STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055016	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount San Antonio Gardens	900 E. Harrison Ave Pomona, CA 91767

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure sensor alarms (wireless bed alarms that alert staff when a patient gets up from the bed so staff can go and assist the patient, used to prevent falls) were functioning for, two of four sampled residents (Resident 2 and Resident 3), who were at high risk for falls.This deficient practice had the potential to result in falls and injuries to Resident 2 and Resident 3. Findings:During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 4/20/2021, with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning), other abnormalities of gait, and mobility.During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 1/8/2026, the MDS indicated Resident 2 was able to express ideas and wants, understood verbal content, and had problems with short-term and long-term memory. The MDS indicated Resident 2 was dependent on activities of daily living.During a review of Resident 2's Morse Fall Scale dated 1/8/2026, the scale indicated Resident 2 was at high risk for falling.During a review of Resident 2's care plan (CP), revised 1/8/2023, the CP indicated Resident 2 was at risk for falls related to impaired balance, impaired mobility, and trying to get out of bed unassisted. The CP's interventions included a motion sensor [alarm] in Resident 2's room.During a review of Resident 3's AR, the AR indicated the facility admitted Resident 3 9/25/2025, with diagnoses that included history of falling and muscle weakness.During a review of Resident 3's CP, initiated 9/26/2025, the CP indicated Resident 3 was at risk for recurrent falls related to impaired balance and impaired mobility. The CP indicated on 12/23/2025, Resident 3 was assisted slowly to the floor (assisted fall) due to Resident 3 trying to walk without calling for [staff assistance] and Resident 3's legs gave out while walking. The CP's interventions included a motion sensor [alarm].During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had intact cognition and required maximal assistance (helper lifts or holds trunk or limbs and provide more than half the effort).During a review of Resident 3's Change in Condition (COC), dated 12/23/2025 at 9 AM, the COC indicated an unidentified Certified Nursing Assistant (CNA) reported Resident 3 had a fall. During a review of Resident 3's Morse Fall Scale (widely used, evidenced based nursing tool designed to assess a patient's risk of falling), dated 12/30/2025, the scale indicated Resident 3 was at high risk for falling.During a concurrent interview and observation on 1/22/2026 at 10:54 AM, CNA 2 stated CNA 2 had 2 alarms for Resident 2 and Resident 3. CNA 2 pulled out 2 white alarms from inside CNA 2's pocket.During an interview on 1/22/2026 at 1:16 PM, CNA 1 stated the sensor alarms needed to be positioned facing the resident (in general) to monitor and detect the resident's motion. CNA 1 stated [it was facility practice for] CNA's (in general) to carry a white device (paired with the sensor alarms located inside resident rooms) and respond when the device made an audible sound (triggered by motion in front of the sensor alarm), by checking (visually) on the resident.During an (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 1/22/2026 at 2:25 PM, the Director of Nursing (DON), the DON stated CNAs (in general) needed to carry sensor alarms with them all the time.During an interview on 1/22/2026 at 2:30 PM, with the DON, the DON stated the response time for the sensor alarms was an immediate response (as soon as the alarm was heard) to see what was going on with the resident. The DON stated if the CNA was busy and could not respond, the CNA should leave the alarm with the nursing staff.During a concurrent observation and interview on 1/22/2026 at 2:37 PM with LVN 2, LVN 2 entered Resident 2's room, the sensor alarm was placed on top of the table facing Resident 2 who was lying in bed. LVN 2 moved in front of the sensor to activate the alarm. LVN 2 waited inside Resident 2's room waiting for CNA 2 to respond to the sensor alarm and CNA 2 did not come to check on Resident 2. LVN 2 then moved outside Resident 2's room and CNA 2 did not respond to the sensor alarm. LVN 2 stated if CNA 2 was busy with another resident, CNA 2 needed to call out from that room to let LVN 2 know Resident 2's alarm was activated for LVN 2 to check on Resident 2. During an observation on 1/22/2026 at 2:37 PM to 2:41 PM with LVN 2, LVN 2 was standing outside Resident 2's room, there was no audible alarm sound. CNA 2 did not come to check on Resident 2 and CNA 2 did not communicate to LVN 2 CNA 2 was busy.During an observation on 1/22/2026 at 2:44 PM, LVN 2 entered Resident 3's room, Resident 3 was lying in bed, and a sensor alarm was positioned on top of the table and facing Resident 3. LVN 2 moved in front of the sensor to activate the alarm.During an observation on 1/22/2026 at 2:44 PM to 2:45 PM while waiting outside Resident 3's room, there was no audible alarm, CNA 2 did not come to check on Resident 3 and CNA 2 did not communicate to LVN 2 CNA 2 was busy.During an observation on 1/22/2026 at 2:46 PM, CNA 2 was inside the staff lounge.During an observation on 1/22/2026 at 2:48 PM with CNA 2, CNA 2 moved in front of Resident 2's sensor and the alarm located inside CNA 2's pocket did not sound. CNA 2 entered Resident 3's room (located across from Resident 2's room) and moved in front of the sensor, the alarm did not sound. CNA 2 checked the alarm and pressed a button followed by an audible alarm sound. CNA 2 stated the alarm might have turned off while inside CNA 2's pocket.During an interview on 1/22/2026 at 3:06 PM with the DON, the DON stated staff needed to respond to sensor alarms immediately when the alarms were activated.During a review of the facility's sensor alarm's undated Product Description (PD), the PD indicated elderly care alarms is a wireless bed alarms for elderly that alerts you when a patient gets up from bed and go and assist her to prevent from fall when she stands up.During a review of the facility's Policy and Procedure (P&P), titled Fall Prevention and Management Program, dated 1/10/2025, the P&P's policy indicated the facility is to provide high quality care in a safe environment for the residents residing in the community. The P&P indicated the program identifies the factors that place residents at risk for falls, promotes proactive healthcare practices for resident care planning, using the least restrictive method possible to keep the resident safe and identifies the main components of an effective fall prevention program. The P&P indicated these components include fall risk assessment, identifying risk factors, implementing interventions, documentation, evaluation, regular reassessment and re-evaluation.