STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055247	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Oaks Care Center	215 W Pearl St Pomona, CA 91768

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687 Based on interview and record review, the facility failed to provide one of two sampled residents (Resident 1) with dignity and respect in accordance with the facility's policy and procedure (P&P) titled, Resident Rights, by failing to: Ensure Certified Nursing Assistant (CNA) 1 and CNA 2 provided Resident 1 with alternative methods to go to the bathroom and assisted Resident 1 with the resident's toileting needs. CNA 1 and CNA 2 told Resident 1 to void (urinate) in Resident 1's incontinence brief (brief used to capture urine) for CNA 1 and/or CNA 2 to change after voiding. This failure caused Resident 1 to have feelings of depression and burden and made Resident 1 feel like an animal. This failure had the potential to cause further psychosocial (mental, emotional, social, and spiritual effects) harm to Resident 1. Cross Reference F690 Findings: During a review of Resident 1's Admission Record (AR), the AR indicated, the facility admitted Resident 1 to the facility on [DATE], with diagnoses of functional quadriplegia (the complete inability to move due to sever disability frailty caused by another medical condition without physical injury or damage to the spinal cord) and abnormalities of gait and other mobility (inability to walk normally due to injuries or underlying conditions). During a review of Resident 1's untitled care plan (CP) initiated on 6/29/2022, the CP indicated, Resident 1 was continent (able to control) of bowel and bladder function and able to verbalize the need for assistance. The CP interventions indicated, for staff to assist Resident 1 with toileting. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055247	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2024
NAME OF PROVIDER OR SUPPLIER Country Oaks Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 215 W Pearl St Pomona, CA 91768	

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Minimum Data Set (MDS- a standardized resident assessment and care screening tool), dated 3/22/2024, the MDS indicated, Resident 1 had moderate cognitive impairment (ability to think, remember, and reason). The MDS indicated, Resident 1 was dependent (helper did all the effort, resident did none of the effort to complete the activity, or the assistance of 2 or more helpers was required for the resident to complete the activity) with toileting hygiene. The MDS indicated, Resident 1 required substantial/maximal assistance (helper did more than half the effort, helper lifted or held trunk or limbs and provided more than half effort) with rolling left and right, sitting to lying, lying to sitting on side of bed, and chair/bed-to-chair transfers. The MDS indicated, sitting to standing and walking were not attempted to due medical condition or safety concerns. The MDS indicated, Resident 1 was occasionally incontinent of bladder. The MDS indicated, Resident 1 was not on a trial or current toileting program (scheduled toileting, prompted voiding, or bladder training) to manage Resident 1's urinary continence. During an interview on 4/17/2024 at 10:01 am with Resident 1, Resident 1 stated Resident 1 had to go to the bathroom in the diaper (incontinence brief) because Resident 1 required a Hoyer lift (mobility tool used to transfer residents with minimum physical effort) to move. Resident 1 stated staff (unidentified) would tell Resident 1 to go (urinate)in her brief and staff would change Resident 1 after. Resident 1 stated Resident 1 did not like to urinate in the brief because Resident 1 was not incontinent. Resident 1 stated staff (in general) had not provided Resident 1 with an alternative method of going to the restroom that did not involve Resident 1 soiling Resident 1's self before being changed. Resident 1 stated staff (in general) told Resident 1 it was too difficult to get Resident 1 out of bed to urinate in a toilet. Resident 1 stated Resident 1 felt trapped in bed. Resident 1 stated Resident 1 felt like a burden to staff. Resident 1 stated staff making Resident 1 go to the bathroom in the brief made Resident 1 feel like an animal and did not matter. Resident 1 stated Resident 1 felt depressed. During an interview and record review on 4/17/224 at 11:13 am with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 1's continence status did not change. CNA 1 stated Resident 1 was incontinent of urine because CNA 1 always changed Resident 1's briefs after Resident 1 urinated in her brief. CNA 1 stated she did not offer Resident 1 to use a bed pan or be transferred to a toilet before urinating in Resident 1's brief. CNA 1 stated CNA 1 told Resident 1 to go (urinate) in her brief and CNA 1 would change Resident 1's brief after. CNA 1 stated she had not offered Resident 1 an alternative method to use the bathroom such as a bed pan. CNA 1 stated it was difficult to use the Hoyer lift to move Resident 1. CNA 1 stated it could make Resident 1 feel better if Resident 1 was assisted with a bed pan because it could help improve Resident 1's independence and continence status. During an interview on 4/17/2024 at 11:24 am with CNA 2, CNA 2 stated while Resident 1 was continent of urine, Resident 1 urinated in the brief because it was too hard to assist Resident 1 with going to the bathroom. CNA 2 stated it was standard for Resident 1 to urinate in her brief and then ask to be changed. CNA 2 stated CNA 2 had not offered Resident 1 to use a bed pan before urinating in her brief. CNA 2 stated (in general) if a resident had mobility issues but was continent, CNA 2 could offer a bed pan. CNA 2 stated it was important to offer alternatives to having a resident go to the bathroom in a brief because it could help a resident build strength and independence and stop a resident from being soaked in his/her own urine until being changed by staff. CNA 2 stated making Resident 1 urinate in her brief instead of assisting Resident 1 with a bed pan could make Resident 1 feed bad and frustrated. (continued on next page)

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/2024 at 11:54 am with Licensed Vocational Nurse (LVN) 1, LVN 1 stated having mobility issues and/or being bed bound (unable to get out of bed without assistance) did not mean Resident 1 was incontinent. LVN 1 stated Resident 1 was continent most of the time. LVN 1 stated Resident 1 could control when Resident 1 needed to urinate and should be offered a bed pan every time Resident 1 needed to use the bathroom. LVN 1 stated if other staff (such as CNAs) did not know Resident 1 was only occasionally incontinent and were not offering toileting assistance with a bed pan, Resident 1 would not know that option was available as an alternative. LVN 1 stated telling Resident 1 to go in her brief instead of offering a bed pan could weaken Resident 1's bladder, worsen incontinence, and was a dignity issue. LVN 1 stated Resident 1 should not urinate in Resident 1's brief if Resident 1 had the ability to control her bladder occasionally. During a concurrent interview and record review on 4/17/2024 at 2:38 pm with the MDS Coordinator (MDSC), Resident 1's MDS dated [DATE] was reviewed. The MDSC stated Resident 1 was assessed as occasionally incontinent according to what the CNAs documented in Resident 1's chart. The MDSC stated being occasionally incontinent meant Resident 1 had more periods of continence than incontinence. The MDSC stated Resident 1 had control over the bladder most of the time. The MDSC stated based off the MDS assessment, Resident 1 needed to have assistance with toileting to maintain and potentially improve Resident 1's continence status. The MDSC stated if staff were providing Resident 1 toileting assistance it could give Resident 1 more independence, prevent skin breakdown and infection, and allow Resident 1 to maintain as much continence as possible. The MDSC stated Resident 1 would benefit from a toileting schedule to assess what times of the day Resident 1 generally went to the bathroom so the staff could create a schedule based off Resident 1's toileting patterns. The MDSC stated staff could then offer toileting assistance with a bed pan at those times to help Resident 1 maintain, if not improve Resident 1's continence status. The MDSC stated making Resident 1 go in her brief instead of assisting the resident to use a bed pan was a dignity issue. During an interview on 4/17/2024 at 3:45 pm with the Director of Nursing (DON), the DON stated residents with occasional incontinence were more often continent than incontinent. The DON stated a resident with occasional incontinence like Resident 1 should be offered toileting assistance to help maintain his/her level of continence or improve it, promote independence, and decrease the risk for infections and falls. The DON stated Resident 1 being told to urinate in the brief before being changed was not an accurate portrayal or assessment of Resident 1's continence status. The DON stated this could contribute to incontinence and cause Resident 1 to feel helpless, not cared for, depressed, and embarrassed, affecting Resident 1 mentally. The DON stated Resident 1 should be offered a bed pan every time Resident 1 felt the urge to go to the bathroom. The DON stated it was not acceptable for staff to tell residents to go to the bathroom in their briefs because residents must be assisted with toileting as much as possible to maintain or improve their continence status. The DON stated making Resident 1 urinate in the brief forced Resident 1 to be incontinent and did not give an accurate assessment of Resident 1's care needs, level of assistance, and continence status. During a review of the facility's P&P titled, Resident Rights, revised on 12/19/2022, the P&P indicated, the facility ensured that all direct care and indirect care staff members, including contractors and volunteers, were educated on the rights of resident and the responsibility of the facility to properly care for its residents. The P&P indicated, resident had the right to be treated with dignity and respect, including the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences. The P&P indicated, residents had the right to make choices about aspects of his or her life in the facility that were significant to the resident.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687 Based on interview and record review, the facility failed to provide treatment and services to restore continence (ability to control movements of the bowels [intestines] and bladder [organ that stores urine]) to the extent possible for one of two sampled residents (Resident 1) by failing to: Ensure Resident 1, who was occasionally incontinent (less than seven episodes of incontinence [inability to control the bladder] in a seven-day period) of urine and had mobility issues, was provided alternative methods to go to the bathroom and assisted with the resident's toileting (urination) needs as indicated in Resident 1's care plan. These failures had the potential for Resident 1 to become more incontinent of urine and lead to a decline of Resident 1's health. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated, the facility admitted Resident 1 to the facility on [DATE], with diagnoses of functional quadriplegia (the complete inability to move due to sever disability frailty caused by another medical condition without physical injury or damage to the spinal cord) and abnormalities of gait and other mobility (inability to walk normally due to injuries or underlying conditions). During a review of Resident 1's untitled care plan (CP) initiated on 6/29/2022, the CP indicated, Resident 1 was continent (able to control) of bowel and bladder function and able to verbalize the need for assistance. The CP interventions indicated, for staff to assist Resident 1 with toileting. During a review of Resident 1's Minimum Data Set (MDS- a standardized resident assessment and care screening tool), dated 3/22/2024, the MDS indicated, Resident 1 had moderate cognitive impairment (ability to think, remember, and reason). The MDS indicated, Resident 1 was dependent (helper did all the effort, resident did none of the effort to complete the activity, or the assistance of 2 or more helpers was required for the resident to complete the activity) with toileting hygiene. The MDS indicated, Resident 1 required substantial/maximal assistance (helper did more than half the effort, helper lifted or held trunk or limbs and provided more than half effort) with rolling left and right, sitting to lying, lying to sitting on side of bed, and chair/bed-to-chair transfers. The MDS indicated, sitting to standing and walking were not attempted to due medical condition or safety concerns. The MDS indicated, Resident 1 was occasionally incontinent of bladder. The MDS indicated, Resident 1 was not on a trial or current toileting program (scheduled toileting, prompted voiding, or bladder training).to manage Resident 1's urinary continence. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/17/2024 at 10:01 am with Resident 1, Resident 1 stated Resident 1 had to go to the bathroom in the diaper (incontinence brief) because Resident 1 required a Hoyer lift (mobility tool used to transfer residents with minimum physical effort) to move. Resident 1 stated staff (unidentified) would tell Resident 1 to go (urinate)in her brief and staff would change Resident 1 after. Resident 1 stated Resident 1 did not like to urinate in the brief because Resident 1 was not incontinent. Resident 1 stated staff (in general) had not provided Resident 1 with an alternative method of going to the restroom that did not involve Resident 1 soiling Resident 1's self before being changed. Resident 1 stated staff (in general) told Resident 1 it was too difficult to get Resident 1 out of bed to urinate in a toilet. Resident 1 stated Resident 1 felt trapped in bed. Resident 1 stated Resident 1 felt like a burden to staff. Resident 1 stated staff making Resident 1 go to the bathroom in the brief made Resident 1 feel like an animal and did not matter. Resident 1 stated Resident 1 felt depressed. During an interview and record review on 4/17/224 at 11:13 am with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 1's continence status did not change. CNA 1 stated Resident 1 was incontinent of urine because CNA 1 always changed Resident 1's briefs after Resident 1 urinated in her brief. CNA 1 stated she did not offer Resident 1 to use a bed pan or be transferred to a toilet before urinating in Resident 1's brief. CNA 1 stated CNA 1 told Resident 1 to go (urinate) in her brief and CNA 1 would change Resident 1's brief after. CNA 1 stated she had not offered Resident 1 an alternative method to use the bathroom such as a bed pan. CNA 1 stated it was difficult to use the Hoyer lift to move Resident 1. CNA 1 stated it could make Resident 1 feel better if Resident 1 was assisted with a bed pan because it could help improve Resident 1's independence and continence status. During an interview on 4/17/2024 at 11:24 am with CNA 2, CNA 2 stated while Resident 1 was continent of urine, Resident 1 urinated in the brief because it was too hard to assist Resident 1 with going to the bathroom. CNA 2 stated it was standard for Resident 1 to urinate in her brief and then ask to be changed. CNA 2 stated CNA 2 had not offered Resident 1 to use a bed pan before urinating in her brief. CNA 2 stated (in general) if a resident had mobility issues but was continent, CNA 2 could offer a bed pan. CNA 2 stated it was important to offer alternatives to having a resident go to the bathroom in a brief because it could help a resident build strength and independence and stop a resident from being soaked in his/her own urine until being changed by staff. CNA 2 stated making Resident 1 urinate in her brief instead of assisting Resident 1 with a bed pan could make Resident 1 feed bad and frustrated. During an interview on 4/17/2024 at 11:54 am with Licensed Vocational Nurse (LVN) 1, LVN 1 stated having mobility issues and/or being bed bound (unable to get out of bed without assistance) did not mean Resident 1 was incontinent. LVN 1 stated Resident 1 was continent most of the time. LVN 1 stated Resident 1 could control when Resident 1 needed to urinate and should be offered a bed pan every time Resident 1 needed to use the bathroom. LVN 1 stated not consistently offering Resident 1 toileting assistance could cause Resident 1 to have more incontinence. LVN 1 stated if other staff (such as CNAs) did not know Resident 1 was only occasionally incontinent and were not offering toileting assistance with a bed pan, Resident 1 would not know that option was available as an alternative. LVN 1 stated telling Resident 1 to go in her brief instead of offering a bed pad could weaken Resident 1's bladder and worsen incontinence. (continued on next page)

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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 - Some	During a concurrent interview and record review on 4/17/2024 at 2:38 pm with the MDS Coordinator (MDSC), Resident 1's MDS dated [DATE] was reviewed. The MDSC stated Resident 1 was assessed as occasionally incontinent according to what the CNAs documented in Resident 1's chart. The MDSC stated being occasionally incontinent meant Resident 1 had more periods of continence than incontinence. The MDSC stated Resident 1 had control over the bladder most of the time. The MDSC stated based off the MDS assessment, Resident 1 needed to have assistance with toileting to maintain and potentially improve Resident 1's continence status. The MDSC stated if staff were providing Resident 1 toileting assistance it could give Resident 1 more independence, prevent skin breakdown and infection, and allow Resident 1 to maintain as much continence as possible. The MDSC stated Resident 1 would benefit from a toileting schedule to assess what times of the day Resident 1 generally went to the bathroom so the staff could create a schedule based off Resident 1's toileting patterns. The MDSC stated staff could then offer toileting assistance with a bed pan at those times to help Resident 1 maintain, if not improve Resident 1's continence status. During an interview on 4/17/2024 at 3:45 pm with the Director of Nursing (DON), the DON stated residents with occasional incontinence were more often continent than incontinent. The DON stated a resident with occasional incontinence like Resident 1 should be offered toileting assistance to help maintain their level of continence or improve it and to promote independence and decrease the risk for infections and falls. The DON stated Resident 1 being told to urinate in the brief before being changed was not an accurate portrayal or assessment of Resident 1's continence status and could contribute to incontinence. The DON stated Resident 1 should be offered a bed pan every time Resident 1 felt the urge to go to the bathroom. The DON stated it was not acceptable for staff to tell residents to go to the bathroom in their briefs because residents must be assisted with toileting as much as possible to maintain or improve their continence status. The DON stated making Resident 1 urinate in the brief forced Resident 1 to be incontinent and did not give an accurate assessment of Resident 1's care needs, level of assistance, and continence status. The DON stated Resident 1 would benefit from a toileting program because it would help to establish patterns and would allow staff to better anticipate when Resident 1 needed to use the bathroom. The DON stated if Resident 1's care plan indicated to assist with toileting, it meant staff needed to ask Resident 1 if she needed to use the bathroom before Resident 1 urinated in her brief. During a review of the facility's policy and procedure (PP) titled, Incontinence, revised on 12/19/2022, the PP indicated, based on a resident's comprehensive assessment, all residents that were incontinent received the appropriate treatment and services. The PP indicated, the facility ensured residents who were continent of bladder and bowel function upon admission received appropriate treatment, services, and assistance to maintain continence unless his or clinical condition was or became such that continence was not possible to maintain. The PP indicated, residents that were incontinent of bladder and bowel received appropriate treatment to prevent infections and restore continence to the extent possible.