

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055016	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Mount San Antonio Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108</p> <p>Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 23) was accurately assessed for elopement risk.</p> <p>This deficient practice had the potential to result in inadequate treatment and care services rendered to Resident 23.</p> <p>Findings:</p> <p>During a review of Resident 23's Admission Record (AR), the AR indicated Resident 23 was admitted to the facility initially on 4/4/2022 with diagnoses including dementia (a decline in mental ability severe enough to interfere with daily life), osteoarthritis (degeneration of joint cartilage and the underlying bone) and repeated falls.</p> <p>During a review of Resident 23's Nursing-Elopement Risk Assessment ([NAME]), dated 3/20/2023, indicated Resident 23 had a history of leaving the facility.</p> <p>During a review of Resident 23's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 2/13/2024 indicated Resident 23 was cognitively intact and able to make needs known.</p> <p>During a review of Resident 23's History and Physical (H&P), dated 3/14/2024, the H&P indicated Resident 23 was alert and able to make decisions regarding routine medical decisions and immediate needs.</p> <p>During a review of Resident 23's Progress Note (PN), effective date 3/19/2024 timed at 4:54 PM, the PN indicated on 3/19/24, Resident 23 was witnessed outdoors without calling for assistance. The PN indicated Resident 23 was being monitored for elopement/exit seeking [behavior] and Resident 23 had a history of not asking for assistance to spend time outdoors.</p> <p>During a review of Resident 23's care plan (CP), initiated 9/26/2022, the CP indicated on 3/19/2024, Resident 23 went outside to get fresh air without [staff] assistance. The CP include the following problems: poor safety awareness, preferred to be independent beyond Resident 23's ability and verbalized wanting to leave and come back (to the facility) without assistance.</p> <p>(continued on next page)</p>

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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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 23's Behavior Monitoring-Medication Administration Record (MAR), for the month of April 2024, the MAR indicated Resident 23 attempted to leave the facility without assistance on 4/23/2024 and 4/27/2024.</p> <p>During a review of Resident 23's Order Summary Report (OSR), active orders as of 5/1/2024, the OSR included a physician's order, dated 3/20/2024, that indicated to apply wander tag to prevent [Resident 23] from leaving the facility without assistance. The OSR included a physician's order, dated 4/11/2024, that indicated to monitor the number of episodes of leaving without assistance to go outside for fresh air every shift.</p> <p>During a review of Resident 23's [NAME], dated 5/14/2024, the [NAME] indicated Resident 23 was not an elopement risk.</p> <p>During an interview with Registered Nurse 1 (RN 1) and concurrent review of Resident 23's paper and electronic chart on 5/16/2024 at 11:11 AM, RN 1 stated Resident 23 wore an ankle monitor guard because Resident 23 had a history of, and expressed, wanting to go outside of the facility without supervision. RN 1 stated the ankle monitor was used to alert staff when Resident 23 was near the exit doors. RN 1 stated Resident 23 was an elopement risk because Resident 23 vocalized Resident 23 wanted to leave the facility. RN 1 stated accuracy of assessment was important to ensure proper interventions were in place and staff was aware of Resident 23's behavior.</p> <p>During an interview and concurrent review of Resident 23's paper and electronic records with the Director of Nursing (DON), on 5/16/2024 at 12:15pm, the DON stated the elopement assessment dated [DATE], was incorrect. The DON stated Resident 23 was found outside of the courtyard 3/2024 and attempted to leave the facility twice on 4/23/24 and 4/27/24.</p> <p>During a review of the facility's policy and procedure (P&P), titled Elopement/Missing Resident and Absentee Notification Plan, revised 3/8/2024, the P&P indicated an elopement risk assessment is conducted by staff for residents identified with risk factors: prior history of elopement, or diagnosis of Alzheimer's, dementia, or other cognitive impairment. The P&P indicated the assessment would be done within 24 hours of admission, quarterly, or when there is a significant change of condition by the charge nurse.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 12) received treatment and care in accordance with the facility's policies and procedures (P&P) by failing to ensure Resident 12's skin tear and edema (swelling caused by too much fluid trapped in the body's tissues) were monitored and cared for adequately.</p> <p>This deficient practice resulted in no improvement to Resident 12's skin tear and edema and caused Resident 12 to feel worried, in addition, the failure had the potential to result in a physical decline to Resident 12.</p> <p>Findings:</p> <p>During a review of Resident 12's Admission Record (AR), the AR indicated, Resident 12 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including unspecified atrial fibrillation (an irregular, often very rapid heart rate that commonly causes poor blood flow), essential primary hypertension (high blood pressure) and other specified disorders of bone density and structure, unspecified site.</p> <p>During a review of Resident 12's Care Plan (CP) titled, Risk for developing pressure ulcers, bruising, and other types of impaired skin integrity, date initiated 2/23/2024, the CP indicated, one of the interventions was to assess skin integrity during care.</p> <p>During a review of Resident 12's CP, titled, At risk for skin breakdown, weight loss, formation of contractures (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and tightness of the joints), joint limitation, increase pain, intractable pain, isolation, and reduced social interaction, date initiated 2/27/2024, the CP indicated, one of the interventions was to assess skin condition.</p> <p>During a review of Resident 12's CP, titled, Skin tear proximal left ankle clarification of location from left ankle date initiated 5/2/2024, the CP indicated, one of the interventions was to Geri (skin) sleeves to be applied to legs daily and removed at bedtime every day and evening shift for Skin Maintenance.</p> <p>During a review of Resident 12's History and Physical Examination (H&P), dated 3/1/2024, the H&P indicated, Resident 12's skin had erythema (redness of the skin caused by injury or another inflammation-causing condition) with mottling (blotchy, red-purplish marbling of the skin). The H&P indicated, Resident 12 had generalized weakness and was alert and oriented.</p> <p>During a review of Resident 12's Minimum Data Set (MDS, an assessment and screening tool), dated 3/1/2024, the MDS indicated, Resident 12's cognition (ability to understand and process information) was intact. The MDS indicated, Resident 12 was at risk for developing pressure ulcers/injuries (injury to skin and underlying tissue resulting from prolonged pressure on the skin) and Resident 12 had no ulcers/wounds/skin problems on Resident 12's feet.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 12's Change in Condition (COC), dated 5/2/2024, timed at 4:05 PM., the COC indicated, noted skin tear to [Resident 12's] left ankle and edema +2 (a grading system to determine the severity of the edema on a scale from +1 to +4, none to severe) on BLE (bilateral lower extremities, both legs) with some weeping (fluid leaking out directly from the skin) on the LLE (left lower extremities).</p> <p>During a review of Resident 12's Interdisciplinary Team (IDT, a team of health care professions who work together to establish plans of care for residents), dated 5/3/2024, timed at 12:58 PM., the IDT indicated, Resident 12 had pitting edema (when an indentation remains after pressing swollen skin) and had fragile skin and recommended [putting on] geri sleeves (to protect the skin) on the BLE and continue the plan of care for skin breakdown. The IDT indicated, Resident 12 was at risk for further skin breakdown due to anticoagulant (blood thinner) therapy, poor fluid/dietary intake, aging process, fragile skin, impaired balance, impaired mobility, poor safety awareness, impaired vision, and ambulating without assistance.</p> <p>During a concurrent observation and interview on 5/13/2024 at 1:46 PM., with Resident 12 in Resident 12's room, Resident 12 was ambulating (walking) slowly independently. Resident 12's legs were open to air, appearing light purple in color, had edema (more edema on the left side) on both legs, and had minimal weeping. Resident 12 had a bandage on the left inner ankle and stated, the facility was not doing anything about Resident 12's legs and Resident 12 was disappointed, concerned, and felt the staff had neglected the edema on her legs. Resident 12 asked, What are they doing? Why is it not healing? Resident 12 stated, the swelling was small when Resident 12 was admitted to the facility but got worse and was not better. Resident 12 stated, it's been a month and thought Resident 12 should see a dermatologist (a medical doctor who specializes in treating the skin, hair, and nails). Resident 12 stated, the staff told Resident 12 to only elevate her legs, but really nothing.</p> <p>During an interview on 5/13/2024 at 2:05 PM., with the Personal Caregiver (PCG), the PCG stated, the PCG reported Resident 12's edema 2 weeks ago after the PCG noticed the left foot was bigger than the right foot.</p> <p>During a concurrent observation and interview on 5/14/2024 at 3:10 PM., with Resident 12, Resident 12 was up in Resident 12's room using a rollator walker (a walker with a built-in seat). Resident 12's legs were swollen, open to air, with the left side worse than the right side. Resident 12 stated, nobody had checked on Resident 12's swollen legs and the evening [shift] staff would look at it they always pass it on.</p> <p>During a concurrent interview and record review on 5/15/2024 at 9:58 AM., with the Quality Assurance Nurse (QAN), Resident 12's Physician Orders (PO), were reviewed. The PO indicated, Geri (skin) sleeves [were] to be applied to the legs daily and removed at bedtime every day and during the evening shift for Skin Maintenance ordered on 5/3/2024. The QAN stated, Resident 12 did not have a geri sleeve on and this was important to protect Resident 12's skin.</p> <p>During an observation on 5/15/2024 at 10:26 AM., with the QAN, Resident 12's legs were observed. Resident 12 had no geri sleeves on. Resident 12's legs were swollen, the left leg had a dry kerlix (dressing used to cover wounds) dressing wrapped around the left ankle, and the dressing was constricting the area. The QAN removed the kerlix dressing and Resident 12's left leg had a dark purplish, blackish discolored section with a skin tear/wound and scanty weeping.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/15/2024 at 10:30 AM., with Resident 12, Resident 12 stated, the staff had not told Resident 12 about [Resident 12 wearing] geri sleeves and Resident 12 had not heard about a geri sleeve.</p> <p>During a concurrent interview and record review on 5/15/2024 at 11:24 AM., with Registered Nurse 1(RN 1), Resident 12's PO, were reviewed. The PO indicated, a Geri sleeves to be applied to the legs daily and removed at bedtime every day and evening shift for Skin Maintenance ordered on 5/3/24. RN 1 stated, RN 1 was aware of Resident 12's edema and skin tear on Resident 12's left ankle. RN 1 stated, the order for a geri sleeve was not carried out. RN 1 stated, it was important to carry out the PO because the geri sleeve was an extra layer [added] to protect Resident 12's skin.</p> <p>During a concurrent interview and record review on 5/15/2024 at 11:51 AM., with the Assistant Director of Nursing (ADON), Resident 12's medical records (MR), were reviewed. The ADON stated, there was no skin assessment done on Resident 12 and a skin assessment should have been done for a skin tear that was either not responding well to the treatment or worsening. The ADON stated, Resident 12's skin tear should have been assessed due to not responding to the treatment, change in edema, and [the staff] should have reached out to the doctor [to obtain] further recommendations. The ADON stated, the geri sleeve could have minimized further skin [breakdown] and for protection.</p> <p>During a review of the facility's undated P&P titled, Skin-Open Wound, Skin Tears, Bruises, Abrasions, Edema and Minor Breaks, Care Of, the P&P indicated, the purpose of the P&P procedure was to guide the prevention and treatment of abrasions, skin tears, bruises, edema, swelling and minor breaks in the skin. The P&P indicated, to review the resident's care plan, current orders, and diagnoses to determine resident needs.</p> <p>During a review of the facility's P&P titled, Quality of Care - Quality of Life, dated 2015, the P&P indicated, OBRA (Omnibus Reconciliation Act of 1987) emphasized the need for all health care providers to follow and uphold the Residents Rights which stresses Quality of Care for residents. The standard stresses the need to care for all residents in a manner and in such an environment as will promote maintenance or enhancement of the Quality of Life for each resident. The P&P indicated, performing safe and effective care included recognizing changes in residents' condition and reporting them promptly and performing care correctly as assigned.</p> <p>During a review of the facility's P&P titled, Skin Integrity/Wound Care Program, date revised 12/14/2018, the P&P indicated, residents who have suffered loss of skin integrity receive appropriate treatment.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</p> <p>Based on observation, interview, and record review, the facility failed to follow safe and proper food storage practices in accordance with professional standards for food service safety and the facility's policy and procedure (P&P) by failing to label/date food items in one of one kitchen (Kitchen 1).</p> <p>This deficient practice could result in a risk for serious complications from food borne illness (illness caused by the ingestion of contaminated food or beverage) and/or affect the quality and palatability of food given to the residents.</p> <p>Findings:</p> <p>During a concurrent observation and interview on [DATE], at 8:02 AM., with the Purchasing Clerk (PC) during the initial tour of Kitchen 1, the following were observed on the top open shelf of the preparation counter area:</p> <ol style="list-style-type: none"> 1. An unlabeled 20 oz (ounces, unit of weight) Lawry's Salt-Free 17 Seasoning with less than one fourth contents remaining with a label date Received date [DATE] 2. An unlabeled 16 oz Sysco Imperial Ground Nutmeg with three quarters contents remaining. 3. An unlabeled 26 oz Sysco Imperial Granulated Garlic <p>with two thirds content remaining.</p> <p>In addition, there was an unlabeled orange and an apple wrapped in [NAME] wrap on top of the counter, stored in a steel wire fruit basket. Inside Refrigerator 10, there was a plastic bag of frozen potato wedges and a plastic bag of frozen onion rings that were unlabeled. Inside Refrigerator 3, there were 2 boxes of fresh apples, 3 boxes of fresh oranges, 1 box of fresh lemons, 1 bin of fresh white onions, 1 bin of fresh red onions, and 2 unlabeled 1-gallon Sysco Ultra Premium Lime Juice one with one fourth contents remaining, the other with one third contents remaining.</p> <p>The PC stated, the food items should have been labeled with opened dates to ensure the facility was not using any expired foods. The PC stated, it was important to know the expiration dates and not to serve expired foods because it [expired food] can cause someone to get sick, could cause food borne illness, and could affect the taste of the food.</p> <p>During an interview on [DATE] at 8:22 AM., with the Cold Food Prep (CFP), the CFP stated, the food items were labeled with the arrival date for the facility to know when the food item expired if it's good or bad and to prevent serving expired food items to prevent residents from getting sick, I wouldn't want them to get sick.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's P&P titled, Labeling and Dating, dated ,d+[DATE], the P&P indicated, all foods would be appropriately wrapped, labeled, and dated based on food storage guidelines. The P&P indicated, all foods were labeled, dated, and securely covered and use-by dates were monitored and followed.</p> <p>During a review of the facility's undated P&P titled, Food Safety Management System, revision date [DATE], the P&P indicated, storage guidelines for quality were as follow:</p> <p>Fresh apples=3 to 5 months in the refrigerator; no guidelines indicating for dry storage</p> <p>Fresh lemons=2 to 5 weeks in the refrigerator</p> <p>Fresh oranges=5 to 6 weeks in the refrigerator; 3 to 4 days in dry storage</p> <p>Spices, ground=6 to 12 months in dry storage.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</p> <p>Based on observation, interview, and record review, the facility failed to implement infection control practices to ensure a safe, sanitary, and comfortable environment in accordance with the facility's policy and procedure (P&P) by failing to properly store dirty laundry for one of five sampled residents (Resident 33).</p> <p>This deficient practice had the potential to result in cross contamination (process by which bacteria can be transferred from one area to another) and/or the development and transmission of disease and infection amongst residents and staff.</p> <p>Findings:</p> <p>During a review of Resident 33's Admission Record (AR), the AR indicated, Resident 33 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (also known as a stroke, damage to tissues in the brain due to a loss of oxygen to the area), unspecified, essential primary hypertension (high blood pressure) and unspecified atrial fibrillation (an irregular, often very rapid heart rate that commonly causes poor blood flow).</p> <p>During a review of Resident 41's History and Physical Examination (H&P), dated 5/12/2024, the H&P indicated, Resident 33 was alert but confused, could make immediate needs known, but was unable to make complex medical decisions.</p> <p>During a review of Resident 33's Minimum Data Set (MDS, an assessment and screening tool), dated 4/4/2024, the MDS indicated, Resident 33's cognitive (ability to think and process information) skills for daily decision making was moderately impaired. The MDS indicated, Resident 33 was dependent (helper does all of the effort) for toileting hygiene.</p> <p>During an observation on 5/13/2024 at 8:58 AM., Resident 33 was awake and alert, sitting on a wheelchair in the hallway by the nursing station. A closed bag of dirty laundry including bed linen was observed on top of the toilet seat in Resident 33's restroom.</p> <p>During a concurrent observation and interview on 5/13/2024 at 9:05 AM., with Certified Nursing Assistant (CNA) 1, a closed bag of dirty laundry including bed linen was on top of the toilet seat of Resident 33's restroom. CNA 1 stated, it was hospice (a type of health care that focuses on the care, comfort, and quality of life of a person with a serious illness who is approaching the end of life) staff who came in early in the morning to help with Resident's 33 care. CNA 1 stated, the hospice staff had already been at the facility when CNA 1 arrived to the facility at 6:40 am_ CNA 1 stated, the hospice staff was supposed to put the bag of dirty laundry in the dirty linen barrel.</p> <p>During an interview on 5/16/2024 at 11:12 AM., with the Infection Preventionist Nurse (IP), the IP stated, hospice staff came to the facility and helped with [resident] care. The IP stated the hospice staff was supposed to put the bag of dirty laundry in the dirty linen barrel and not leave it [bag of dirty laundry] on the toilet seat because it's contamination and for infection control [purposes].</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's undated P&P titled, Infection Prevention & Control Program, the P&P indicated, an infection prevention and control program was established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>During a review of the facility's P&P titled, Personal Laundry, revised date 7/10/2023, the P&P indicated, the purpose of the P&P procedure was to provide a process for the safe and aseptic handling, washing, and storage of laundry. The P&P indicated; all soiled laundry must be placed directly into a closed laundry hamper bag.</p>		