

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 10/23/2024
NAME OF PROVIDER OR SUPPLIER Country Oaks Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34273</p> <p>Based on interview and record review, the facility failed to ensure abdominal X-ray (pictures of the inside of the abdomen) results were received timely for 2 of 3 sampled residents (Resident 1 and Resident 2).</p> <p>These failures resulted in Resident 1 and Resident 2 not receiving their gastrostomy tube (G-tube, a feeding tube inserted through the abdomen that brings nutrition directly to the stomach) feeding (liquid nutrition given through the G-tube) and medications for 3 days.</p> <p>Findings:</p> <p>1. During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure and dysphagia (difficulty swallowing foods or liquids). The AR indicated Resident 1 had a tracheostomy tube (a tube inserted in a surgically created hole in the windpipe to provide an alternative airway for breathing) and a G-tube.</p> <p>During a review of Resident 1's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 7/8/24, the H&P indicated Resident 1 had the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 7/15/24, the MDS indicated Resident 1 was dependent on staff for oral hygiene, toileting hygiene, showering/bathing, personal hygiene, dressing, and putting on/taking off footwear. The MDS indicated Resident 1 had a feeding tube and received 51 percent or more of Resident 1's total calories through the tube feeding.</p> <p>During a review of the Physician's Order (PO), dated 10/10/24 and timed 5:47 am, the PO indicated Resident 1 may have a G-tube replacement by the wound consultant and to verify G-tube placement by abdominal X-ray.</p> <p>During a review of the Change In Condition Evaluation (CIC), dated 10/10/24 and timed 6:19 am, the CIC indicated at 5:45 am a Certified Nursing Assistant (CNA) (unknown) found Resident 1 sitting on the edge of the bed with Resident 1's G-tube dislodged.</p> <p>(continued on next page)</p>

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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<p>F 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Wound Care Expert Progress Report (WCEPR), dated 10/10/24 and untimed, the progress report indicated Resident 1's G-tube was replaced by the wound care consultant and the wound care consultant ordered a stat (immediately/urgently) abdominal X-ray to verify the placement of the G-tube and to not resume tube feeding until after the position of the G-tube was confirmed by X-ray.</p> <p>During a review of the Nurses Progress Note (NPN), dated 10/11/24 and timed 11:36 am, the NPN indicated a licensed nurse (LN) (unknown) called the diagnostic company to ask about Resident 1's abdominal X-ray result which was done on 10/10/24 and the licensed nurse was told the results were not available yet. The NPN indicated the diagnostic company representative told the licensed nurse they will fax the abdominal X-ray result to the facility as soon as it was available.</p> <p>During a review of the NPN, dated 10/12/24 and timed 4:24 pm, the NPN indicated a LN called the diagnostic company 3 times on 10/12/24 to ask about Resident 1's abdominal X-ray result and the LN was told the X-ray result was not available yet. The LN informed the physician Resident 1's abdominal X-ray result was not available yet and asked the physician if Resident 1 could be sent out to the general acute care hospital (GACH) for G-tube placement confirmation.</p> <p>During a review of the NPN, dated 10/13/24 and timed 12:30 am, the NPN indicated Resident 1 went to GACH 1 for G-tube placement confirmation.</p> <p>During a review of the NPN, dated 10/13/24 and timed 1:59 am, the NPN indicated Resident 1 came back from GACH 1 and Resident 1's G-tube position was confirmed. The NPN indicated Resident 1 came back from GACH 1 with physician's order to resume Resident 1's tube feeding and medications.</p> <p>2. During a review of Resident 2's AR, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure and dysphagia. The AR indicated Resident 2 had a G-tube.</p> <p>During a review of the Resident 2's H&P, dated 3/19/24, the H&P indicated Resident 2 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 was dependent on staff for oral hygiene, toileting hygiene, showering/bathing, personal hygiene, dressing, and putting on/taking off footwear. The MDS indicated Resident 2 had a feeding tube and received 51 percent or more of Resident 2's total calories through the tube feeding.</p> <p>During a review of the PO, dated 10/5/24 and timed 3:10 pm, the PO indicated Resident 2 may have a stat X-ray to confirm G-tube placement and a stat G-tube placement.</p> <p>During a review of the WCEPR, dated 10/5/24 and timed 4 pm, the progress report indicated Resident 2's G-tube was replaced by the wound care consultant.</p> <p>During a review of the CIC, dated 10/5/24 and timed 4:19 pm, the CIC indicated when CNA 1 turned Resident 2 in bed, Resident 2's G-tube got caught in the sheet and was dislodged.</p> <p>During a review of the NPN, dated 10/7/24 and timed 12:10 pm, the NPN indicated the LN (unknown) spoke to a representative of the diagnostic company at 10:44 am on 10/7/24 and the representative told the LN Resident 2's abdominal X-ray result which was done on 10/5/24 was not ready yet.</p> <p>(continued on next page)</p>		

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<p>F 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the NPN, dated 10/8/24 and timed 4 pm, the NPN indicated the LN (unknown) received the results of Resident 2's abdominal X-ray results which was done on 10/5/24. The NPN indicated the LN informed the physician of the results and the physician ordered to resume Resident 2's tube feeding.</p> <p>During an interview on 10/23/24 at 12:45 pm with Licensed Vocational Nurse 1 (LVN 1). LVN 1 stated whenever a resident's G-tube was dislodged, the wound care consultant would come in to replace the resident's G-tube and an abdominal X-ray was done to confirm the placement of the new G-tube. LVN 1 stated LNs could not use a G-tube until the G-tube's position was confirmed. LVN 1 stated with the previous diagnostic company, the facility used to get abdominal X-ray results within 24 hours. LVN 1 stated it was important to get the abdominal X-ray results right away to resume the resident's feeding and to give the resident's medications.</p> <p>During an interview on 10/23/24 at 1:12 pm with LVN 2, LVN 2 stated the facility used to get stat abdominal X-ray results right away from the previous diagnostic company. LVN 2 stated with the new diagnostic company the licensed nurses were having a problem with not sending the results right away.</p> <p>During an interview on 10/23/24 at 1:28 pm with the Registered Nurse Supervisor (RNS), the RNS stated abdominal X-ray results for Resident 1 was delayed. The RNS stated it was important for abdominal X-ray results to come right away to be able to give food and medicine to the resident.</p> <p>During an interview on 10/23/24 at 3:11 pm with the Director of Nursing (DON), the DON stated the previous diagnostic company provided X-ray results within 6-8 hours. The DON stated the licensed nurses called the diagnostic company multiple times to follow-up on Resident 1's abdominal X-ray result but they did not get the results, so Resident 1 was sent out the GACH 1 to confirm G-tube position and Resident 1 came back to the facility a few hours later and Resident 1's tube feeding, and medications were resumed. The DON stated it was important to get abdominal X-ray results right away to verify G-tube placement and resume tube feeding and medications.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Laboratory Services and Reporting, dated 12/19/22, the P&P indicated, the facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for following up the result from the laboratory .</p>		