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	06/24/2026

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

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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 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 ensure,A. Adequate monitoring (supervision from staff) to prevent a fall for one of three sampled residents (Resident 6), who was at high risk for falls. B. Proper placement of sensor alarm (wireless bed alarms that alert staff when a patient gets up from the bed for staff to assist the resident, an intervention used to prevent falls) transmitters (paired with the sensor alarm receiver located inside the resident's rooms [in general]) used to detect the resident's motion for two of three sampled residents (Resident 32 and Resident 34), who were at high risk for falls. This deficient practice resulted in Resident 6 sustaining a fall on 6/15/2026 and had the potential to result in falls with injury to Resident 32 and Resident 34. Findings: A. During a review of Resident 6's admission Record (AR), the AR indicated Resident 6 was admitted to the facility on [DATE] with multiple diagnoses including dementia (a gradual decline in mental ability usually caused by a brain disease), generalized muscle weakness (overall reduction in physical strength throughout the body), and other abnormalities of gait and mobility (changes in the natural walking pattern or the ability to move freely.) During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool), dated 5/6/2026, the MDS indicated Resident 6 had severely impaired cognition (ability to understand and process information) and required substantial/ maximal assistance (helper does more than half the effort) for toileting hygiene and bathing. The MDS indicated Resident 6 required partial/ moderate assistance (helper does less than half the effort) for toilet transfers (the ability to get on and off a toilet or commode). During a review of Resident 6's Morse Fall Scale (MFS), dated 5/6/2026, the MFS indicated Resident 6 was at high risk for falling. The MFS indicated under Mental Status, an assessment of a resident's ability to go to the bathroom alone, Resident 6 overestimated or forgot limits. During a review of Resident 6's Progress Notes (PN) dated 6/15/2026 at 5:18 AM, the PN indicated Resident 6 was observed by [Certified Nursing Assistant (CNA) 2 and Registered Nurse (RN) 4] sitting on the floor with legs straight out and leaning on the right elbow. The PN indicated CNA 2 stated CNA 2 assisted Resident 6 to the bathroom and momentarily left Resident 6 on the toilet to check on another resident (unidentified) next door and when CNA 2 returned two to three minutes later, Resident 6 was sitting on the floor outside the bathroom door. During a review of Resident 6's Care Plans (CP), the CP initiated on 2/12/2025, revised 6/15/2026, indicated Residence 6 was at risk for recurrent falls. The CP's interventions indicated to minimize (continued on next page)

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 - Some	hazards and provide a safe environment. The CP, initiated 6/15/2026, indicated Residence 6 was at risk for further falls/ injuries due to Resident 6 being found sitting on the floor outside the bathroom door. The CP's interventions indicated to continue to educate staff not to leave Resident 6 unattended when toileting. During an interview on 6/23/2026 at 10:39 AM with Resident 37's Private Caregiver (PC) 1, PC 1 stated PC 1 had cared for Resident 37 for almost two years Monday through Friday for 6 hours a day starting at noon. PC 1 stated Resident 37's ability to walk started to decline this year beginning a couple months ago by Resident 37's attempts to sit down if a chair is in sight. PC 1 stated Resident 37 was on a toileting schedule and is taken to a toilet or offered toileting every 2 hours under PC 1's care. PC 1 stated Resident 37 was not able to verbalize when Resident 37 was done using the toilet and usually only smiled or giggled when responding to questions or directions. PC 1 stated PC 1 did not leave Resident 37 alone in the restroom to be able to provide assistance when needed by Resident 37. During an interview on 6/24/2026 at 3:15 PM with the Director of Nursing (DON), the DON stated Resident 6 was considered a high fall risk even prior to the fall that occurred on 6/15/2026 due to Resident 6's dementia. The DON stated the CNA [CNA 2] was not supposed to leave Resident 6 in the bathroom alone because Resident 6 had dementia and anything such as a fall could occur. The DON stated it was a general protocol of the facility not to leave residents [in general] alone in the restroom. 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 indicated staff will monitor at risk residents closely during the following times: shift change; meal time; going from inside to the outside or reverse; wearing very new or very old shoes; standing up after sitting or lying down for a while; cold, fever or other acute illness; and using the bathroom, tub or shower room, etc. During a review of the facility's undated P&P titled, Safety and Supervision of Residents, the P&P indicated the facility strives to make the environment as free from accident hazards as possible. The P&P indicated resident supervision is a core component of the systems approach to safety. The P&P indicated the type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. B. During a review of Resident 32's AR, the AR indicated the facility admitted Resident 32 on 3/1/2024 with diagnoses that included age related osteoporosis (bone mass is lost faster than it's created as people age) and muscle weakness. During a review of Resident 32's CP, initiated on 2/19/2026, the CP indicated Resident 32 was at risk for falls. The CP's goal indicated the facility would minimize Resident 32's risk for falls. The CP's interventions indicated a motion sensor [transmitter] in [Resident 32's] room as a fall precaution and to check for proper function and placement of the [motion sensor transmitter]. The CP's interventions indicated to minimize hazards and provide a safe environment for Resident 32. During a review of Resident 32's MFS, dated 3/26/2026, the MFS indicated Resident 32 was at high risk for falls. During a review of Resident 32's MDS, dated [DATE], the MDS indicated Resident 32's cognition was intact. The MDS indicated Resident 32 required maximal assistance (helper lifts or holds trunk or (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	limbs and provides more than half the effort) for toileting hygiene, personal hygiene, and toilet transfers. During a review of Resident 32's Order Summary Report (OSR), dated active as of 6/24/2026, the OSR indicated a physician order, dated 2/20/20206, indicating motion sensor [transmitter] in [Resident 32's] room for fall precautions. The order indicated to check the motion sensor [transmitter] proper function and placement. During a concurrent observation and interview on 6/23/2026 at 8:52 AM with Licensed Vocational Nurse 2 (LVN 2), Resident 32 was sitting on a wheelchair beside Resident 32's bed. The sensor alarm transmitter was on top of a shelf located in front of Resident 32's bed and was not facing Resident 32. LVN 2 stated the sensor alarm transmitter needed to be positioned facing Resident 32 for the sensor to detect Resident 32's motion. LVN 2 stated [facility practice was] the white sensor alarm receiver (activated by an audible sound triggered by motion in front of the sensor alarm transmitter) was kept on top of the medication carts for facility staff to respond [to the alarm]. During a review of Resident 34's AR, the AR indicated the facility admitted Resident 34 on 6/5/2020 with diagnoses that included age related osteoporosis and history of falling. During a review of Resident 34's MDS, dated [DATE], the MDS indicated Resident 34 understood verbal content and was able to express ideas and wants. The MDS indicated Resident 34 required moderate assistance (helper lifts, holds or supports trunk or limbs but provides less than half the effort) with toilet transfers and chair/bed-to-chair transfers. During a review of Resident 34's MFS, dated 6/1/2026, the MFS indicated Resident 34 was at high risk for falls. During a review of Resident 34's CP, initiated 7/4/2023, revised 6/15/2026, the CP indicated Resident 34 was at risk for falls. The CP's goal indicated the facility would minimize Resident 34's risk for falls. The CP's interventions indicated to check battery function and proper placement of the motion sensor [transmitter] in Resident 34's room as a fall precaution. The CP's interventions indicated to minimize hazards and provide a safe environment for Resident 34. During a review of Resident 34's OSR, dated active as of 6/24/2026, the OSR indicated a physician order, dated 8/28/2024, for motion sensor [transmitter] in [Resident 34's] room. The OSR indicated a physician order, dated 1/23/2026, to check battery function and proper placement of the motion sensor [transmitter]. During an observation on 6/24/2026 at 7:55 AM Resident 34 was sitting on the wheelchair eating breakfast. The sensor alarm transmitter was not facing Resident 34 and was facing toward the window. During a concurrent observation and interview on 6/24/2026 at 8:05 AM with CNA 5, the sensor alarm transmitter was not facing Resident 34. CNA 5 stated the sensor alarm [transmitter] needed to face Resident 34, so the alarm activated if Resident 34 attempted to get up from bed. During an interview on 6/24/2026 at 3:38 PM with the DON, the DON stated the sensor alarm [transmitter] needed to be positioned facing the residents (in general) for the alarm to work. The DON stated the alarm's purpose for use was to alert staff when the residents got out of bed or out of the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wheelchair without asking for assistance from staff and for staff to assist the resident. During a review of the facility's undated product instruction manual, titled Wireless Door & Bed Alarm the manual indicated that for elderly/dementia [residents], install the transmitter at the patient's bedside and obtain the best installation position by repeatedly adjusting the sensing angle and range of the transmitter. The manual indicated the transmitter detects the infrared signal range released from body surface temperature. During a review of the facility's P&P, titled, Fall Prevention and Management Program, dated 1/10/2025, the P&P's policy indicated the facility was to provide high quality of care in a safe environment for the residents residing in the facility. The P&P indicated all residents will be assessed for falls using the Morse Fall Scale. The P&P indicated any resident at risk [for falls] will have fall interventions placed on the resident's CP.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure three of five sampled residents (Resident 47, Resident 17 and Resident 30) received proper respiratory (relating to breathing) care in accordance with the facility's policy and procedures (P&P) and physician's orders by failing to:a. Post Oxygen in Use - No Smoking (signage) in the sign plate holder outside of Resident 17 and Resident 47's rooms in accordance with the facility's policy and procedure (P&P) titled, Oxygen Administration.b. Change Resident 30's nasal cannula (NC - a small plastic tube that fits into the person's nostrils and used to provide supplemental oxygen [02 - a colorless, odorless, tasteless gas essential for living) and 02 humidifier (a medical device attachment used during 02 therapy to add moisture to supplemental 02) every Sunday in accordance with the facility's P&P titled, Oxygen Administration.These deficient practices had the potential to result spark producing activities by visitors due to a lack of highly visible warning signage posted outside of the resident's rooms and the potential to result in a fire and burns to Resident 17 and Resident 47. Additionally, there was a potential for bacterial (microscopic, single celled living organism some can cause disease) infections, mold (an invasive microscopic fungus, can trigger an immune reaction, can actively grow and cause serious sometimes life-threatening infections) growth, and skin irritation to Resident 30 due to the facility using an old NC and humidifier.Findings:a. During a review of Resident 47's admission Record (AR), the AR indicated Resident 47 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including chronic obstructive pulmonary disease (COPD - a long-standing lung disease causing difficulty in breathing), unspecified, and heart failure, unspecified.During a review of Resident 47's Encounter - Office Visit (EOV), dated 6/22/2026, the EOV indicated Resident 47 did not have decision-making capacity.During a review of Resident 47's Order Summary Report (OSR), active orders as of 6/24/2026, the OSR indicated a physician's order, dated 6/19/2026, for O2 at five (5) LPM (liters per minute - the speed or volume of 02 a device delivers to a resident) via NC every shift for SOB (short of breath) continuously.During a review of Resident 47's Treatment Administration Record (TAR), dated 6/1/2026 - 6/30/2026, the TAR indicated Resident 47 was receiving 02 at 5 LPM via NC every shift for SOB continuously since readmission to the facility.During a review of Resident 17's AR, the AR indicated Resident 17 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including anemia (a condition where the body does not have enough healthy red blood cells), unspecified, and other specified symptoms and signs involving the circulatory (the body's delivery network that includes the heart, blood vessels and blood), and respiratory systems.During a review of Resident 17's History and Physical Examination (H&P), dated 6/1/2026, the H&P indicated Resident 17 was alert, but confused, could make immediate needs known, but was unable to make complex medical decisions.During a review of Resident 17's Minimum Data Set (MDS - a resident assessment tool), dated 4/9/2026, the MDS indicated Resident 17's cognitive (the ability to think and process information) skills for daily decision making were moderately impaired (decisions poor; cues/supervision required). The MDS indicated Resident 17 required substantial/maximal assistance (helper does more than half the effort) to setup or clean-up (helper sets up or cleans up with activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 17's OSR, active orders as of 6/24/2026, the OSR indicated, a physician's order, dated 6/15/2026, for O2 at two (2) LPM via NC, may titrate (adjusting the dose up or down) up to four (4) LPM every shift as needed to maintain 02 saturation (02 sat - a measurement indicating how much 02 the blood is carrying as a percentage) level to equal ninety two (92)%.b. During a review of Resident 30's AR, the AR indicated Resident 30 was originally admitted to the facility on [DATE] with multiple diagnoses including anemia unspecified, and heart failure, unspecified.During a review of Resident 30's Care Plan (CP), initiated (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/4/2026, the CP indicated Resident 30 was at risk for respiratory distress. The CP's indicated to change 02 tubing and humidifier every week.During a review of Resident 30's H&P, dated 6/5/2026, the H&P indicated Resident 30 was alert, oriented, and competent to make complex medical decisions.During a review of Resident 30's MDS, dated [DATE], the MDS indicated Resident 30's cognitive skills for daily decision making were intact. The MDS indicated Resident 30 required substantial/maximal assistance for setup or clean-up assistance with ADL. The MDS indicated Resident 30 was on 02 while a resident at the facility and was on intermittent 02 therapy on admission.During a review of Resident 30's OSR, active orders as of 6/24/2026, the OSR indicated a physician's order, dated 6/3/2026, for 02 at 2 LPM via NC at bedtime for comfort and an order indicating to change tubing [NC], humidifier and check the filter every week every night shift every Saturday.During a review of Resident 30's TAR, dated 6/1/2026 to 6/30/2026, the TAR indicated Resident 30 was receiving 02 at 2 LPM via NC administered at 9 PM at bedtime for comfort.a. During an observation and interview on 6/22/2026 at 10:16 AM with Private Caregiver (PC) 2, Resident 47 was in bed, frail and receiving 02 at 5 LPM with the NC and humidifier labeled with a date of 6/15/2026. PC 2 stated, Resident 47 was always on 02 at 5 LPM. There was no signage posted outside of Resident 47's room indicating 02 was in use.During a concurrent observation and interview on 6/22/2026 at 10:34 AM with Certified Nursing Assistant (CNA) 4, there was no signage posted outside of Resident 47's room. CNA 4 stated, when a resident was receiving 02, a signage was to be posted outside of the resident's room because it's [02] flammable.During an interview on 6/22/2026 at 10:45 AM with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Resident 47 was admitted to the facility on Friday afternoon [6/19/2026] and a signage should have been posted outside of Resident 47's room. LVN 3 stated, posting signage [indicating 02 was in use] was important and was needed for safety purposes so visitors and staff knew Resident 47 was on 02.During an observation and interview on 6/22/2026 at 10:56 AM with Resident 17, Resident 17 was sitting in Resident 17's wheelchair with no 02 administration. Resident 17 stated, Resident 17 used 02 only when Resident 17 needed 02. Resident 17's room did not have signage [indicating 02 in use] posted outside of Resident 17's room.During a concurrent observation and interview on 6/22/2026 at 11:12 AM with LVN 3, LVN 3 stated LVN 3 would get the signage [indicating 02 was in use] to post outside of Resident 17's room.b. During observation and interview on 6/22/2026 at 11:24 AM with Resident 30, Resident 30 was in bed and was not receiving 02. Resident 30's bedside had a 02 concentrator, humidifier, and NC tubing with pink colored label stickers indicating, Change[d] Sunday 6/14/2026 and with the Patient Set-Up Bag [a bag used for keeping respiratory equipment clean and dry], dated 6/14/2026. Resident 30 stated, Resident 30 used pretty low amount of 02 during the night.During an interview on 6/23/2026 at 1:14 PM with LVN 2, LVN 2 stated the night shift [11 PM - 7 AM] was responsible for changing resident's (in general) NCs and humidifiers once a week every Sunday, for infection control and it's the policy also. LVN 2 stated Resident 30's NC and humidifier should have been changed on 6/21/2026.During an interview on 6/23/2026 at 2:07 PM with the Director of Nursing (DON), the DON stated NCs and humidifiers were to be changed every week on Sunday by the night shift and changing NCs and humidifiers was important for infection control and if there was a build-up like mucous, the resident would of course, not get enough oxygen.During an interview on 6/24/2026 at 9:38 AM with the DON, the DON stated posting signage [indicating oxygen was in use] outside of the resident's room for residents who were receiving 02 was vital for safety and to alert visitors not to light a candle and/or smoke.During a review of the facility's P&P titled, Oxygen Administration, date revised 6/2026, the P&P indicated, NC and face masks would be changed weekly (Sundays 11-7), regardless of PRN (as needed) changes, labeled with initials, date, and time. The P&P indicated, to post the Oxygen in use - No Smoking sign in the sign plate holder outside of the room.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 implement infection prevention and control measures for two of five sampled residents (Resident 37 and Resident 1) by failing to ensure:A. Certified Nursing Assistant (CNA) 5 wore personal protective equipment (PPE, protective clothing or equipment, designed to protect the wearer from injury or the spread of infection [the invasion and growth of germs in the body] or illness) while providing care to Resident 37 and Resident 1 who were under Enhanced Barrier Precautions (EBP, extra measures, like wearing gowns and gloves, used during high-contact care activities for residents who are at a higher risk of having or spreading germs that are hard to treat, like multidrug-resistant organisms [MDROs, bacteria that have become resistant to certain antibiotics [medication used to treat bacterial infections], and these antibiotics can no longer be used to control or kill the bacteria] e.g., residents with wounds or indwelling [resides, exist, or operates from within] medical devices).B. Licensed Vocational Nurse (LVN) 2 disinfected blood pressure equipment (BP, monitor and cuff used to check blood pressure) before and after use for Resident 1.These deficient practices had the potential to result in infections and the spread microorganisms (bacteria, virus, fungus) to Resident 1 and Resident 37. Findings: A. During a review of Resident 37's admission Record (AR), the AR indicated Resident 37 was admitted to the facility on [DATE] with multiple diagnoses including dysphagia (difficulty swallowing), gastrostomy (surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), transient ischemic attack (temporary blockage of blood flow to the brain), and cerebral infarction (a stroke, where a blockage interrupts blood flow to the brain leading to tissue death) without residual deficits. During a review of Resident 37's Minimum Data Set (MDS- a resident assessment tool), dated 6/15/2026, the MDS indicated Resident 37 had severely impaired cognition (ability to understand and process information) and was dependent (helper does all of the effort) on staff for personal hygiene and toileting. During a review of Resident 37's Order Summary Report (OSR), active orders as of 6/23/2026, the OSR indicated Resident 37 had a physician order, start date 5/1/2024, for EBP every shift for the presence of a gastrostomy tube. During a review of Resident 37's Care Plan (CP), initiated on 4/30/2024, the CP indicated Resident 37 was at risk for the development of MDROs and was on EBP for the presence of a gastrostomy tube (G-tube, a small flexible medical device inserted directly through the abdomen into the stomach). The CP's interventions indicated to initiate EBP and wear appropriate PPE (gown and gloves) during high contact care [activities]. During an observation on 6/22/2026 at 9:30 AM, Resident 37's doorway was observed with signage titled, Enhanced Barrier Precautions, from the Los Angeles County Department of Public Health (LACDPH), revised 2/23/2026. The signage indicated providers and staff must wear gloves and gowns for the following high-contact resident care activities: caring for devices and giving medical treatments. During an observation on 6/23/2026 at 11:03 PM with LVN 1 in Resident 37's room, LVN 1 was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed removing Resident 37's G-tube feeding from Resident 37's G-tube and delivered approximately five milliliters (ml – unit of volume) of water via Resident 37's G-tube while wearing only gloves for PPE. During a concurrent observation and interview on 6/23/2026 at 1:03 PM with LVN 1 in Resident 37's room, LVN 1 was observed administering water and medications to Resident 37 via Resident 37's G-tube without wearing a PPE gown. LVN 1 administered 30 ml of water via the piston syringe (tool used to pump liquids or gases, consisting of a tight-fitting plunger [piston] that slides up and down inside a hollow cylinder) to Resident 37's G-tube. During the time the water was draining via gravity (plunger is not used), Resident 37 coughed causing water in the piston syringe to spill out of the top of the syringe onto Resident 37. LVN 1 stated staff needed to wear gowns when performing patient care with Resident 37 including a gown to prevent anything potentially getting on a staff's clothing and [result] in the spread of infection. During an interview on 6/24/2026 at 3:15 PM with the Director of Nursing (DON), the DON stated all residents (in general) who had G-tubes were under EBP. The DON stated staff should be wearing a gown and gloves when touching a resident's G-tube because there could be splash back when administering medications. The DON stated EBP is a part of the facility's infection control because a G-tube is considered an opening and a staff's clothes could become contaminated and [result in the] spread infection to other residents. During a review of the facility's policy and procedure (P&P) titled, Infection Control Program, dated 2/8/2019, the P&P indicated to wear PPE as necessary to prevent exposure to spills or splashes of blood or body fluids or other potentially infectious materials. During a review of the facility's undated P&P titled, Enhanced Barrier Precautions, the P&P indicated EBP are infection control measures that involve gown and glove use during high-contact resident care activities for residents who have open wounds or indwelling devices or who have a known recent colonization or infection with a multidrug-resistant organisms MDROs in the facility. During a review of Resident 1's AR, the AR indicated the facility admitted Resident 1 on 3/3/2026 with diagnoses that included cerebral infarction and malignant neoplasm of the prostate (prostate cancer). During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1 usually understood verbal content and was usually able to express ideas and wants. The MDS indicated Resident 1 was dependent on toileting hygiene, oral hygiene, showers and baths. During observations on 06/23/2026 at the following times: At 10:05 AM, CNA 5 entered Resident 1's room with CNA 6, there was a sign posted at the doorway indicating Resident 1 was on EBP. CNA 5 and CNA 6 did not wear a gown prior to entering Resident 1's room. At 10:06 AM, CNA 5 emptied Resident 1's foley catheter (a device that helps drain urine from the bladder [hollow muscular balloon-like organ that stores urine]) then dumped the urine into the toilet. CNA 5 removed CNA 5's gloves then washed CNA 5's hands with soap and water. CNA 5 put gloves on and lowered Resident 5's head of the bed, removed the blanket from Resident 1, and started putting pants on Resident 1. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 10: 20 AM, CNA 5 and CNA 6 moved Resident 1 side to side to position a sling (a supportive fabric device that cradles an individual so a mechanical lift [a device used to help lift and move residents] can safely transfer the person between a bed, wheelchair, or toilet) underneath Resident 1. CNA 5 and CNA 6's clothes touched part of Resident 1's bed while turning Resident 1 side to side. CNA 5 hooked the sling to the mechanical lift and transferred Resident 1 from the bed to the wheelchair. CNA 5 and CNA 6 were not wearing gowns during the transfer. At 10:25 AM, CNA 5 changed Resident 1's bed linens and was not wearing a gown. During an interview on 6/23/2026 at 10:35 AM with CNA 5, CNA 5 stated CNA 5 did not need to wear a gown during Resident 1's transfer but needed to wear a gown when CNA 5 emptied the foley catheter. CNA 5 stated CNA 5 needed to wear proper PPE for infection control and to protect Resident 1. CNA 5 stated CNA 5 could pass bacteria to Resident 1 and to other residents. During an interview on 6/24/2026 at 3:35 PM, the DON stated Resident 1 was on EBP because Resident 1 had a foley catheter. The DON stated CNA's (in general) were in serviced (trained) on wearing proper PPE when providing care to residents who were on EBP. During a review of the facility's undated P&P titled Enhanced Barrier Precautions, the P&P indicated enhanced barrier precautions are infection control measures that involve gown and glove use during high contact resident-care activities for residents who have open wounds or indwelling (foley) devices or who have a known recent colonization or infection with an MDRO (when contact precautions do not apply). The P&P indicated PPE was used to reduce the risk of exposure to and the transmission of microorganisms including the use of gowns, gloves, face protection, and eye protection. The P&P indicated high contact activities included activities that placed the resident and the person helping them in close physical contact that increases the risk of transmission of MDRO between the resident and health care provider. The activities included: Bathing/showering Transferring Providing hygiene (brushing teeth, combing hair, and shaving). Changing linens Changing briefs Device care such as central line, urinary catheter, feeding tube, tracheostomy/ventilator. Wound care and dressing changes B. During an observations on 6/23/2026 at the following times, At 8:30 AM, LVN 2 took the BP equipment (monitor and cuff) on wheels from the hallway toward Resident 1's room. LVN 2 wheeled the BP equipment and entered resident 1's room. LVN 2 checked Resident 1's BP and did not disinfect the equipment before using for Resident 1. At 8:38 AM, LVN 2 exited Resident 1's room and wheeled the BP equipment with LVN 2. LVN 2 (continued on next page)

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	06/24/2026

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	proceeded to prepare Resident 1's medications. LVN 2 did not disinfect the BP equipment. At 8:42 AM, LVN 2 entered Resident 1's room to administer Resident 1's medications. At 8:43 AM, LVN 2 exited the room and disinfected the medication tray used to administer Resident 1's medications. At 8:45 AM, LVN 2 walked towards another resident's (unidentified) room and wheeled the BP equipment away from Resident 1's room. At 9:17 AM, LVN 2 disinfected the medication cart then parked the medication cart across the Nurse's station. During an interview on 6/23/2026 at 9:30 AM, with LVN 2, LVN 2 stated the BP equipment was used to check BPs for multiple residents. LVN 2 stated the BP equipment was not dedicated (assigned) to one resident. LVN 2 stated LVN 2 forgot to disinfect the BP equipment [before and after using the equipment on Resident 1], LVN 2 stated LVN 2 needed to disinfect the BP equipment to prevent cross contamination (the process by which microorganisms are unintentionally transferred from one area/object to another with a harmful effect). During a review of the facility's P&P titled Cleaning and Disinfection of Resident-Care Equipment, revised 4/2026, the P&P indicated resident-care equipment can be a source of indirect transmission of pathogens (an organism that causes disease). The P&P indicated multiple-resident use equipment shall be cleaned and disinfected after each use. Most equipment may be cleaned/disinfected in the areas in which the equipment is used.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a baseline care plan (CP) was developed and implemented within forty-eight hours of admission for one of five sampled residents (Resident 47), who was on supplemental oxygen (02 - a colorless, odorless, tasteless gas essential for living) therapy.This deficient practice had the potential to result in unmet individualized needs for Resident 47 and the potential to affect the resident's physical and psychosocial well-being.Findings:During a review of Resident 47's admission Record (AR), the AR indicated Resident 47 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including chronic obstructive pulmonary disease (COPD - a long-standing lung disease causing difficulty in breathing), unspecified, and heart failure, unspecified.During a review of Resident 47's Encounter - Office Visit (EOV), dated 6/22/2026, the EOV indicated Resident 47 did not have decision-making capacity.During a review of Resident 47's Order Summary Report (OSR), active orders as of 6/24/2026, the OSR indicated a physician's order, dated 6/19/2026, for oxygen at five (5) LPM (liters per minute - the speed or volume of 02 a device delivers to a resident) via nasal cannula (NC - a small plastic tube that fits into the person's nostrils, used to provide supplemental 02) every shift for SOB (short of breath) continuously.During a review of Resident 47's Treatment Administration Record (TAR), dated 6/1/2026 - 6/30/2026, the TAR indicated Resident 47 was administered 02 at 5 LPM via NC every shift for SOB continuously since readmission to the facility.During an observation and interview on 6/22/2026 at 10:16 AM with Private Caregiver (PC) 2, Resident 47 was in bed, frail and receiving 5 LPM of 02 via NC. PC 2 stated Resident 47 had always received 02 at 5 LPM. During a concurrent interview and record review on 6/23/2026 at 2:07 PM with the Director of Nursing (DON), Resident 47's medical records via PCC (Point Click Care - electronic health record) were reviewed. The DON stated Resident 47 was admitted on [DATE] with an order for 02 at 5 LPM via NC every shift for SOB continuously. The DON stated a baseline CP for Resident 47 had to be created upon admission and creating a CP was important for staff to provide [appropriate] care and interventions to Resident 47 because Resident 47 was on 02, that's respiratory.During a concurrent interview and record review on 6/24/2026 at 11:47 AM with the DON, Resident 47's medical records via PCC were reviewed. The DON stated a document titled Baseline Care Plan was created for Resident 47. The Baseline CP indicated it was completed on 6/22/2026 by the Social Worker (SW), the Minimum Data Set Nurse (MDSN), the Life Enrichment Director (LED) and the Registered Dietician (RD). The DON stated a [baseline] CP consisted of a problem, a goal, and interventions. The DON stated Resident 47's Baseline CP did not have a goal or interventions for Resident 47 that addressed resident 47 was receiving 02 therapy.During a review of the facility's policy and procedure (P&P) titled, Base Line Care Plan, date revised 12/29/2021, the P&P indicated the facility would develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality of care. The P&P indicated the baseline care plan would be developed within 48 hours of a resident's admission.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to ensure one of four corner areas (Corner Area 1) in the facility's kitchen was free of pests on 6/22/2026.This deficient practice had the potential to result in foodborne illness (an illness caused by eating contaminated food) for the residents consuming the food prepared in the facility's kitchen. Findings:During a kitchen tour observation and interview on 6/22/2026 at 8:53 AM, with the Dining Services Manager (DSM), there was a separate area inside the kitchen used for baking and trays with freshly baked cookies placed in a cart. The separate area had unidentified debris and an insect that was not moving on the floor at the back of the oven. The DSM stated there was a dead insect behind the oven and the dead insect was a cricket. The DSM stated all areas of the kitchen needed to be cleaned because food debris or other dirt could attract pest into the kitchen.During an interview on 6/24/2026 at 3:50 PM with the Administrator (ADM), the ADM stated all areas of the kitchen needed to be clean.During a review of the facility's undated Dining Services Master Cleaning Schedule (DSMCS), the DSMCS indicated sweeping the floors with a broom ensuring sweeping under equipment, counters, and racks to gather all debris on the floor to be completed daily.During a review of the facility's Policy and Procedure (P&P) titled Sanitation and Infection Control Cleaning Services dated 1/2024, the P&P indicated the daily cleaning schedule delineates how often equipment must be cleaned and whose responsibility it is to clean each specific piece of equipment or area. The P&P indicated heavy cleaning such as under equipment, walls and floors, and major equipment can be planned on a weekly basis.