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	05/30/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review, the facility failed to ensure the provision of necessary care and services for one of one sampled resident (Resident 15) when, a. Licensed Vocational Nurse (LVN) 1 failed to notify the Medical Doctor (MD, Resident 15's phycisian) promptly (immediately) of Resident 15's Change of Condition (COC, a sudden clinically important deviation in the resident's health or functioning that requires further assessments and interventions) on 5/28/2025. This deficient practice had the potential to result in life-threatening consequences and untimely medical treatment for Resident 15. Findings: a. During a review of Resident 15's admission Record (AR), the AR indicated the facility admitted Resident 15 on 1/18/2020, with diagnoses that included chronic obstructive pulmonary disease (COPD, long standing group of diseases that cause airflow blockage and breathing-related problems, make it difficult to breathe) and systolic congestive heart failure (the heart cannot effectively contract with each heartbeat). During a review of Resident 15's Minimum Data Set (MDS - a resident assessment tool), dated 5/5/2025, the MDS indicated Resident 15's cognition (ability to think and process information) was severely impaired. The MDS indicated Resident 15 required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) with toileting and personal hygiene. During a review of Resident 15's COC, dated 5/28/2025 at 7:26 PM, the COC indicated Resident 15 had shortness of breath (SOB) and increased fatigue. The MD was notified and new physician orders that included Levaquin 750 milligrams (mg, unit of measurement) oral tablet (antibiotic, medication to treat infections), an increased dose of Methylprednisolone (used in the treatment of COPD, particularly during flare-ups by reducing inflammation in the airways) oral tablet from 8 mg. to 16 mg for 14 days. During a review of Resident 15's Medication Administration Record (MAR), dated 5/2025, the MAR indicated albuterol sulfate inhalation was routinely administered at 8 AM to Resident 15. During an observation on 5/28/25 at 9:18 AM, Resident 15 was lying in bed, breathing was shallow and fast, and Resident 15 was receiving oxygen. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/28/2025 at 1 PM, Resident 15 was lying in bed, breathing was fast and shallow and was receiving oxygen. During an interview on 5/30/2025 at 1:08 PM, Certified Nursing Assistant 2 (CNA 2) stated on 5/28/2025 at the start of CNA 2's shift [6:30 AM], Resident 15 looked confused, did not look good and Resident 15 was not too responsive. CNA 2 stated CNA 2 notified LVN 1 who checked Resident 15's oxygen level and administered a breathing treatment to Resident 15. During an interview on 5/30/2025 at 2:45 PM, with LVN 1, LVN 1 stated, on 4/28/2025, LVN 1 administered oxygen to Resident 15 to maintain Resident 15's oxygen level. LVN 1 stated LVN 1 administered the routine breathing treatment (albuterol). LVN 1 stated Resident 15 did not normally have shortness of breath. LVN 1 stated LVN 1 did not notify the MD immediately of Resident 15's COC on 4/28/2025. During an interview on 5/30/2025 at 3:07 PM, the Activities Assistant (AA) stated Resident 15's daily routine included going outside Resident 15's room and tending to Resident 15's plants. The AA stated on 5/28/2025, the AA did not see Resident 15 because Resident 15 stayed in bed. During an interview on 5/30/2025 at 3:15 PM, Registered Nurse 1 (RN 1) stated signs and symptoms of respiratory distress included low oxygen saturation, the use of accessory muscles used for breathing, and breathing fast. RN 1 stated when a resident (in general) exhibited these symptoms, it was considered a COC, and the licensed nurse needed to notify the physician immediately. RN 1 stated changes in respiratory status needed immediate treatment because the resident's status could go bad quickly. During an interview on 5/30/2025 at 4:29 PM, the Director of Nursing stated a COC needed to be reported promptly [immediately] to the physician to get proper treatment. During a review of the facility's Policy and Procedure (P&P) titled Change of Condition dated 10/2015, the P&P indicated to observe and report any condition change to the attending physician so proper treatment will be implemented. The P&P indicated the facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical/mental condition and/or status.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure adequate perineal (an area lower in the body located between the thighs) care was provided for, one of one sampled resident (Resident 9), who had a history of urinary tract infections (UTI, an infection in any part of the urinary system: kidneys, bladder, or urethra [tube through which the urine leaves the body], sits just in front of the vaginal opening) and as indicated in the facility's Policy and Procedure (P&P) titled, Perineal Care. This deficient practice had the potential to result in a UTI and a physical decline to Resident 9. Findings: During a review of Resident 9's admission Record (AR), the AR indicated the facility admitted Resident 9 on 7/6/2017, with diagnoses that included disorders of the bladder, neurocognitive disorder with lewy bodies (a disease associated with abnormal deposits of a protein called Lewy bodies, affects chemicals in the brain. These changes, in turn, can lead to problems with thinking, movement, behavior, mood, and other body functions). During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool) dated 4/9/2025, the MDS indicated Resident 9 sometimes understood verbal content and sometimes was able to express ideas and wants. The MDS indicated Resident 9 was dependent (helper does all the effort) with all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) including personal and toileting hygiene. The MDS indicated Resident 9 frequently had urine and bowel (long tubed-shaped organ in the abdomen that completes the process of digestion) incontinence (involuntary leakage of bodily fluids, inability to control bladder [urine reservoir] or bowel movements). During a review of Resident 9's Clinical Laboratory results indicated the following: On 4/3/2025, the urine culture identified E. coli (type of bacteria commonly found in the GI [gastrointestinal, refers collectively to the organs of the body that play a part in food digestion] tract) present in the urine. On 5/8/2025, the urine culture identified yeast (fungal cells) in the urine. During an interview on 5/28/2025 at 3:20 PM, Resident 9's family member (FM) stated the FM was concerned about Resident 9's recurrent UTIs. During a concurrent observation and interview on 5/30/2025 at 9:38 AM, with the FM. Certified Nursing Assistant 1 (CNA 1) transferred Resident 9 from the wheelchair to the commode (piece of furniture containing a concealed chamber pot used as a portable toilet for individuals with mobility issues) using a mechanical lift (lift, a mobility tool designed to help residents with mobility challenges). The FM stated Resident 9 sat on the commode for 30 minutes once Resident 9 was up and out of bed to allow Resident 9 to urinate and/or have a bowel movement. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/30/2025 at 10:16 AM, with Registered Nurse (RN) 1, CNA 1 cleaned the perineal area from front to back using wipes. CNA 1 folded the wipes halfway, wiped Resident 9 from front to back, and wiped Resident 9 again. CNA 1 transferred Resident 9 from the lift back to Resident 9's bed. RN 1 applied clotrimazole (antifungal medication) external cream to Resident 9's left and right groin area. RN 1 stated the medication was an antifungal cream. RN 1 stated the groin area looked better, and the area was not as reddened. RN 1 stated Resident 9's left groin area was pink in color. During an interview on 5/30/2025 at 1:41 PM, CNA 1 stated when cleaning [Resident 9] after urination, CNA 1 cleaned from front to back. CNA 1 stated CNA 1 needed to use new clean wipes when cleaning Resident 9 from front to back a second time. During an interview on 5/30/2025 at 2:05 PM, RN 1 stated when cleaning the perineal area, the CNA would clean from front to back and if staff would clean the front side again using the same wipes, bacteria from the back, from the anal area could contaminate the front. During a review of the facility's P&P titled, Perineal Care, dated 9/2022, the P&P indicated it is the practice of the facility to provide perineal care to all incontinent residents in order to promote cleanliness and comfort, prevent infection, skin irritation and to observe resident's skin condition. The P&P indicated for females, open packaged product and obtain the wet cloth, separate the resident's labia (fleshy folds of skin that make up the external female genitalia) with one hand, and cleanse perineum with the other hand by wiping in direction from front to back (from pubic area toward the anus). The P&P indicated repeat on the opposite side using separate section of the washcloth or new disposable wipe. The P&P indicated to clean urethral meatus and vaginal orifice using clean a portion of washcloth or new disposable wipe with each stroke. The P&P indicated to pat dry with a towel. During a review of the Centers for Disease Control and Prevention's (CDC, national public health agency of the United States) topic on Urinary Tract Infection Basics, dated 1/22/2024, the CDC indicated UTI's are common infections that happen when bacteria, often from the skin or rectum (responsible for storing and transporting stool) enter the urethra and infect the urinary tract. https://www.cdc.gov/uti/about/index.html

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview, and record review, the facility failed to ensure safe and appropriate use of side (bed) rails for one of one sampled resident (Resident 8) when, 1. The facility failed to complete a side rail assessment that aligned with the physician's order indicating bilateral half [½-equal part] rails times four and did not reflect the side rails used for Resident 8. 2. The facility failed to obtain a side rail consent for Resident 8 that reflected the physician's order for the use of side rails. Resident 8's side rail consent indicated the use of quarter [¼- one of four equal parts of something] side rails to two sides, The consent did not reflect four quarter side rails used for Resident 8. Additionally, there was no documented evidence that indicated the risks and benefits for the use of all four quarter side rails were explained to Resident 8's responsible party (RP). This deficient practiced placed Resident 8 at risk for injury. (Cross Reference F842) Findings: During a review of Resident 8's admission Record (AR), the AR indicated the facility admitted Resident 8 on 1/18/2018, with diagnoses including dementia (a progressive state of decline in mental abilities), hypertension (HTN-high blood pressure), and dysphagia (difficulty swallowing). During a review of Resident 8's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 3/25/2025, the MDS indicated Resident 8 had severe cognitive (the ability to think and process information) impairment. The MDS indicated Resident 8 was dependent (helper does all of the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and dependent with mobility. During an observation on 5/28/2025 at 09:54 AM, Resident 8 was observed lying in bed in a semi-Fowler's position (when a person lies on their back with the head and upper body raised at an angle of about 30 to 45 degrees). All four quarter (¼-one of four equal parts of something) rails were noted to be up (raised) and in a locked position - two on each side of the bed, at the head and foot of the bed. During a concurrent interview and record review on 5/29/2025 at 11:09 AM, with LVN 1, Resident 8's Side Rail Assessment, dated 3/24/2025 was reviewed. LVN 1 stated the side rail assessment indicated, full side rails on two sides" were selected as the type of side rail to be used for Resident 8. LVN 1 stated a full side rail was a long, continuous rail running the entire length of the bed on one or both sides. LVN 1 stated when both sides had full-length rails, it was considered full rails on two sides. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/29/2025 at 11:09 AM, with LVN 1, Resident 8's Order Summary Report (OSR), the OSR indicated a physician's order dated 4/8/2025, reviewed with LVN 1. LVN 1 stated the active physician's order for Resident 8 indicated bilateral (both sides) half (½-equal part) [side] rails times four to provide comfort and security. LVN 1 stated this setup included two half-length rails on each side of the bed - one toward the head and one toward the foot - totaling four rails. During a concurrent interview and record review on 5/29/2025 at 11:09 AM, with LVN 1, Resident 8's Side Rail Consent Form, dated 4/8/2025 was reviewed. LVN 1 stated Resident 8's side rail consent form indicated the use of quarter (¼) rails on two sides. LVN 1 stated (¼) rails on two sides referred to shorter bed rails that were typically used to assist with repositioning or bed mobility, that covered a small portion of the bed used at the head or foot - not a combination of both on all four sides. LVN 1 stated Resident 8's current side rails were placed as indicated in the physician's order of two half-length rails on each side of the bed - one at the head and one at the foot - for a total of four side rails. LVN 1 stated Resident 8's side rail consent form did not accurately reflect resident 8's current bed rail configuration. LVN 1 stated this represented a discrepancy between the side rail consent form and the physician's order. LVN 1 stated that the consent form obtained did not match the physician's directive nor did it reflect the actual side rail configuration in use. There was no documented evidence that indicated the risks and benefits for the use of all four quarter side rails were explained to Resident 8's responsible party (RP). During an interview on 5/29/2025 at 11:09 AM, LVN 1 stated the inconsistencies between Resident 8's side rail assessment, physician's order, and the side rail consent form resulted in a lack of clarity regarding the actual type of side-bed rail to be used and whether the resident's representative was fully informed and consented to the correct intervention. During an interview on 5/30/2025 at 11:30 AM, with the Director of Nursing (DON), the DON stated when bed rails were considered for use, the facility was required to complete a bed rail assessment to determine the clinical necessity, identify any risks, and evaluate alternatives. The DON stated any inconsistencies between each document could result in the wrong type of rail implemented or the resident and family not being fully informed of what type of rail was used. The DON stated this opened the door to potential safety issues or other physical injuries related to improper use of side rails. The DON stated it was very important the side rail assessment accurately reflected Resident 8's current physical and cognitive needs, and for the assessment to align with the physician's order. The DON stated if a mismatch occurred, it could lead to the use of a rail configuration that was not properly evaluated for safety or clinical appropriateness. The DON stated the side rail consent form should match the physician's order and match the bed rail configuration implemented for Resident 8. The DON stated this ensured the resident (in general) or their representative (when a resident is not able to make own decisions) understood and agreed to the exact type of side rails used. The DON stated the side rail assessment and consent form needed to be revised. During a review of the facility's policy and procedure (P&P) titled, Side Rails, undated, the P&P indicated that if it is determined that side rails are appropriate, the risks and benefits of side rail use will be explained to the resident or their representative and written informed consent for the use of side rails will be obtained. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Charting & Documentation, undated, the P&P indicated that documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. During a review of the facility's policy and procedure (P&P) titled, Informed Consent, revision dated 9/2023, the P&P indicated it is the policy of the facility to uphold the rights of residents to participate in the planning and decision-making process concerning their care and treatment. When situations arise that involve complex decisions, the facility will verify that informed consent has been obtained prior to any medical intervention or treatment is initiated, including, bot not limited to, administration of psychotherapeutic medications, application of a physical restraint or the prolonged use of a device that may lead to the inability to regain use of a normal body function and for transfer and discharge. Until such time as devices are identified by statue or regulation that led to the inability to regain use of a normal bodily function are defined this portion of the policy will not be enacted. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, revision dated 8/2013, the P&P indicated the resident has the right to be fully informed in advance about the care and treatment and of any changes in that care or treatment that may affect the resident's well-being, and unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment changes in care and treatment.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review, the facility failed to ensure accurate documentation for the use of side (bed) rails, for one of one sampled resident (Resident 8), as indicated in the facility's policy and procedure (P&P), titled, Charting & Documentation, The facility failed to: 1.Complete a side rail assessment aligned with the physician's order to indicate bilateral half [½-equal part] rails times four, the assessment did not reflect the side rails used for Resident 8. 2.Obtain a side rail consent for Resident 8 that reflected the physician's order for the use of side rails. Resident 8's side rail consent indicated the use of quarter [¼- one of four equal parts of something] side rails to two sides, The consent did not reflect four quarter side rails used for Resident 8. This deficient practice had the potential to lead to inconsistent and/or inaccurate treatments provided to Resident 8. (Cross Reference F700) Findings: During a review of Resident 8's admission Record (AR), the AR indicated the facility admitted Resident 8 on 1/18/2018, with diagnoses including dementia (a progressive state of decline in mental abilities), hypertension (HTN-high blood pressure), and dysphagia (difficulty swallowing). During a review of Resident 8's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 3/25/2025, the MDS indicated Resident 8 had severe cognitive (the ability to think and process information) impairment. The MDS indicated Resident 8 was dependent (helper does all of the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and dependent with mobility. During an observation on 5/28/2025 at 09:54 AM, Resident 8 was observed lying in bed in a semi-Fowler's position (when a person lies on their back with the head and upper body raised at an angle of about 30 to 45 degrees). All four quarter (¼-one of four equal parts of something) rails were noted to be up (raised) and in a locked position - two on each side of the bed, at the head and foot of the bed. During a concurrent interview and record review on 5/29/2025 at 11:09 AM, with LVN 1, Resident 8's Side Rail Assessment, dated 3/24/2025 was reviewed. LVN 1 stated the side rail assessment indicated, full side rails on two sides" were selected as the type of side rail to be used for Resident 8. LVN 1 stated a full side rail was a long, continuous rail running the entire length of the bed on one or both sides. LVN 1 stated when both sides had full-length rails, it was considered full rails on two sides. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/29/2025 at 11:09 AM, with LVN 1, Resident 8's Order Summary Report (OSR), the OSR indicated a physician's order dated 4/8/2025, reviewed with LVN 1. LVN 1 stated the active physician's order for Resident 8 indicated bilateral (both sides) half (½-equal part) [side] rails times four to provide comfort and security. LVN 1 stated this setup included two half-length rails on each side of the bed - one toward the head and one toward the foot - totaling four rails. During a concurrent interview and record review on 5/29/2025 at 11:09 AM, with LVN 1, Resident 8's Side Rail Consent Form, dated 4/8/2025 was reviewed. LVN 1 stated Resident 8's side rail consent form indicated the use of quarter (¼) rails on two sides. LVN 1 stated Resident 8's side rail consent form did not accurately reflect resident 8's current bed rail configuration. LVN 1 stated this represented a discrepancy between the side rail consent form and the physician's order. LVN 1 stated that the consent form obtained did not match the physician's directive nor did it reflect the actual side rail configuration in use. During an interview on 5/29/2025 at 11:09 AM, LVN 1 stated the inconsistencies between Resident 8's side rail assessment, physician's order, and the side rail consent form resulted in a lack of clarity regarding the actual type of side-bed rail to be used and whether the resident's representative was fully informed and consented to the correct intervention. During an interview on 5/30/2025 at 11:30 AM, with the Director of Nursing (DON), the DON stated when bed rails were considered for use, [documents should] accurately reflect Resident 8's current physical and cognitive needs, and the assessment should align with the physician's order. The DON stated if a mismatch occurred, it could lead to the use of a rail configuration that was not properly evaluated for safety or clinical appropriateness. The DON stated the side rail consent form should match the physician's order and match the bed rail configuration implemented for Resident 8. The DON stated the side rail assessment and consent form needed to be revised. During a review of the facility's policy and procedure (P&P) titled, Charting & Documentation, undated, the P&P indicated that documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.