STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055183	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Gardens Health Care Center	25271 Barton Rd Loma Linda, CA 92354

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were secured and administered in accordance with the facility's medication administration policy and procedure (P&P) for one (1) of three (3) sampled residents(Resident 3), when a License Vocational Nurse (LVN 1) left a medication cup containing four (4) tablets unattended on Resident 3's beside table. This failure had the potential to cause medication errors, accidental ingestion and intentional misuse, which jeopardized the health and safety of Resident 3, who had severe cognitive impairment (a person has lost their ability to think, remember, or make decisions so much that they cannot live independently) or any person who could access Resident 3's room.During a review of Resident 3's Face Sheet (contains demographic and medical information) undated, the Face Sheet indicated, Resident 3 was admitted to the facility on [DATE], with diagnoses which included encephalopathy (brain disease, damage, or malfunction), senile degeneration of brain (a severe, progressive decline in brain tissue as you age). During a review of Resident 3 ' s [Minimum Data Set (MDS - facility assessment tool), dated May 6, 2026, the MDS under Section C (cognitive pattern), indicated Resident 3's Brief Interview for Mental Status (BIMS-memory and thinking test used by to quickly check a person's brain health) score was 00 (a BIMS score of 00 suggests severe cognitive impairment). During concurrent observation and interview on July 2, 2026, at 10:35 AM, with Resident 3, in Resident 3's room, a medication cup containing four (4) tablets was found left unattended on Resident 3's bedside table. When asked if the medication belongs to her, Resident 3 stated, I don't know, and shook her head in a manner that suggested confusion. During concurrent observation and interview on July 2, 2026, at 10:44 AM, with Registered Nurse (RN1), in Resident 3's room, RN 1 confirmed and verified there were four (4) tablets in the medication cup left unattended on Resident 3's bedside table. RN 1 stated, it is against facility protocol to leave medication unattended at the bedside. RN 1 further stated, the medications had likely been left there by LVN 1 and stated that Resident 3's medications should remain under the direct supervision of LVN1 until administered. During concurrent observation and interview on July 2, 2026, at 10:48 AM with LVN 1, in Resident 3's room, LVN 1 stated the four (4) tablets in the medication cup left unattended on Resident 3's bedside table belonged to Resident 3. LVN 1 further stated, she had placed the medications on the bedside table while she went to obtain juice for Resident 3. LVN 1 stated, it was a mistake, because it was incorrect for her to leave the medications unattended, as another individual could potentially access, take, or dispose of the medications, leading to a missed dose for Resident 3. LVN 1 admitted her actions were not consistent with the facility's medication administration policy. During concurrent interview and record review on July 2, 2026, at 11:40 AM, with the Director of Nursing (DON), the facility's Policy and Procedure (P&P), titled Administering Medications, dated April 2019, was reviewed. The P&P indicated, . 19. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart . The DON stated, this P&P also applies to medication removed from the medication cart and the expectation was that medications should not be left unattended on a resident's bedside table. DON stated, LVN 1's actions violated facility policy and failed to meet the expected standard of practice, placing Resident 3 and others at risk for unauthorized access or ingestion of medications.

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