STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055129	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Terrace Health Care Center	12000 Mount Vernon Ave Grand Terrace, CA 92313

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an effective system wide infection control program for the prevention, control, and investigation of infections and communicable diseases for 14 of 19 sampled residents (Resident 6, 11, 23, 31, 36, 41, 44, 45, 49, 51, 52, 53, 70, and 77), when: 1. For five residents (Resident 6, 23, 77, 41, and 49), the facility staff did not wear an isolation gown (gown-cloth covering protection from neck to below knee) while providing high contact care to residents who are on Enhanced Barrier Precautions (EBP-an infection control intervention that involves wearing gown and gloves during high contact resident care activities). 2. For six residents (Resident 41, 45, 49, 52, 53, and 70), Licensed Vocational Nurse (LVN 1) did not clean the glucometer (a small machine used to check blood glucose) before and after use. 3. For eight residents (Resident 6, 23, 77, 36, 51, 11, 31, and 44), the facility staff did not provide Personal Protective Equipment (PPE-equipment used to protect staff and residents from germs or infections) cart or precaution poster (a sign used to identify resident who are on EBP) in front of resident's rooms. 4. For Resident 11, Intravenous (IV- in the vein) tubing was missing a label with date, time, and initials. 5. For Resident 31, indwelling foley catheter (foley- a soft tube that stays inside the bladder used to drain urine) was observed on the floor. 6. For two residents (Resident 11 and 31), Registered Nurse (RN 1) did not clean the Peripherally Inserted Center Catheter (PICC- a long, thin tube placed in a vein in the arm that goes up to a large vein near the heart to give medications or fluids) line with alcohol swab prior to administering IV medication. These failures in infection prevention practices had the potential to result in cross-contamination (transfer of harmful bacteria from one person to another), healthcare-associated infections (infections that occur while receiving care in the healthcare facility), bloodstream infections, urinary tract infections, and other serious complications, placing residents at risk for illness, delayed recovery, hospitalization, or worsening of their medical conditions.Findings: 1a. A review of Resident 6's face sheet (FS- a document with resident demographics, brief medical history, and emergency contacts), the FS indicated, Resident 6 was admitted on [DATE] with diagnoses of diabetes (DM- High blood sugar), pleural effusion (fluid in the lungs), chronic obstructive pulmonary disease (COPD-a long term lung condition that makes it hard to breathe because the airways are damaged and narrowed), and congestive heart failure (CHF-a condition where the heart muscle is unable to pump blood effectively enough to meet the body's needs). A review of Resident 6's Order, dated February 23, 2026, indicated Enhanced Barrier Precautions: PPE required for high resident contact care activities. Indications: Indwelling Foley Catheter every shift. During an observation on March 2, 2026, at 9:52 AM, in room [ROOM NUMBER], CNA 1 was observed transferring Resident 6 from bed to wheelchair without a gown while touching Resident 6. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on March 2, 2026, at 10:12 AM, with CNA 1, in front of room [ROOM NUMBER], there was a purple dot next to Resident 6's name and an EBP poster. CNA 1 stated, if a resident is on EBP the staff is required to wear a gown when providing care. CNA 1 stated she was not informed that Resident 6 was on EBP and was not aware of what the purple sticker next to resident's name meant. During an interview on March 2, 2026, at 10:29 AM, with LVN 2, LVN 2 stated the facility staff are able to determine which residents are on EBP based on the purple dot next to the resident's name and the EBP poster. LVN 2 confirmed Resident 6 was on EBP. During a follow-up interview on March 2, 2026, at 10:40 AM, CNA 1 stated she should have been wearing a gown when transferring Resident 6 from bed to wheelchair. During an observation on March 4, 2026, at 5:50 AM, in room [ROOM NUMBER], CNA 3 was observed changing and removing linens from Resident 6's room without a gown. 1b. A review of Resident 77's FS, the FS indicated, Resident 77 was admitted on [DATE], with diagnosis of DM. A review of Resident 77's Order, dated March 1, 2026, indicated Enhanced Barrier Precautions D/T [due to] wound every shift. During an observation on March 4, 2026, at 5:52 AM, in room [ROOM NUMBER], CNA 3 was observed changing and removing linens from Resident 77's room without a gown. During an interview on March 4, 2026, at 5:54 AM, with CNA 3, CNA 3 stated, he was removing the linens from Resident 6 and Resident 77's room. CNA 3 confirmed Resident 6 and Resident 77 are on EBP, and he should have been wearing a gown. 1c. A review of Resident 23's FS, the FS indicated, Resident 23 was admitted on [DATE], with diagnoses of DM, osteomyelitis (an infection in the bone) to right foot and ankle, and methicillin resistant staphylococcus aureus infection (MRSA- a type of bacteria that is hard to treat with regular antibiotics). A review of Resident 23's Order, dated February 16, 2026, indicated Enhanced Barrier Precautions: PPE required for high resident contact care activities. Indications: wounds, infection and/or MDRO [Multidrug-resistant organisms—bacteria that is resistant to multiple antibiotics] status every shift. During an observation on March 2, 2026, at 11:12 AM, in room [ROOM NUMBER], CNA 1 was observed assisting Resident 23 with toileting without a gown. During an interview on March 2, 2026, at 11:15 AM, CNA 1 stated she was assisting Resident 23 with removing her diaper because Resident 23 needed to use the bedside commode. CNA 1 verified that Resident 23 was on EBP and stated that she should have worn a gown. 1d. A review of Resident 41's FS, the FS indicated, Resident 41 was admitted on [DATE], with diagnoses of DM, hemiplegia (paralysis on one side of the body) affecting the left non dominant side, dementia (a condition that affects the brain, making it difficult to think, remember, and make (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	decisions). A review of Resident 41's Order, dated February 8, 2026, indicated Enhanced Barrier Precautions: PPE required for high resident contact care activities. Indication: HX [history] of MDRO every shift. During an observation on March 4, 2026, at 5:33 AM, in room [ROOM NUMBER], LVN 1 was observed taking Resident 41's blood glucose without a gown. During an interview on March 4, 2026, at 5:37 AM, with LVN 1, LVN 1 stated, Resident 41 is on EBP because there is a purple dot next to Resident 41's name. LVN 1 added, she should have worn a gown to take the blood sugar since it is a high contact activity. 1e. A review of Resident 49's FS, the FS indicated, Resident 49 was admitted on [DATE], with diagnoses of DM, CHF, and immunodeficiency (the ability to fight infection is weaker than normal). A review of Resident 49's Order, dated January 12, 2026, indicated Enhanced Barrier Precautions: PPE required for high resident contact care activities. Indication: wounds. During an observation on March 4, 2026, at 6:26 AM, in room [ROOM NUMBER], LVN 1 was observed taking Resident 24's blood glucose without a gown. During an interview on March 4, 2026, at 6:27 AM, with LVN 1, LVN 1 stated she did not see that Resident 49 is on EBP. LVN 1 verified Resident 49 on EBP because there was a purple dot next to Resident 49's name and stated she should have worn a gown for infection control. During an interview on March 5, 2026, at 7:28 AM, with LVN 3, LVN 3 stated, nursing staff are expected to wear PPE for residents on EBP when transferring resident, taking vital signs (measure body basic functions such as heart rate, body temperature, blood pressure, and breathing rate), taking blood sugars, and when staff are assisting with anything that would have high contact with residents. During a concurrent interview and record review on March 5, 2026, at 1:38 PM, with the DSD/IP, Resident 6's Order, dated February 23, 2026, Resident 77's Order, dated March 1, 2026, Resident 23's Order, dated, February 16, 2026, Resident 41's Order, dated February 8, 2026, and Resident 49's Order, dated January 12, 2026, were reviewed. Resident's 6, 23, 77, 41, and 49 Order indicated, the residents were on EBP. The DSD/IP confirmed and verified, Resident's 6, 23, 77, 41, and 49 were on EBP. The DSD/IP stated, the expectation is that any staff who is providing high contact care, for a resident on EBP, should wear a gown and gloves. The DSD/IP added, it is important to wear appropriate PPE to prevent the spread of infection. During a concurrent interview and record review on March 5, 2026, at 2:12 PM, with the Director of Nurse (DON) and Administrator (Admin), the facility's policy and procedures (P&P) titled, IPCP [Infection Prevention and Control Program] Standard and Transmission- Based Precautions, dated February 2026, was reviewed. The P&P indicated, Enhanced Barrier Protection (EBP): expand the use of PPE and refer to the use of gown and gloves during high contact resident care activities that provide opportunities for indirect transfer of MDRO's to staff hands and clothing then indirectly transferred to residents or from resident-to-resident.Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: i. dressing, ii. Bathing/ showering, iii. Transferring, iv. Providing hygiene, v. changing linens, vi. Changing linens, vi. Changing briefs or assisting with toileting, vii. device care.viii. Wound care. The DON stated that the policy was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	diagnoses of DM, osteomyelitis to right foot and ankle, and MRSA. A review of Resident 23's Order, dated February 16, 2026, indicated Enhanced Barrier Precautions: PPE required for high resident contact care activities. Indications: wounds, infection and/or MDRO status every shift. 3c. A review of Resident 77's FS, the FS indicated, Resident 77 was admitted on [DATE], with diagnosis of DM. A review of Resident 77's Order, dated March 1, 2026, indicated Enhanced Barrier Precautions D/T wound every shift. During an interview on March 2, 2026, at 10:29 AM, with LVN 2, LVN 2 stated the facility staff is able to determine which residents are on EBP based on the purple dot next to the resident's name and the EBP poster. LVN 2 confirmed Resident 6 and Resident 77 in room [ROOM NUMBER] were on EBP. During a concurrent observation and interview on March 2, 2026, at 10:52 AM, with CNA 1, in front of room [ROOM NUMBER] and 4, there was no observable PPE cart. CNA 1 verified and confirmed the missing of PPE cart. CNA 1 stated that PPE cart should be readily available in front of resident's room with EBP. CNA 1 further stated, Resident 23 who is on EBP, residing in room [ROOM NUMBER]. 3d. A review of Resident 36's FS, the FS indicated Resident 36 was admitted on [DATE], with diagnoses of HLD, HTN, and COPD. A review of Resident 36's Order, dated February 16, 2026, indicated Enhanced Barrier Precautions D/T RLE [Right lower extremity- right leg] surgical site every shift . 3e. A review of Resident 51's FS, the FS indicated Resident 51 was admitted on [DATE], with diagnoses of muscle weakness, HTN, and COPD. A review of Resident 51's Order, dated February 17, 2026, indicated Enhanced Barrier Precautions D/T wound to the coccyx [the small bone at the bottom of the spine] every shift. During a concurrent observation and interview on March 2, 2026, at 10:53 AM, with CNA 1 in front of Rooms 6, there were no PPE carts present or PPE signage indicating Resident's 36 and 51 were on EBP. CNA 1 confirmed and verified there were no PPE carts or PPE signage. 3f. During a review of Resident 11's FS, the FS indicated, Resident 11 was admitted to the facility on [DATE], with the diagnosis of arthritis (a condition in which inflammation, pain and swelling of one or more joints) due to other bacteria, left elbow. During a review of Resident 11's Order, dated February 6, 2026, the Order indicated, Resident 11 is on EBP precaution for implanted (inside the body) IV access and wounds. 3g. During a review of Resident 31's FS, the FS indicated Resident 31 was admitted to the facility on [DATE], with diagnosis of unspecified open wound of vagina and vulva. During a review of Resident 31's Order, dated February 24, 2026, the Order indicated, Resident 31 is on EBP precaution for implanted IV access, wound and indwelling foley catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3h. During a review of Resident 44's FS, the FS indicated Resident 44 was admitted to the facility on [DATE], with diagnosis of cellulitis (serious skin infection) of left lower limb. During a review of Resident 44's Order, dated February 17, 2026, the Orders indicated, Resident 44 is on EBP for wounds. During an interview on March 2, 2026, at 10:40 AM, with treatment nurse (TN- a person who takes care of wounds and dressing), TN verified and acknowledged that there is no PPE cart and EBP precaution poster in front of room [ROOM NUMBER] for Resident 11 and 44, and room [ROOM NUMBER] for Resident 31. TN stated, that the residents in both rooms are on EBP precaution and it is expected for the staff to wear PPE while in direct contact with the residents. During an interview on March 2, 2026, at 10:48 AM, with Minimum data set (the detailed assessment for residents) nurse (MDS), MDS stated, it is important to have the EBP precaution poster and PPE cart in front of all EBP precaution room as the staff will be reminded to wear the PPE. MDS further stated that the precautions are updated, and posters and PPE cart should be placed as soon as the orders are prescribed by the physician. During a follow-up interview on March 5, 2026, at 1:41 PM, the DSD/IP stated, it is important to have a PPE cart readily accessible to the staff outside of the room, for the staff to gown up (properly put on isolation gown) when needed and the poster should be clearly visible to ensure the staff know when to gown up. During a concurrent interview and record review on March 5, 2026, at 2:18 PM, with the DON and Admin, the facility's P&P titled, IPCP Standard and Transmission- Based Precautions, dated February 2026, was reviewed. The P&P Indicated, .Implementation: .i. post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE (E.G [for example] gown and gloves). ii. For Enhanced Barrier Precautions, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves. b. Make PPE, including gowns and gloves, available immediately outside of the resident room. The DON stated that the policy was not followed and should have been because the cart and poster are a reminder for staff and there should be PPE available during urgent needs. 4. During a review of Resident 11's FS, the FS indicated Resident 11 was admitted to the facility on [DATE], with diagnosis of arthritis due to other bacteria, left elbow. During a concurrent observation and interview on March 2, 2026, at 9:40 AM, with RN 1, in Resident 11's room, cefazolin (medication to treat infection) 2 gram (G—unit of dosing medication) IV was observed hanging by Resident 11's bed. RN 1 verified and confirmed, the IV tubing did not have any label attached. RN 1 stated, it is within the facility's policy to place a label with date, time, and initial of the person who prepared and administered the medication. RN 1 further stated, it is important to have the label as an indication when IV tubing needs to be changed. RN 1 added, IV tubing should be changed every 24 hours to prevent risk of infection. During a review of Resident 11's Order, dated February 6, 2026, the Order indicated, cefazolin 2 G IV was ordered to be given every eight hours for cellulitis for six weeks until March 15, 2026. During an interview on March 5, 2026, at 1:30 PM, with the DSD/IP, the DSD/IP stated, the staff are educated to complete and label IV tubing prior to administering IV medications according to the policy. (continued on next page)

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Grand Terrace Health Care Center	12000 Mount Vernon Ave Grand Terrace, CA 92313

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	vancomycin to Resident 31's PICC line. RN 1 started the IV infusion. RN 1 exited the room. A follow-up interview on March 4, 2026, at 8:30 AM, with RN 1, RN 1 stated, it is expected to clean the injection connector with alcohol swab before giving IV medication. RN 1 further stated, it is infection control issue. RN 1 acknowledged that she did not clean PICC injector connector prior to access and administered medication to Resident 11 and 31. During a concurrent interview and record review on March 5, 2026, with the DON, the facility's P&P titled, Intermittent administration of medications, [undated], was reviewed. The P&P indicator, . Policies and guidelines: .6. Injection caps/connectors will be prepared with an alcohol swab prior to each injection. The DON stated, staff are educated to clean the connector with alcohol swab. The DON further stated it has a high chance for infection.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a medication was stored in accordance to the facility's policy and procedure (P&P) for Storage of medication and Disposal of medication, for one of one medication storage room when one bottle of 30 milliliter (ml-a unit of dosing medication) acetylcysteine (medication that can be used to clear airways) was found inside the refrigerator with an expiration date of February 28, 2026 (four days expired), and readily available for use. This failure had the potential to cause adverse health outcomes from administering expired medication which could negatively affect the vulnerable residents' health and safety.Findings: During a concurrent observation and interview on [DATE], at 5:30 AM, with Minimum Data Set (a detail assessment of the resident) nurse (MDS), the facility medication storage room was observed and found one bottle of 30 ml acetylcysteine. MDS verified and stated that the pharmacy indicated on the medication label that the medication would expire 96 hours or four days after opening. MDS further stated that this acetylcysteine bottle was delivered and opened on February 24, 2026, and expired on February 28, 2026 (four days expired), and it is expected to be discarded. During an interview on [DATE], at 1:40 PM, with the Director of staff development /Infection preventionist (DSD/IP), the DSD/IP stated that the expired medication should be discarded and should not be available in the patient care area. During a concurrent interview and record review on [DATE], with the Director of Nursing (DON), the facility's P&P titled, Storage of medication, dated 2023, and Disposal of medication, dated 2023, were reviewed. The P&P of Storage of medication indicated, .13. Outdated, contaminated, re deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to the procedures of medication disposal (section on disposal of medications, syringes and needles), and reordered from the pharmacy (C-section on ordering and receiving medications), if a current order exist. The P&P of Disposal of medication indicated, Policy 1. Discontinued medications and/our medications left in the care center after a residence discharge, which do not qualify to return to the pharmacy, are identified and removed from current medication supply in a timely manner for disposition. The DON acknowledged that the policies were not followed. The DON stated that she is not aware that the expired medication is still inside the refrigerator. The DON further stated that the facility failed to discard expired medication.

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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 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two rooms(room [ROOM NUMBER] and 2) accommodate no more than four residents per room when room [ROOM NUMBER] and 2 had 5 beds in each room. This failure had the potential to place residents housed in room [ROOM NUMBER] and 2 at risk of decreased privacy, increased infection transmission, and limiting the ability of staff to provide safe and individualized care. Findings: During an interview on March 2, 2026, at 8:10 AM, with the Director of Nursing (DON) and the Administrator (Admin), the Admin stated, the facility had two rooms (rooms [ROOM NUMBERS]) that were approved for a waiver to have more than four residents in each room. During an observation on March 2, 2026, at 9:09 AM, in room [ROOM NUMBER], there were currently four residents in the room. The room was free of clutter, with no concerns with the beds, bedside table, and the room was wheelchair accessible. During observation on March 2, 2026, at 9:31 AM, in room [ROOM NUMBER], there were currently four residents in the room. The room was free of clutter, with no concerns with the beds, bedside table, and the room was wheelchair accessible. During a concurrent environmental tour observation and interview on March 3, 2026, at 11:23 AM, with the Maintenance Director (DOM), the residents' room [ROOM NUMBER] and 2 measurements of livable space were noted as follows: -room [ROOM NUMBER] (5 beds) measured: 638.45 Sq Ft [Square feet- unit of measurement] (127.69 Sq. Ft. per residents)-room [ROOM NUMBER] (5 beds) measured: 644.08 Sq Ft. (128.81 Sq. Ft. per residents) The DOM confirmed the measurements and verified that there were currently five beds in room [ROOM NUMBER] and 2. During an interview on March 5, 2026, at 7:39 AM, with Certified Nurse Assistant (CNA 2), CNA 2 stated that room [ROOM NUMBER] and 2 are wheelchair accessible and have sufficient space to provide care to all the residents. CNA 2 stated there are no safety hazards due to the number of beds in the room. During an interview on March 5, 2026, at 2:12 PM, with the Admin and DON, the Admin stated there have been no issues with care in relation to the rooms having more than four residents. The rooms were not crowded and did not impose any safety hazards on the residents. There were no complaints about space or room issues from the residents occupying these rooms. The survey team recommends the approval of the room waiver request for the rooms listed in this deficiency.