flow), cirrhosis of the liver (is permanent scarring that damages your liver and interferes with its functioning) and pancytopenia (a lower-than-normal count of all three types of blood cells: red blood cells [anemia], white blood cells [leukopenia], and platelets [thrombocytopenia]) During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool) dated 11/21/2025, the MDS indicated Resident 2 had moderately impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 2 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in toileting hygiene, shower/ bathe self, lower body dressing, putting on/ taking off footwear, sit to stand, and chair/ bed-to-chair transfer. During a concurrent observation and interview on 1/7/2026 at 12:53 PM in Resident 2's Room, Resident 2 was lying on his bed eating cookies. The floor had multiple used tissues scattered, and the wall had splattered brownish stains. Resident 2 stated that he dropped the used tissues on the floor because he could not find the trash can. During a concurrent observation and interview on 1/7/2026 at 12:59 PM with Housekeeper 1 (HSK 1) in Resident 2's room, the wall was observed to have splattered brownish colored stains. HSK 1 stated that the stains might be from juice or coffee. HSK 1 added that the wall needed to be cleaned to prevent bacteria growth and to reduce the risk of Resident 2 becoming ill. During a concurrent observation and interview on 1/7/2026 at 1:01 PM with Certified Nursing Assistant 2 (CNA 2) in Resident 2's room, multiple used tissues were still on the floor. CNA 2 picked up the garbage can from the corner of the room, then used gloved hands to collect the tissues and placed the garbage can near Resident 2's bed. CNA 2 stated that the room needed to be kept clean and trash removed from the floor to maintain infection control. During a concurrent observation and interview on 1/7/2026 at 1:02 PM with Licensed Vocational Nurse 1 (LVN 1) in Resident 2's room, the wall was observed to have splattered brownish stains. LVN 1 stated that the stains were from coffee and that the wall was dirty. LVN 1 added that housekeeping (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should clean the wall to maintain infection control. During an interview on 1/7/2026 at 1:03PM with Resident 2, Resident 2 stated he did not throw coffee on the wall. Resident 2 stated that he did not throw coffee on the wall. Resident 2 stated that he was trying to place his coffee cup on the corner of the table in front of him, but he missed, and the cup fell on the floor, causing a mess. Resident 2 stated the housekeeper mopped the floor but did not clean the wall. During a review of the facility's policy and procedure (P&P) titled, Cleaning and Disinfection of Environmental Surfaces. revised 8/2019, the P&P indicated, 9. Housekeeping surfaces (e.g. floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. 11. Walls blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled. 2. During a review of Resident 4's admission Record, the admission Record indicated the facility admitted Resident 4 on 8/1/2025. Resident 4's diagnoses included dementia (progressive brain disorder that slowly destroys memory and thinking skills), schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). During a review of Resident 4's MDS, dated [DATE]. The MDS indicated Resident 4's cognitive (processes of thinking and reasoning) skills for daily decision making were moderately impaired. The MDS indicated Resident 4 required partial moderate assistance (helper does less than half the effort) on toilet hygiene, shower bathe self (the ability to bathe self), personal hygiene (the ability to maintain personal hygiene. The MDS also indicated Resident 4 used manual wheelchair as mobility device. During an observation on 1/6/2026 at 12:10 PM, Resident 4 was in the hallway sitting in her wheelchair. The wheelchair's left armrest black leather covering was cracked and torn, exposing the foam padding. During a concurrent observation and interview on 1/7/2026 at 2:40 PM with the Social Services Director (SSD), the SSD stated that the armrest of Resident 4's wheelchair was ripped, and the foam was exposed. During an interview on 1/7/2026 at 2:45 PM, Resident 4 stated, I want a new wheelchair. 3. During a review of Resident 44's admission Record indicated the facility admitted Resident 44 on 1/15/2025. Resident 4's diagnoses included major depressive disorder, seizure (a sudden and temporary change in the electrical and chemical activity in the brain which leads to a change in a person's movement, behavior, level of awareness and/or feelings), muscle weakness. During a review of Resident 44's MDS, dated [DATE]. The MDS indicated Resident 44's cognitive skills for daily decision making were cognitively intact (skills for daily decision making were intact). The MDS indicated Resident 44 required substantial maximal assistance (helper does more than half (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the effort) on toilet hygiene, shower bathe self, personal hygiene. The MDS also indicated Resident 44 used manual wheelchair as mobility device. During a concurrent observation and interview on 1/6/2026 at 9:54 AM with Resident 44, while seated in his room in his wheelchair, Resident 44 stated that the wheelchair armrests were old, peeling, and rough on the skin. During a concurrent observation and interview on 1/7/2026 at 2:53 PM with the SSD, the SSD stated that the armrest of Resident 44's wheelchair was peeling. The SSD stated that residents could possibly feel discomfort, which could cause skin tears, and that peeling armrests can harbor bacteria. The SSD also stated that wheelchairs should be in good condition. During a concurrent interview and record review on 1/8/2026 at 8:31 AM with Licensed Vocational Nurse (LVN 2), the facility's policy and procedure (P&P) titled, Maintenance Services, revised in 12/2009 was reviewed. LVN 2 stated that the P&P indicated maintenance services shall be provided to all areas of the building, grounds, and equipment. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. LVN 2 also stated that the facility did not follow the P&P, as the wheelchair armrest was not in good condition.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review, the facility failed to provide grooming services for two (2) of three (3) sampled residents (Resident 9 and 22) under activities of daily living (ADLs- are activities related to personal care that include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating) care area, in accordance with the facility's policy. This deficient practice resulted in Resident 9 and 22 having long and jagged (having rough, sharp points protruding) fingernails, potentially leading to skin injury, infection, and scarring (mark left on the skin after a wound or injury has healed). Findings: 1. During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was initially admitted to the facility on [DATE] with diagnosis which included lack of coordination, type 2 diabetes mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). During review of Resident 9's Minimum Data Set (MDS, a resident assessment tool), dated 11/7/2025, the MDS indicated Resident 9's cognitive skills (processes of thinking and reasoning) for daily decision-making skills were moderately impaired (decisions poor, cues supervision required). The MDS indicated Resident 9 required partial moderate assistance (helper does less than half the effort) with eating, oral hygiene (the ability to use suitable items to clean teeth, dentures if applicable), shower bathe self (the ability to bathe self), personal hygiene (the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing and drying face and hands). During a review of Resident 9's Care Plan, dated 11/5/2025, the Care Plan indicated the resident has an ADL self-care performance deficit and was at risk for further decline in functional abilities. The care plan intervention indicated to assist with ADLs as needed, and to assist with grooming and trimming fingernails. During an observation on 1/6/2026 at 12:28 PM in Resident 9's room, Resident 9's fingernails had visible food debris around the nail edges. The fingernails were discolored with a yellowish-black substance underneath and were chipped and jagged. During a concurrent observation and interview on 1/7/2026 at 2:22 PM with the Social Service Director (SSD), the SSD stated Resident 9's fingernails were dirty and had yellowish- black to brownish spots. The SSD also stated the nurse should wash the resident's hands before and after eating for hygiene and sanitation. The SSD stated that poor hand hygiene can possibly cause illnesses like diarrhea and stomach upset. 2. During a review of Resident 22's admission Record, the admission Record indicated Resident 22 was initially admitted to the facility on [DATE] with diagnosis which included depression (severe feelings of sadness and hopelessness), schizoaffective disorder (a mental illness that causes loss of contact with reality), dementia (progressive brain disorder that slowly destroys memory and thinking skills). During review of Resident 22's MDS, dated [DATE], the MDS indicated Resident 22's cognitive skills for daily decision-making skills were moderately impaired. The MDS indicated Resident 22 required partial moderate assistance with oral hygiene, shower bathe self and personal hygiene. During a review of Resident 22's Care Plan, dated 3/7/2025, the Care Plan indicated the resident has an ADL self-care performance deficit and was at risk for further decline in functional abilities related to impaired mobility, weakness and difficulty in walking. The care plan intervention indicated to assist with ADLs as needed, and to assist with grooming and trimming fingernails. During an observation on 1/6/2026 at 10:07 AM in the hallway, Resident 22's fingernails were observed to be jagged with visible black residue underneath. During a concurrent observation and interview on 1/7/2026 at 2:28 PM with the SSD, the SSD stated Resident 22's fingernails were dirty and jagged with black debris on the nails. The SSD stated Resident 22's nails need to be trimmed, cleaned and smoothed to prevent skin injuries. During a concurrent interview and review on 1/8/2026 at 3:20 PM with the Licensed Vocational Nurse (LVN 3), the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADL) Support, dated 2/2018, (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was reviewed. LVN 3 stated the P&P indicated residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs. LVN 3 stated the P&P was not followed. LVN3 stated Resident 9 and 22's fingernails were long, dirty, and not smooth. LVN 3 stated both Residents 9 and 22 require assistance with nail care and that nails should be kept clean for infection control purposes. LVN 3 stated residents can touch surfaces or fecal matter and may scratch themselves, which can result in cuts and increase risk of skin infections, diarrhea, and stomachache. During a concurrent interview and review on 1/8/2026 at 3:23 PM with LVN 3, the facility's P&P titled, Care of Fingernails / Toenails, dated 2/2018, was reviewed. LVN 3 stated the purpose of this procedure was to clean the nail bed, to keep nail trimmed and to prevent infections. LVN 3 stated the P&P indicated nail care includes daily cleaning and regular trimming. LVN 3 also stated the P&P was not followed. During a review of the facility's P&P titled, Care of Fingernails / Toenails, dated 2/2018, the P&P indicated to clean the resident's nail bed, to keep nail trimmed to prevent infections.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility failed to provide a safe environment for three (3) of six (6) sampled residents (Residents 6, 44, and 45) reviewed under accidents care area, as indicated on the facility policy by failing to: Ensure electrical cords were properly organized and were not wrapped around the metal bed frame of Resident 44. Implement interventions to address Resident 6's wandering behavior, who entered another resident's room. Implement interventions to address Resident 28's wandering behavior, who entered another resident's room. This deficient practice placed Resident 44, 6, and 28, as well as other residents in the facility, at risk for serious injury and/or death. Findings: 1. During a review of Resident 44's admission Record, the admission Record indicated the facility admitted Resident 44 on 1/15/2025. Resident 4's diagnoses included major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), seizure (a sudden and temporary change in the electrical and chemical activity in the brain which leads to a change in a person's movement, behavior, level of awareness and/or feelings), and muscle weakness. During a review of Resident 44's Minimum Data Set (MDS, a resident assessment and tool), dated 11/21/2025, the MDS indicated Resident 44's cognitive skills for daily decision making were cognitively intact (skills for daily decision making were intact). The MDS indicated Resident 44 required substantial maximal assistance (helper does more than half the effort) on toilet hygiene, shower bathe self, personal hygiene. During observation on 1/6/2026 at 9:59 AM at Resident 44's room, multiple electrical cords were observed coiled on the metal base of the bed and are lying loosely on the floor below the bed creating clutter area. During an observation on 1/6/2026 at 9:59 AM in Resident 44's room, multiple electrical cords were observed coiling around the metal base of the bed and lying loosely on the floor below the bed, creating a cluttered area. During a concurrent observation and interview on 1/7/2026 at 2:45 PM with the Social Services Director (SSD) in Resident 44's room, the SSD stated that a white extension cord was wrapped around the metal base of the bed. The bed's plug and cellphone charger were connected to the extension cord. The SSD stated that this created accident hazards that could cause fire, sparks, and electric shock. The SSD also stated that the resident's room was supposed to be safe, clean, and comfortable. During a concurrent interview and record review on 1/8/2026 at 8:31 AM with Licensed Vocational Nurse (LVN 2), the facility's policy and procedure (P&P) titled, Maintenance Services, revised in 12/2009, was reviewed. LVN 2 stated that the P&P indicated maintenance services shall be provided to all areas of the building, grounds, and equipment. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. LVN 2 also stated that the facility did not follow the P&P. LVN 2 stated that extension cords are not supposed to be wrapped around the metal base of the resident's bed, as this can increase the risk of falls, fire, and possible electric shock. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/8/2026 at 10:06 AM with the Maintenance Director (MD), the MD stated that octopus wiring (multiple electrical cords, plugs, power strips, and extension cords connected in a cluttered or overloaded way) was not acceptable and could cause accidents. The MD stated, We will change. During a concurrent interview and record review on 1/8/2026 at 3:42 PM with LVN 3, the facility's P&P titled, Safety and Supervision of Residents, revised 7/2017, was reviewed. LVN 3 stated that the P&P indicated the facility strives to make the environment as free from accident hazards as possible. LVN 3 stated that resident safety, supervision, and assistance to prevent accidents are facility-wide priorities. 2. During a review of Resident 6's admission Record, the admission Record indicated the facility admitted Resident 6 on 7/14/2015. Resident 6's diagnoses included dementia (progressive brain disorder that slowly destroys memory and thinking skills), hyperlipidemia (a condition in which there are high levels of fat particles in the blood), hypertension (high blood pressure). During a review of Resident 6's MDS, dated [DATE]. The MDS indicated Resident 6's cognitive skills for daily decision making were severely impaired (never/ rarely made decisions). The MDS indicated Resident 6 was independent (resident completes the activity by themselves) on eating, oral hygiene and personal hygiene. The MDS also indicated Resident 6 was independent on walking 50 feet (ft. unit of measurement) with two turns (once standing, the ability to walk at least 50 ft. and make two turns), and walking 150 ft. (once standing, the ability to walk at least 150 ft. in a corridor or similar space). During a concurrent observation and interview on 1/7/2026 at 8:38 AM with Certified Nursing Assistant (CNA 10), CNA 10 stated that Resident 6 was wandering around the hallway and entering Room A. During a concurrent observation and interview on 1/7/2026 at 1:20 PM with the Dietary Supervisor (DST), the DST observed Resident 6 enter Room A, take a glass of soda from the bedside table of Resident 30, and drink it. During an interview on 1/7/2026 at 1:25 PM with CNA 11, CNA 11 stated that Resident 6's room was not Room A. CNA 11 also stated that this was not acceptable because Resident 6 could take other residents' belongings or eat other residents' food, which may result in an allergic reaction or cause harm. During a concurrent interview and record review on 1/8/2026 at 3:45 PM of Resident 6's care plans with LVN 3, LVN 3 stated that no specific care plan for wandering from room to room was found in Resident 6's chart. LVN 3 stated that Resident 6 was a wanderer and that residents are not supposed to go into other residents' rooms for safety reasons. During a concurrent interview and review on 1/8/2026 at 3:47 PM with LVN 3, the facility's policy and procedures (P&P) titled, Care Plan Comprehensive Person-Centered, dated 3/2022, was reviewed. LVN 3 stated that the P&P indicated a comprehensive, person-centered care plan includes measurable objectives and timetables to meet the resident's physical, psychosocial (combined influence of psychological factors and the surrounding social environment on physical, emotional, and/or mental wellness), and functional needs, and is developed and implemented for each resident. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and review on 1/8/2026 at 3:49 PM with LVN 3, f the facility's P&P titled Wandering and Elopements, dated 3/2019, was reviewed. LVN 3 stated that the P&P indicated the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. LVN 3 stated that if a resident is identified as at risk for wandering, elopement, or other safety issues, the care plan will include strategies and interventions to maintain the resident's safety. LVN 3 stated that the P&P was not followed, as there should have been someone in the hallway to monitor and redirect residents. LVN 3 also stated that Resident 6 is a wanderer. 3. a. During a review of Resident 28's admission Record, the admission Record indicated Resident 28 was admitted to the facility on [DATE], Resident 28's diagnoses included dementia (a progressive state of decline in mental abilities), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), anxiety disorder (a disorder characterized by nervousness characterized by a state of excessive uneasiness and apprehension, typically with compulsive behavior [repetitive, persistent, and often uncontrollable actions that a person feels driven to perform] or panic attacks), During a review of Resident 28's Minimum Data Set (dated 11/4/2025, the MDS indicated Resident 28 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 28 needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) in toileting hygiene, shower/ bathe self, lower body dressing, putting on/ taking off footwear, sit to stand, chair/bed-to-[NAME] transfer, toilet transfer, tub/shower transfer, and walk 10 feet. a. During medication administration observation on 1/8/2026 at 8:30 AM in the hallway, Resident 28 was observed propelling his wheelchair and trying to get inside multiple Residents' rooms multiple times. During a medication administration observation in Resident 21's room on 1/8/2026 at 8:36 AM with Licensed Vocational Nurse 1 (LVN 1), Resident 28 came inside Resident 21's room while LVN 1 was administering medication to Resident 21. During a concurrent observation on 1/8/2026 at 8:37 AM in the hallway, with the Quality Assurance Nurse (QAN) and LVN, Resident 28 was observed getting out of another Resident's room. During a medication administration observation in Resident 21's room on 1/8/2026 at 8:56 AM with LVN 1, Resident 28 came inside Resident 21's room while LVN 1 was administering medication to Resident 21. During an observation on 1/8/2026 at 9:02 AM in the hallway, Resident 28 went inside another female resident's room. There were no staff observed watching Resident 28 During an observation on 1/8/2026 at 9:05 AM in the hallway, Resident 28 was propelling his wheelchair and went inside another residents' room. During an interview on 1/8/2026 at 9:05 AM with LVN 1, LVN 1 stated it was not acceptable for Resident 28 to enter other residents' room because this could be an invasion of privacy. During an interview on 1/8/2026 at 9:28 AM with Certified Nurse Assistant 7 (CNA 7), CNA 7 stated Resident 28 wanders in the hallway and into other Resident's, which is a privacy issue. CNA 7 stated (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the staff needed to redirect and supervise Resident 28 because he is confused and wandering. During an interview on 1/8/2026 at 9:38 AM with QAN, QAN stated another resident might hit Resident 28 because he was in another Resident's room. QAN stated Facility staff should always supervise and redirect Resident 28. 3b. During a review of Resident 28's History and Physical Exam (H&P), dated 11/10/2025, the H&P indicated Resident 28 had a fluctuating mental capacity with a dementia cognitive impairment. H&P indicated a plan to monitor for safety/function. During a review of Resident 28's Impaired Cognitive Function and Impaired Thought Processes. care plan, dated 12/8/2025, the care plan indicated the staff interventions included were to cue, reorient, and supervise as needed. During a review of Resident 28's Nursing Skilled Evaluation, dated 1/5/2026, the Nursing Skilled Evaluation indicated under safety note that Resident 28 needs visual monitoring while up in wheelchair and in bed. The Nursing Skilled Evaluation also indicated Resident 28's room was Room A. During an observation on 1/8/2026 at 12:34 PM in Resident 45's room (Room B) with CNA 7, Resident 28 was observed unsupervised in his wheelchair, entering Room B. Resident 45 was observed stating for Resident 28 to get out his room. During an observation on 1/8/2026 at 12:42 PM in Room B, Resident 28 was observed unsupervised in his wheelchair, reentering Room B and Resident 45 stated, Here he goes coming in again. During an observation on 1/8/2026 at 12:49 PM in the facility hallway, Resident 28 was observed unsupervised in wheelchair, entering Room B. Resident 45 was observed grabbing Resident 28's wheelchair and pushing Resident 28 out of Room B and back into the hallway. There were no staff observed in the hallway or in Room B to intervene and ensure the safety, redirection and or re-cue Resident 28. During an interview on 1/8/2026 at 1:07 PM with LVN 1, LVN 1 stated Resident 28 has Alzheimer's disease and needs to be redirected. LVN 1 stated it was unsafe for Resident 28 to enter Room B and for Resident 45 to push his wheelchair out of the room. LVN 1 stated Resident 28 could have fallen or been hit or pushed by Resident 45. LVN 1 also stated Resident 28 needed to have 1 to 1 supervision to ensure his safety because redirection does not always work because he continues to enter other resident's rooms. During an interview on 1/9/2025 at 3:03 PM with the Director of Nursing (DON), the DON stated that Resident 28 has a tendency to wander and that a CNA is usually assigned to frequently monitor him. However, the DON stated that Resident 28 should be on one-to-one supervision to ensure his safety and prevent him from entering other residents' rooms. During a review of the facility's P&P titled, Safety and Supervisions of Resident, revised on 7/2017, the P&P indicated Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The P&P also indicated the facility will have an individualized, resident-centered approach to address safety and accident hazards for individual residents and ensure interventions are implemented.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor the use of anticoagulant therapy (AC, a medical treatment using drugs, called blood thinners, to prevent or treat dangerous blood clots [thrombi] by slowing down the blood's clotting process, stopping existing clots from growing, and preventing new ones from forming) for two (2) of 2 sampled residents (Residents 2, and 39) under AC care area, as indicated on the facility's policy when facility failed to: 1. Monitor Resident 2 for signs and symptoms of bleeding while receiving Heparin injection (is an anticoagulant used to decrease the clotting ability of the blood and help prevent harmful clots from forming in blood vessels) on 11/16/2025 to 11/18/2025. 2. Monitor Resident 39 for signs and symptoms of bleeding for the use of Apixaban (Eliquis, a medication used to help prevent strokes or blood clots in people who have atrial fibrillation [afib, a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes]) on 8/28/2025 as indicated in the comprehensive person-centered care plan. This deficient practice had the potential for Residents 2 and 39 to suffer excessive bleeding which could lead to complications such as organ damage, severe anemia (a condition in which the body does not have enough healthy red blood cells. [red blood cells provide oxygen to body tissues]), or death. Findings: 1. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE], Resident 2's diagnoses included hydronephrosis (swelling of the kidney) with renal and ureteral calculous (kidney stones) obstruction (preventing urine flow), cirrhosis of the liver (is permanent scarring that damages your liver and interferes with its functioning) and pancytopenia (a lower-than-normal count of all three types of blood cells: red blood cells [anemia], white blood cells [leukopenia], and platelets [thrombocytopenia]). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool) dated 11/21/2025, the MDS indicated Resident 2 had moderately impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 2 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in toileting hygiene, shower/ bathe self, lower body dressing, putting on/ taking off footwear, sit to stand, and chair/ bed-to-chair transfer. During a concurrent observation in Resident 2's room and an interview on 1/6/2026 at 10:32 PM, Resident 2 was sitting up in his bed, and multiple areas of discoloration were noted on his bilateral upper extremities. Resident 2 stated that he was taking an anticoagulant and had bruises on his arms as well as his legs. During a concurrent interview and record review on 1/8/2026 at 3:44 PM with MDS Nurse (MDSN), Resident 2's Physician Orders (PO) dated 11/16/2025 to 11/17/2025 were reviewed. The PO indicated the following: On 11/15/2025, Heparin Sodium Injection Solution 5000 units/milliliter (ml, measure of volume) Inject 1 vial subcutaneous (SQ, is a shot that delivers medicine into the fatty tissue layer just under the skin, above the muscle, using a short, small needle for slow, steady absorption) every eight (8) hours for deep vein thrombosis (DVT, a blood clot in a vein located deep within the body, usually in the leg) prophylaxis (prevention) until 12/6/2025, discontinued on 11/17/2025. On 11/17/2025, Heparin Sodium Injection Solution 5000 units/ml Inject 1 vial subcutaneously two times a day for DVT Prophylaxis until 12/6/2025, discontinued on 11/18/2025. MDSN stated the PO had no order for monitoring for signs and symptoms of bleeding on 11/16/2025 to 11/18/2025. MDSN stated the staff needed to have an order for monitoring signs and symptoms of bleeding, so that the staff can monitor Resident 2's signs and symptoms of bleeding every shift while on Anticoagulant use. MDSN stated the staff did not and should have monitored Resident 2 for bleeding due to Heparin use. During a concurrent interview and record review on 1/8/2026 at 3:46 PM with MDSN, Resident 2's Medication Administration Record (MAR) dated 11/1/2025 to 11/30/2025 was reviewed. MDSN stated Heparin was administered to Resident 2 on 11/16/2025, 11/17/2025, 11/18/2025. MDSN also stated the MAR did not have documented evidence that Resident 2 was monitored for signs and symptoms of (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bleeding. During a concurrent interview and record review on 1/8/2026 at 3:50 PM with MDSN, Resident 2's Care Plan (CP) dated 11/1/2025 to 1/8/2025 was reviewed. MDSN stated there was no CP formulated for Resident 2 when he was on Anticoagulant. MDSN also stated if Resident 2 was started on Anticoagulant, the staff should have a care plan right away, to include interventions to monitor Resident 2 for signs and symptoms of bleeding and side effects of the medication. During a concurrent interview and record review on 1/8/2026 at 4:07 PM with MDSN, the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 3/2022, the P&P indicated, a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each Resident. MDSN stated a care plan should be formulated to monitor bleeding, to make sure Resident 2 will not have any bleeding episodes. During an interview on 1/9/2026 at 11:35 AM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated if there was an order for Heparin and there was no monitoring for bleeding, the staff should have followed up with the physician and obtained an order. LVN 1 stated this was important to ensure Resident 2 will be monitored for bleeding episodes by the staff. During an interview on 1/9/2026 at 11:38 AM with LVN 1, LVN 1 stated if there were no care plans, it means there were no interventions for the use of anticoagulant such as monitoring Resident 2 for signs and symptoms of bleeding. 2. During a review of Resident 39's admission Record, the admission Record indicated Resident 39 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 39's diagnoses included metabolic encephalopathy (ME, occurs when problems with your metabolism cause brain dysfunction), Afib, and hypertension (high blood pressure) During a review of Resident 39's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 39 was dependent on oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, toilet transfer and tub/shower transfer. During a concurrent interview and record review on 1/8/2026 at 4:16 PM with MDSN, Resident 39's PO dated, 6/5/2025 was reviewed. The PO indicated Eliquis oral tablet 2.5 milligram (mg, a unit of weight/mass) Give 1 tablet by mouth two times a day for afib. MDSN stated Resident 39 did not have an order to monitor for bleeding while using anticoagulant. MDSN also stated if there was no order for monitoring for bleeding while Resident 39 was on anticoagulant therapy, it means the resident will not be monitored for it. During a concurrent interview and record review on 1/8/2026 at 4:22 PM with MDSN, Resident 39's CP on Anticoagulant therapy, dated 8/28/2024, was reviewed. The CP Interventions indicated:Administer anticoagulant medications as ordered by physicians. Monitor for side effects and effectiveness every shift.Monitor signs and symptoms of bleeding every shift. Document: Y if monitored and N if no of the above was observed. If monitored progress notes and notify the MD if any signs and symptoms of side effects noted.MDSN stated the CP interventions were not implemented because there was no documented evidence on the MAR or anywhere in Resident 39's chart. During a concurrent interview and record review on 1/8/2026 at 4:23 PM with MDSN, Resident 39's MAR dated 6/5/2025 to 1/8/2026 was reviewed. MDSN stated there was no documentation that Resident 39 was monitored for signs and symptoms of bleeding. During a concurrent interview and record review on 1/8/2026 at 4:31 PM with MDSN, Resident 39's Nurse's Progress Notes dated 6/1/2025 to 6/30/2025 was reviewed. MDSN stated there was no documentation that Resident 39 was monitored for signs and symptoms of bleeding in the nurses' progress notes. MDSN stated, If it was not documented, it was not done, During a concurrent interview and record review on 1/8/2026 at 4:33 PM with MDSN, Resident 39's NPN, dated 1/1/2026 to 1/8/2026 was reviewed. MDSN stated there was no documentation in the nurses' progress notes of the staff monitoring Resident 39 for signs and symptoms of bleeding, as indicated in the care plan. During a concurrent interview and review on 1/8/2026 at 4:37 PM with MDSN, the facility's P&P titled, Care Plans, Comprehensive Person-Centered revised 3/2022 was reviewed. The P&P indicated,The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	representative, develops and implements a comprehensive, person-centered care plan for each resident. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes b. describes the services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being. MDSN stated the staff did not follow the policy by not implementing Resident 39's care plan interventions. During a review of the facility's P&P titled, Anticoagulation- Clinical Protocol revised 11/2018, the P&P indicated, the physician and staff will identify individuals who are currently anticoagulated; for example, those with a recent history of deep vein thrombosis (DVT), or heart valve replacement, atrial fibrillation or those who have had recent joint replacement surgery. a. Assess any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications. Monitoring and follow up 1. The physician will order appropriate lab testing to monitor anticoagulant therapy and potential complications. 5. The staff and physician will monitor for possible complications in individuals who are being anticoagulated and will manage related problems. a. If an individual in anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant.		

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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. Based on observation, interview, and record review, the facility failed to prepare food in accordance with professional standards for food service safety in accordance with the facility's policy and procedure (P&P) titled Glove Use Policy by failing to: Ensure dietary staff (Cook 1, Kitchen Staff 1 and 2) performed hand hygiene (is the act of cleaning the hands with soap or handwash and water to remove viruses/bacteria/microorganisms, dirt, grease, or other harmful and unwanted substances stuck to the hands). Change gloves during cooking and tray line assembly. These deficient practices had the potential to result in pathogen (germ) exposure to residents, which could place the residents at risk for developing foodborne illness (-food poisoning- with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever) and can lead to other serious medical complications and hospitalization. Findings During an observation of the tray line assembly on 1/8/2026 at 11:37AM, [NAME] 1 touched her kitchen facemask with her left hand while wearing disposable gloves and then began scooping food for the tray line assembly. During an observation of the tray line assembly on 1/8/2026 at 11:39AM, [NAME] 1 put on the oven mittens while wearing the same disposable gloves observed at 11:37 AM, then pulled the tray of bread from inside the oven, removed the oven mittens, touched the serving plates wearing the same disposable gloves, and removed the foil that was covering the food trays. During a concurrent observation of the tray line assembly and interview on 1/8/2026 at 11:42 AM with [NAME] 1, [NAME] 1 put on mittens while wearing the same disposable gloves observed at 11:37 AM, then touched tray of bread, then grabbed another food tray, and then started scooping food from food tray to the serving plates. [NAME] 1 stated they need to change gloves if they touch different utensils and they need to wash their hands after removing the disposable gloves and changing the gloves in between changing of task (cooking/ serving/ preparing the plate) because of infection control. During an observation of the tray line assembly on 1/8/2026 at 11:47 AM, [NAME] 1 was wearing disposable gloves and touched her hairnet, then held the food scooper while using the same gloves. During an observation of the tray line assembly on 1/8/2026 at 11:56 AM with [NAME] 1, [NAME] 1 was wearing disposable gloves then touched the blender and continue serving food without changing gloves. During an observation of the tray line assembly on 1/8/2026 at 11:57 AM, KS 1 was wearing disposable gloves, then touched the refrigerator handle, took food items from the refrigerator, and touched the serving plate without changing gloves. During an observation of the tray line assembly on 1/8/2026 at 12 PM, KS 2 was wearing disposable gloves, then touched the refrigerator handle, took two (2) glasses of chocolate milkshakes and placed it on the resident's tray, and pushed the serving tray cart to the dry storage room without removing the disposable gloves and performing hand hygiene. During an interview on 1/8/2026 at 12:05 PM with [NAME] 1, [NAME] 1 stated the staff were not supposed to wear the disposable gloves inside the mittens because of cross contamination. [NAME] 1 stated, I should have removed my disposable gloves before using the oven mittens and when I was changing tasks, when I used the blender, because I can contaminate the food and the residents can get sick. During an interview on 1/8/2026 at 12:08PM with KS 1, KS 1 stated she did not change gloves after she changed her tasks during train line assembly today (1/8/2026). KS 1 stated she should have removed her gloves and washed her hands to prevent food contamination because residents can get sick. During an interview on 1/8/2026 at 12:13 PM with KS 2, KS 2 stated she should have washed her hands before using the serving/ pushcart because it can contaminate the other kitchen items used to serve the residents food, and it can cause the residents to get sick. During a concurrent interview and record review on 1/8/2026 at 12:16 PM with Dietary Supervisor (DTS), the facility's P&P titled, Glove Use Policy revised in 2023 was reviewed. The P&P indicated, gloves needed to be changed before beginning a different task and after touching bare skin or hair. DTS stated the staff should have changed gloves in between tasks or after touching their clothing/ mask or hairnet because of (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infection control issues that can arise, and the residents can get sick. During a review of the facility's P&P titled, Preventing Foodborne Illness- Employee Hygiene and Sanitary Practices revised on 10/2017, the P&P indicated employees must wash their hands:Before coming in contact with any food surfaces.After handling soiled equipment or utensils.During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; and/orAfter engaging in other activities that contaminate the hands.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the antibiotic (a drug that kills or stops the growth of harmful bacteria) stewardship (the effort to measure and improve how antibiotics are prescribed by and used by residents) was completed for two (2) of 2 residents (Residents 20 and 2) while receiving antibiotic treatment in the facility. This deficient practice had the potential for Residents 20 and 2 to develop antibiotic resistance (when bacteria, viruses, fungi, and parasites no longer respond to antimicrobial medicine and become ineffective making infections difficult or impossible to treat increasing the risk of disease spread, severe illness, disability, and death) and suffer adverse side effects (an undesired harmful effect resulting from a medication or other intervention) from unnecessary or inappropriate antibiotic use. Findings: 1. During a review of Resident 20's admission Record, the admission Record indicated Resident 20 was admitted to the facility on [DATE] with diagnoses that included hypertensive heart disease (heart complications caused by high blood pressure that is present over a long time) with heart failure (a chronic condition in which the heart does not provide adequate blood flow to meet the body's needs), chronic kidney disease (CKD - longstanding disease of the kidneys leading to renal failure), and generalized muscle weakness. During a review of Resident 20's Minimum Data Set (MDS, resident assessment tool), dated 10/30/2025, the MDS indicated Resident 20 had moderately impaired cognitive (ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 20 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with toileting and personal hygiene, shower/bathing, dressing, partial/moderate assistance with eating and substantial/maximal assistance with oral hygiene. During a review of Resident 20's Physician Order, dated 11/9/2025, the order indicated doxycycline hyclate (a broad-spectrum tetracycline antibiotic used for bacterial infections) 100 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) give one (1) tablet by mouth every 12 hours for pneumonia (an infection/inflammation in the lungs) for five (5) days. During a review of Resident 20's Medication Administration Record (MAR), dated 11/1/2025 through 11/30/2025, the MAR indicated Resident 20 received doxycycline hyclate 100 mg by mouth from 11/9/2025 through 11/14/2025. 2. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses included urinary tract infection (UTI- an infection in the bladder/urinary tract), hydronephrosis (swelling of the kidney) with renal and ureteral calculous (kidney stones) obstruction (preventing urine flow), and cirrhosis of the liver (permanent scarring that damages your liver and interferes with its functioning). During a review of Resident 2's MDS dated , 11/21/2025, the MDS indicated Resident 2 had moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 2 was dependent on toileting hygiene, shower/ bathe self, lower body dressing, and substantial/maximal assistance (helper does more than half the effort) with personal and oral hygiene. During a review of Resident 2's Physician Order, dated 11/17/2025, the order indicated neomycin sulfate (an antibiotic used orally and topically to treat a wide variety of infections in the body) oral tablet 500 mg, give 1 tablet by mouth two times a day for UTI for 10 days. During a review of Resident 2's MAR, dated 11/1/2025 through 11/30/2025, the MAR indicated Resident 2 received neomycin sulfate 500 mg by mouth from 11/17/2025 through 11/27/2025. During an interview on 1/9/2026 at 8:46 AM with the Infection Preventionist Nurse 1 (IPN 1), IPN 1 stated per facility protocol, when antibiotics are ordered, the IP nurse completes a Surveillance Data Collection Form that evaluates if Loeb's criteria (a set of clinical guidelines for long-term care [LTC] facilities, providing a minimum checklist of signs and symptoms to help decide when to start antibiotics that aims to reduce unnecessary antibiotic use) and/or McGreer's criteria (standardized definitions for identifying infections in LTC facilities that provides clear guidelines for surveillance, research, and antibiotic stewardship) are met for continued use of the prescribed antibiotics. IPN 1 stated this (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	evaluation is documented in addition to monitoring during therapy for any adverse reactions or changes to stop antibiotic use. The IPN 1 also stated it was important to ensure the antibiotic stewardship program including evaluations and monitoring was completed for residents to prevent unnecessary medication use and create antibiotic resistance. During a concurrent interview and record review on 1/9/2026 at 12:21 PM with the IPN 1, the facility's Order Listing Report, dated 9/1/2025 through 11/30/2025 was reviewed. The Order Listing Report indicated Resident 20 completed her doxycycline hyclate therapy for PNA on 11/9/2025 and Resident 2 completed his neomycin sulfate therapy for UTI on 11/17/2025. The IPN 1 stated the facility had no antibiotic surveillance tracking forms or antibiotic reviews documented for Resident 20 and/or Resident 2 during antibiotic administration. IPN 1 stated there should be documented reviews and tracking per facility policy. IPN 1 further stated that without documentation, she cannot ensure the antibiotic use for Residents 20 and 2 was evaluated and monitored appropriately, and that the antibiotic stewardship program was followed. During an interview on 1/9/2026 at 2:35 PM with the Director of Nursing, the DON stated the antibiotic use for Residents 20 and 2 should have been evaluated and tracked according to the facility's policy. The DON further stated, it was important to ensure residents receive the appropriate antibiotic and that antibiotic use was appropriately evaluated and monitored. During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship, revised 12/2016, the P&P indicated that antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program and the purpose of the Antibiotic Stewardship Program is to monitor the use of antibiotics in the residents. During a review of the facility's P&P titled, Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes, revised 12/2016, the P&P indicated: Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. As part of the facility Antibiotic Stewardship Program, all clinical infections treated with antibiotics will undergo review by the Infection Preventionist, or designee. All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include: a. Resident name and medical record number; b. Unit and room number; c. Date symptoms appeared; d. Name of antibiotic (see approved surveillance list); e. Start date of antibiotic; f. Pathogen identified (see approved surveillance list); g. Site of infection; h. Date of culture; i. Stop date; j. Total days of therapy; k. Outcome; and l. Adverse events		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a safe, clean, comfortable, and home like environment for two (2) of five sampled residents (Resident 8 and 20) under environment care area, when the facility failed to ensure air vents (openings in buildings for air passage, essential for ventilation, air circulation, and maintaining indoor air quality) inside the resident's rooms were free from dust particles. This deficient practice had the potential for the residents to feel discomfort and suffer from respiratory problems which could negatively affect the residents' well-being and quality of life. Findings:1. During a review of Resident 8's admission Record, the admission Record indicated Resident 8 was admitted to the facility on [DATE], Resident 8's diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral vascular accident (CVA, or stroke is an interruption in the flow of blood to cells in the brain) of the left non-dominant side, anxiety disorder (a disorder characterized by nervousness characterized by a state of excessive uneasiness and apprehension, typically with compulsive behavior [repetitive, persistent, and often uncontrollable actions that a person feels driven to perform] or panic attacks), and major depressive disorder (or also called clinical depression, it affects how you feel, think and behave and can lead to a variety of emotional and physical problems) During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool) dated 12/3/2025, the MDS indicated Resident 8 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 8 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, roll left and right, sit to lying, and lying to sitting on the side of the bed. During an observation on 1/7/2026 at 8:48 AM in Resident 8's room, the air vent directly on top of Resident 8 was full of dust. Resident 8 stated The air vent on top of me is so filthy! During a concurrent observation and interview on 1/8/2026 at 10:09 AM with Maintenance Assistant 1 (MTA 1) in Resident 8's room, Resident 8's air vent was full of dust. MTA 1 stated Resident 8's air vent was dirty, and it was necessary to move Resident 8's bed so it could be cleaned. MTA stated the air vents should be cleaned at least once a month because it was connected to other residents' rooms. MTA stated it was important to clean it because the dust can affect Resident 8's breathing causing respiratory problems. 2. During a review of Resident 20's admission Record, the admission Record indicated Resident 20 was admitted to the facility on [DATE], Resident 20's diagnoses included metabolic encephalopathy (ME, occurs when problems with your metabolism cause brain dysfunction), anemia (a condition where the body does not have enough healthy red blood cells) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest. During a review of Resident 20's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 20 was dependent on toileting hygiene, sit to stand, chair/bed-to-chair transfer, and toilet transfer. During a concurrent observation and interview on 1/8/2026 at 9:15 AM in Resident 20's room, Resident 20 was observed lying on her bed and the air vent above her was dusty. During a concurrent observation an interview on 1/8/2026 at 10:12 AM with MTA 1 in Resident 20's room, Resident 20 was lying on her bed and air vent above her was dusty. MTA 1 stated Resident 20's air vent was also dirty. MTA stated they need to clean the residents' air vents at least once a month because those are connected to other residents' rooms and residents can get sick. During a review of the facility's policy and procedure (P&P) titled, Inspection of Heat/Air-conditioning system, revised 5/2008, the P&P indicated, the facility's heating and air-conditioning system shall be inspected at lease semi-annually. Prior to the beginning of each heating/cooling season our facility's heating and air-conditioning systems shall be inspected for possible gas leaks, lines that have burst, etc. During a (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of the facility's P&P titled, Quality of Life - Homelike Environment revised 5/2017, the P&P indicated,2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include:a. Clean. sanitary and orderly environment. During a review of the facility's P&P titled, Cleaning and Disinfection of Environmental Surfaces revised 8/2019, the P&P indicated,14. Horizontal surfaces will be wet dusted regularly (e.g., daily, three times per week) using clean cloth moistened with an EPA-registered hospital disinfectant (or detergent). The disinfectant (or detergent) will be prepared as recommended by the manufacturer.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the medical doctor (MD) of changes with the residents' condition for two (2) of 22 sampled residents (Residents 57 and 20) as indicated in the facility's policy and procedures (P&P): Resident 57's refusal of medications and meals from 11/5/2025 to 11/10/2025. Resident 20's new complaint of itching on bilateral hands and feet on 1/6/2026. These failures resulted in delayed treatments and interventions for Residents 20 and 57 with the potential for inadequate care, services and a preventable decline in Resident 20's and 57's mental, physical and psychosocial well-being. Findings: 1. During a review of Resident 57's admission Record, the admission Record indicated Resident 57 was admitted to the facility on [DATE] with diagnoses that included adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and type 2 Diabetes Mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 57's Minimum Data Set (MDS - a resident assessment tool), dated 11/10/2025, the MDS indicated Resident 57 had moderately impaired cognitive (ability to understand and make decisions) skills for daily decision making. The MDS also indicated that Resident 57 was dependent (helper does all of the effort to complete the activity) with toileting, bathing/shower, lower body dressing, substantial/maximal assistance (helper does more than half the effort) with oral and personal hygiene and partial/moderate assistance (helper does less than half the effort) with eating. During a review of Resident 57's Medication Administration Record (MAR), dated 11/1/2025 through 11/30/2025, the MAR indicated Resident 57 did not receive all prescribed doses of 12 medications from 11/5/2025 through 11/12/2025 due to Resident 57's refusals. The MAR also indicated Resident 57 had 10 refused meals from 11/5/2025 - 11/12/2025. During a concurrent interview and record review on 1/9/2026 at 2:42 PM with the Director of Nursing (DON) and Licensed Vocational Nurse 4, Resident 57's electronic medical chart dated from 11/5/2026 to 11/10/2025 was reviewed. Resident 57's medical chart failed to indicate any MD notification of refused medications and/or meals from 11/5/2025 to 11/10/2025. The DON stated the MD should have been made aware/ notified of Resident 57's refusals by the licensed nurse to coordinate with the MD on the next plan of care and interventions for Resident 57. During a review of the facility's P&P titled, Requesting, Refusing, and/or Discontinuing Care or Treatment, revised 5/2017, the P&P indicated when a resident refuses care or treatment, the healthcare practitioner (MD) must be notified of refusal of treatment, in a time frame determined by the resident's condition and potential serious consequences of the request. For example, a resident's refusal to take a diuretic while experiencing acute congestive heart failure should be reported immediately, while a refusal to take a blood pressure medication while the blood pressure is well controlled can be reported within 24 hours. The P&P defined treatment as services provided for purposes of maintaining/restoring health, improving functional level, or relieving symptoms and the refusal of treatment documentation must be done and include the date and time the practitioner was notified and the practitioner's response. 2. During a review of Resident 20's admission Record, the admission Record indicated Resident 20 was admitted to the facility on [DATE] with diagnoses that included hypertensive heart disease (heart complications caused by high blood pressure that is present over a long time) with heart failure (a chronic condition in which the heart does not provide adequate blood flow to meet the body's needs), chronic kidney disease (CKD - longstanding disease of the kidneys leading to renal failure) and generalized muscle weakness. During a review of Resident 20's MDS, dated [DATE], the MDS indicated Resident 20 had moderately impaired cognitive (ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 20 was dependent on toileting and personal hygiene, shower/bathing, (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dressing, partial/moderate assistance with eating and substantial/maximal assistance with oral hygiene. During a concurrent interview and observation on 1/6/2026 at 8:43 AM at Resident 20's bedside, Resident 20 was observed telling Certified Nursing Assistant 9 that both of her hands were itchy. CNA 9 then stated he would inform Resident 20's licensed nurse. During an interview on 1/8/2026 at 8:57 AM, CNA 9 stated he informed Licensed Vocational Nurse 5 (LVN 5) regarding Resident 20's itchiness on both hands on 1/6/2026. During a concurrent observation and interview on 1/8/2026 at 9:10 AM with LVN 1 and Resident 20, at Resident 20's bedside, LVN 1 was observed preparing medication administration for Resident 20. Resident 20 stated she had itching in both her hands and has now moved to both of her feet as well. Resident 20 stated she has had itching in her hands since 1/6/2026 and in her left and right foot for a day. LVN 1 stated she just became aware of the itching and Resident 20 did not have any prescribed treatments for the itching on hands and feet. During an interview on 1/8/2026 at 9:38 AM with LVN 5, LVN 5 stated she was made aware of dry skin only by CNA 9 and did not inform the doctor about Resident 20's itching hands. During an interview on 1/9/2026 at 2:03 PM with LVN 1, LVN 1 stated she became aware of Resident 20's itching on hands and feet on 1/8/2026 but did not inform the MD because she thought LVN 5 would have done it. LVN 1 stated a change in condition evaluation with MD notification should have been done the day it occurred per facility policy. During a concurrent interview and record review on 1/9/2026 at 2:54 PM with the DON and LVN 4, Resident 20's electronic medical chart from 1/6/2026 through 1/9/2026 were reviewed. Resident 20's medical chart failed to indicate a change of condition evaluation and an MD notification for Resident 20's bilateral (left and right) hand itching that started on 1/6/2026 and bilateral feet itching that started on 1/8/2026. The DON stated the MD should have been notified with documentation of the date and time of notification, a revised care plan created and monitoring by nursing staff of the resident's change of condition for 72 hours according to facility policy. The DON also stated it was important to communicate with the MD regarding Resident 20's itching so that an order can be given and the itching can be treated. During a review of the facility's P&P titled, Change in a Resident's Condition or Status, revised 5/2017, the P&P indicated the facility will promptly notify the resident's attending physician of changes in the resident's medical/mental condition. The P&P also indicated except in medical emergencies, notifications will be made within 24 hours of change occurring in the resident's medical/mental condition or status		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and record review, the facility failed to ensure one (1) of three (3) sampled residents (Resident 39) under activities of daily living care area 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 and speak (primary language) in accordance with the facility policy and procedure. This deficient practice prevented Resident 39 from communicating with the staff and had the potential to delay receiving appropriate care/treatment that the resident needed. 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 and speak (primary language) for one (1) of three (3) sampled residents (Resident 39) in accordance with the facility policy and procedure. This deficient practice prevented Resident 39 from communicating with the staff and had the potential to delay receiving appropriate care/treatment that the resident needed. Findings: During a review of Resident 39's admission Record, the admission Record indicated Resident 39 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included metabolic encephalopathy (ME, occurs when problems with your metabolism cause brain dysfunction), atrial fibrillation (Afib, is an irregular and often very rapid heartbeat), and hypertension (high blood pressure). During a review of Resident 39's Minimum Data Set (MDS, a resident assessment tool), dated 10/31/2025, the MDS indicated the resident's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making were moderately impaired. The MDS indicated Resident 39 was dependent (helper does all of the effort, resident does no effort to complete the activity) on oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, toilet transfer and tub/shower transfer. During a concurrent observation and interview on 1/6/2026 at 12:25 PM with Resident 39 inside Resident 39's room, Resident 39 was sitting up in her wheelchair and eating lunch. Resident 39 was speaking to the surveyor in the resident's primary language. The surveyor asked Resident 39 questions in English and Resident 39 responded in her primary language. There was no communication board provided in Resident 39's room or at the bedside. During an observation on 1/7/2026 at 9:19 AM inside Resident 39's room, there was no communication board provided in Resident 39's room or at the bedside. During a concurrent observation and interview on 1/7/2026 at 12:37 PM with Certified Nursing Assistant 5 (CNA 5) inside Resident 39's room, Resident 39 was sitting in her wheelchair and there was no communication board in Resident 39's room or at the bedside. CNA 5 stated there was no communication board provided for Resident 39. CNA 5 communicated with Resident 39 using in English, and Resident 39 responded in her primary language. During a concurrent observation and interview on 1/8/2026 at 12:20 PM with CNA 4 in Resident 39's room, Resident 39 was sitting in her wheelchair. CNA 4 stated CNA 4 does not speak Resident 39's primary language. CNA 4 stated Resident 39 did not have a communication board and having one would be useful to help Resident 39 express needs and receive assistance promptly. During an interview on 1/8/2026 at 12:21 PM with Director of Social Services (DSS) inside Resident 39's room, DSS stated she just placed the communication board at Resident 39's bedside yesterday (1/7/2026) after lunch, as Resident 39 did not have it before. DSS stated promoting communication such as providing the communication board is part of accommodation of the resident's needs in accordance with the facility's policy. DSS stated it is important to have communication board at the resident's bedside for non-English-speaking residents so the resident/s can effectively communicate their needs to the staff. During a review of (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility's policy and procedure (P&P) titled, Translation and/or interpretation of Facility Services, revised 11/2020, the P&P indicated, the 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. The P&P indicated 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. The P&P also indicated 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, the 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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide appropriate discharge planning (the process of preparing a resident to safely transition from a hospital or care facility to the next level of care) as indicated in the Director of Social Services job duties and the resident's care plan (a document that outlines the facility's plan to provide personalized care to a resident based on the resident's needs) for one (1) of 1 sampled resident (Resident 45) from the discharge care area. This failure resulted in a delay in discharge planning for Resident 45, with the potential for a delayed discharge from the facility. Findings: During a review of Resident 45's admission Record, the admission Record indicated Resident 45 was admitted to the facility on [DATE] with diagnoses that included (difficulty swallowing), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). The admission Record also indicated Resident 45 had a public guardian (PG- a court-appointed individual responsible for managing the affairs of people who are unable to do so themselves due to mental and/or physical disabilities). During a review of Resident 45's quarterly Minimum Data Set (MDS - a resident assessment tool), dated 12/4/2025, the MDS indicated Resident 45 had moderately impaired cognitive (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 45 was independent (resident completes activity by themselves with no assistance from a helper) with eating and supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with bathing, dressing, oral, toileting and personal hygiene. During a review of Resident 45's Discharge Plan- care plan, initiated 6/2/2025, the care plan indicated Resident 45 was expected to be discharged to the community, board and care (B&C- a small residential facility that provides housing, meals, and assistance with activities of daily living [ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves]) or assisted living facility (a residential facility that provides housing, meals, and support for ADLs), with a goal to be discharged to community. The care plan indicated the Social Services Director (SSD) will intervene for appropriate and necessary follow up[s] as indicated. During a review of Resident 45's Interdisciplinary Team (IDT - a coordinated group of experts from several different fields) Conference Record, dated 12/3/2025, the IDT Conference Record indicated Resident 45's discharge plan to lower level of care at an assisted living facility. During an interview on 1/8/2026 at 11:34 AM with Resident 45, Resident 45 stated he asked for a discharge repeatedly, but facility is not telling me anything. Resident 45 stated he wanted to leave the facility and go live at home. During an interview on 1/9/2026 at 8:36 AM with the SSD, the SSD stated Resident 45 had an expected discharge date next month (February), but the facility needed to get Resident 45 approved with waivers to assist with housing and the resident's medical insurance switched. The SSD stated Resident 45's PG signed an application, but unable to recall when. During a concurrent interview and record review on 1/9/2026 at 12:43 PM with the SSD, the following records for Resident 45 were reviewed: Agency 1 Patient Consent to Receive Services and Certification, dated 8/20/2025 and signed by Resident 45's PG. The Patient Consent indicated Resident 45's PG consent for admission and treatment, with authorization of Agency 1 Home Health and associates to provide transition care and/or case management services per policy of the Assisted Living Waiver Program (ALWP- provides Medicaid funding for seniors and people with disabilities who need nursing-level care but prefer to live in a home-like assisted living community, rather than a skilled nursing facility, covering personal care, health services, meals, and activities, though participants typically pay for room & board) care coordination. Agency 1 Consent to be Placed on the Assisted Living Waiver Program Waitlist, dated 8/20/2025 and signed by Resident 45's PG. The Consent indicated Resident 45's PG consented and authorized Agency 1 to submit (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER San Marino Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6812 N. Oak Avenue San Gabriel, CA 91775	
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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 45's medical information to the state for the purpose of being placed on a waitlist for the ALWP. The SSD stated she received the consents the same day they were signed on 8/20/2025 but as of today, nothing further has been done. The SSD stated it was not until she checked her documents on 1/9/2026 that she found the consents and must have overlooked them. The SSD stated her role was to assist the residents in finding the proper placement and financial programs as needed to get them discharged into another facility, and from 8/20/2025 to 1/9/2026, there had been no submission of the signed consents back to Agency 1 for the continued processing towards discharge planning for Resident 45. The SSD stated she should have been aware of the signed consents to ensure a follow up so that Resident 45 was assisted with his discharge planning and does not get lost in the bunch, in which Resident 45 would not get an opportunity to discharge and go to the community or meet the resident's discharge goal. During a review of the facility's form titled Director of Social Services job description/duties, (undated), the form indicated the primary purpose of the job position is to plan, develop and direct the Social Serves Department in accordance with current federal, state, and local standards, guidelines and regulations, established facility policies and procedures, and as may be directed by the Administrator, to assure that the medically related emotional and social needs of the resident are met/maintained on an individual basis. The form also indicated that the Director of Social Services will participate in discharge planning, development and implementation of social care plans and resident assessments.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that an alternative meal was offered and provided to one (1) of 1 sampled resident (Resident 45) from the choices care area, after his lunch meal was refused, as indicated in facility policy. This failure resulted in Resident 45 having preventable hunger with the potential risks for decreased feelings of well-being and/or malnourished (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat). Findings: During a review of Resident 45's admission Record, the admission Record indicated Resident 45 was admitted to the facility on [DATE] with diagnoses that included (difficulty swallowing), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 45's Order Summary Report dated 11/26/2025, the Order Summary Report indicated an order for a regular diet (a balanced, unrestricted eating plan with a variety of foods from all major groups). During a review of Resident 45's quarterly Minimum Data Set (MDS - a resident assessment tool), dated 12/4/2025, the MDS indicated Resident 45 had moderately impaired cognitive (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 45 was independent (resident completes activity by themselves with no assistance from a helper) with eating and supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with bathing, dressing, oral, toileting and personal hygiene. During a review of Resident 45's Potential Nutritional Problem care plan (a document that outlines the facility's plan to provide personalized care to a resident based on the resident's needs), revised 1/9/2026, the care plan indicated a goal for Resident 45 to maintain adequate nutritional status daily. During a review of the facility's Meal Schedule (undated), the Meal Schedule indicated lunch is scheduled daily at 12:00 PM. During a concurrent observation and interview on 1/8/2026 at 12:39 PM with Resident 45 and Certified Nurse Assistant 7 (CNA 7) at Resident 45's bedside, Resident 45's lunch meal tray was observed uneaten. Resident 45 stated the food is terrible. CNA 7 stated she would inform dietary staff Resident 45 of his refused lunch. During a concurrent observation and interview on 1/8/2026 at 1:16 PM with Resident 45 at Resident 45's bedside, Resident 45's uneaten lunch tray was observed. Resident 45 stated he has not been offered a substitute meal but is hungry and wants to eat. During an interview on 1/8/2026 at 2:25 PM with CNA 7, CNA 7 stated she did not inform any additional staff (including dietary and/or licensed) regarding Resident 45's refused lunch meal and did not offer Resident 7 alternative meal items. CNA 7 stated Resident 45 should have been offered an alternative lunch tray, and it is important to make sure resident meal refusals are communicated to the charge nurse and kitchen staff and then follow up with the resident to ensure Resident 7 gets an alternative lunch tray. During an interview on 1/8/2026 at 2:46 PM with the Dietary Supervisor (DTS), the DTS stated dietary staff was not aware of Resident 45's lunch meal refusal on 1/8/2026 so no alternative meal was offered to the resident. During an interview on 1/8/2026 at 3:04 PM with the DTS, the DTS stated according to the facility's policy, when a resident refuses a meal, either nursing staff or dietary staff will offer alternative menu choices/ meal tray and then it would be provided to the resident. The DTS also stated Resident 45 should have been offered an alternative meal after he refused the lunch tray on 1/8/2026. DTS stated it is important to ensure alternative meals are offered to residents when they refuse the delivered meal to ensure they receive balanced and nourished meals to prevent malnutrition. During a review of the facility's policy and procedure (P&P) titled Food Substitutions for Residents Who Refuse the Meal, (undated), the P&P indicated residents will be provided a suitable nourishing alternate meal after the planned, served meal has been refused. The P&P also indicated nursing personnel will ask any resident who does not (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	eat his meal or food item as to why he is not eating and offer a food substitution in accordance with the resident's diet order. The P&P indicated food and nutrition services staff (FNS) will deliver the substituted item(s) to the resident after other residents have been served.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure standard infection prevention control practices (a set of practices that prevent or stop the spread of infections and or diseases in the healthcare setting) for two of five sampled residents (Residents 21 and 2) from the infection control care area were followed in accordance with the facility's policy and procedure when: 1. a. Certified Nurse Assistant 1 (CNA 1) and CNA 8 failed to wear proper Personal Protective Equipment (PPE, is specialized clothing or equipment worn by an employee for protection against infectious materials, such as gowns, gloves, masks, and goggles) for Enhanced Barrier Precautions (EBP, refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) room while repositioning Resident 21 and CNA 1 did not perform hand hygiene after removing CNA 1's gloves. b. Licensed Vocational Nurse 1 (LVN 1) failed to change her gloves in between tasks during medication administration via gastrostomy tube (G-tube, is a tube inserted through the belly that brings nutrition directly to the stomach) to Resident 21. 2. CNA 1, CNA 9 and CNA 4 failed to wear proper PPE in the EBP room while assisting Resident 2 on his Activities of Daily Living (ADLs, are activities related to personal care including bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating). These deficient practices have potential to contaminate clean items or to cross contaminate (the physical movement or transfer of harmful bacteria from one person, object or place to another) and can place Resident 21 and Resident 2 at risk for infection. Findings:1. During a review of Resident 21's admission Record, the admission Record indicated Resident 21 was admitted to the facility on [DATE] and re-admitted on [DATE], with diagnoses that included epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures [are brief episodes of abnormal electrical activity in the brain that can cause a variety of symptoms, including involuntary movements, loss of consciousness, and changes in behavior]), dysphagia (difficulty swallowing) and dementia (impaired ability to remember, think, or make decisions that interfere with doing everyday activities). During a review of Resident 21's Minimum Data Set (MDS, a resident assessment tool) dated 12/10/2025, the MDS indicated Resident 2 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 21 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting, sit to stand, chair/ bed-to-chair transfer, toilet transfer, and tub/shower transfer. During a review of Resident 21's current Physician Order dated 10/30/2025. The physician's order indicated Enhanced Barrier Precautions secondary to G-tube use every shift. During an observation on 1/8/2026 at 8:30 AM inside Resident 21's room, Resident 21 was sitting on a wheelchair. CNA 1 and CNA 8 entered Resident 21's room wearing disposable gloves and was not wearing gown. CNA 1 and CNA 8 lifted and repositioned Resident 21 in the wheelchair. During an observation on 1/8/2026 at 8:31 AM inside Resident 21's Room, CNA 1 removed her disposable gloves and immediately left the room without performing hand hygiene, then entered another resident's room (Room A) that is not on isolation precaution (used in healthcare, that create barriers to stop germs from spreading from a sick person to others (staff, visitors, other patients) by separating them and requiring specific PPE and practices, like hand hygiene, based on how the germ spreads). During a medication administration observation on 1/8/2026 at 8:34 AM with LVN 1, LVN 1 was wearing gown and gloves. LVN 1 pulled the curtain, touched Resident 21's clothes, and then checked Resident 21's G-tube placement. LVN 1 did not remove her gloves before administering Resident 21's medications via the resident's G-tube. During medication administration observation on 1/8/2026 at 8:44 AM with LVN 1, LVN 1 washed and dried Resident 21's flush syringe (a cylindrical, hollow tube, or barrel of a syringe which is medical device (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	used to inject or withdraw fluids) using the same disposable gloves and in the bathroom sink that is shared and being used by two (2) other residents. During an interview on 1/8/2026 at 8:48 AM with LVN 1, LVN 1 stated she did not change her gloves after she checked Resident 21's G- Tube placement and before administering Resident 21's medications. LVN 1 stated she should have changed her gloves because of risk of cross contamination and she can introduce infection the Resident 21. During an interview on 1/8/2026 at 8:49 AM with LVN 1, LVN 1 stated she should have removed her gloves and used a new one before cleaning Resident 21's flushed syringe because when LVN 1 finished rinsing Resident 21's flush syringe the dirty gloves can contaminate the clean flush syringe. During an interview on 1/8/2026 at 10:07 AM with CNA 1, CNA 1 stated Resident 21 was on EBP and that CNA 1 should wear gown and not only gloves when transferring or pulling Resident 21 up in the wheelchair. CNA 1 also stated she should have performed hand hygiene after removing gloves and before going into another resident's room to prevent spread of infection. During a concurrent interview and record review on 1/9/2026 at 3:01 PM with Infection Preventionist Nurse 1 (IPN 1), the facility's policy and procedure (P&P) titled Infection Control revised 5/2025 was reviewed. The P&P indicated, EBP requires staff to wear gloves and gown during moments of providing direct care with the EBP resident. The direct care moments are:> Transferring residents from bed, changing bed linens> Direct contact with the environmentIPN 1 stated, the staff should have worn the gown and gloves in EBP Rooms. IPN 1 stated any activity that they will have contact with the residents. IPN 1 also stated, the staff should wear gowns and gloves because the staff's clothes can get contaminated, and they can spread the infection when they go to other residents. During a review of the facility's P&P titled, Standard Precautions revised 10/2018, the P&P indicated: > Gloves are changed as necessary, during the care of a resident to prevent cross-contamination from one body to another (when moving from a dirty site to a clean one).> Gloves are removed promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident.> After gloves are removed, wash hands immediately to avoid transfer of microorganisms to other residents or environments. 2. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE], Resident 2's diagnoses included hydronephrosis (swelling of the kidney) with renal and ureteral calculous (kidney stones) obstruction (preventing urine flow), cirrhosis of the liver (is permanent scarring that damages your liver and interferes with its functioning) and pancytopenia (a lower-than-normal count of all three types of blood cells: red blood cells [anemia], white blood cells [leukopenia], and platelets [thrombocytopenia]). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool) dated 11/21/2025, the MDS indicated Resident 2 had moderately impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 2 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in toileting hygiene, shower/ bathe self, lower body dressing, putting on/ taking off footwear, sit to stand, and chair/ bed-to-chair transfer. During a review of Resident 2's current Physician Order dated 11/25/2025, the physician's order indicated may have EBP secondary to indwelling catheter (a thin, hollow tube that's inserted into the bladder through the urethra to drain urine. During an observation on 1/8/2026 at 9:42 AM inside Resident 2's room, Resident 2 was lying on his bed. CNA 1 was wearing disposable gloves and was not wearing gown while assisting Resident 2 to remove the resident's clothes. CNA 1 then wiped Resident 2's face with a wet washcloth. During an observation on 1/8/2026 at 9:44 AM inside Resident 2's room, CNA 9 was wearing disposable gloves and was not wearing gown while shaving Resident 2's beard. During an observation on 1/8/2026 at 9:53 AM inside Resident 2's room, CNA 4 was wearing disposable gloves and was not wearing gown while assisting Resident 2 get dressed. During an observation on 1/8/2026 at 9:54 AM inside Resident 2's room, CNA 1 was wearing disposable gloves and was not wearing gown when assisting Resident 2 on his sponge bath. During an interview on 1/8/2026 at 10:02 AM with CNA 4, CNA 4 stated they were supposed to wear gowns and gloves in EBP room and they (CNA 9 and 4) (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	forgot to wear gown while assisting Resident 2 with the resident's ADLs. CNA 4 also stated they should wear PPE when doing high contact activities with residents on EBP. During an interview on 1/8/2026 at 10:04 AM with CNA 1, CNA 1 stated they did not wear gown inside the EBP room while providing Resident 2's morning care. CNA 1 stated they were supposed to wear gowns and gloves when providing care to residents with EBP because of infection control. During a concurrent interview and record review on 1/9/2026 at 3:31 PM with IPN 1, the facility's P&P title Infection Control revised 5/2025 was reviewed. The P&P indicated, EBP requires staff to wear gloves and gown during moments of providing direct care with the EBP resident. The P&P indicated, the direct care moments are:> Bathing or providing AM and PM care> Toileting and changing briefs> Direct contact with the environment> Managing indwelling medical devicesIPN 1 stated if the staff were performing ADLs with a resident with indwelling catheter like Resident 2. IPN 1 stated the staff should wear proper PPE which are gown and gloves because there is a possibility of having splatters of urine when cleaning Resident 2, and it could cause cross contamination if it got into the staff's scrub suit/ uniform and it can spread infection when the staff were also taking care of other residents. During a review of the facility's P&P titled, Standard Precautions revised 10/2018, the P&P indicated gowns (clean, non-sterile) are worn to protect skin and prevent soiling of clothing during procedures and resident care activities that are likely to generate splashes or sprays of blood, body fluids secretions, or excretions or cause soiling of clothing.		