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	04/16/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37198 Based on observation, interview, and record review, the facility failed to follow the facility ' s policy and procedure (P&P) titled, Safe Resident Handling/Transfers, by failing to ensure one of three sampled residents (Resident 1) had two staff members with Resident 1 when staff used a mechanical lift (a device used to assist in lifting and transferring individuals who have difficulty moving independently). This deficient practice had the potential to place Resident 1 ' s safety at risk. Findings: During an observation on 4/15/2025 at 10:43 am, Resident 1 was observed being lifted above the bed on a sling (a soft fabric or mesh material used with a mechanical lift to support and cradle a patient during transfer or movement) attached to a mechanical lift. Restorative Nursing Assistant (RNA) 1 was observed using the mechanical lift to put Resident 1 on the bed and was observed to be the only staff member in the room with Resident 1. During a review of Resident 1 ' s Admission Record (AR), the AR indicated the facility admitted Resident 1 on 3/28/2025 with diagnoses that included acute (sudden onset) and chronic (long-term) respiratory failure (a condition where there is not enough oxygen or too much carbon dioxide in the body) with hypoxia (low levels of oxygen in the body tissues), type 2 diabetes mellitus with hyperglycemia (a chronic condition that happens when having persistently high blood sugar levels), and acute pulmonary edema (abnormal buildup of fluid in the lungs). During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool), dated 3/29/2025, the MDS indicated Resident 1 was understood by others and had the ability to understand others. The MDS indicated Resident 1 was dependent (the assistance of two or more helpers is required for the resident to complete the activity) with oral hygiene, toileting hygiene, showering/bathing self, upper body dressing, lower body dressing, and putting on/taking off footwear. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Care Plan Report (CP), dated 4/6/2025, the CP indicated Resident 1 had an ADL (activities of daily living) self-care performance deficit (the inability to complete activities due to the lack of skills) related to confusion and impaired (weakened) balance. The CP indicated Resident 1 required the use of a mechanical lift with two staff total assistance for transfers. During an interview on 4/15/2025 at 11:14 am, with RNA 1, RNA 1 stated there should have been two staff members present when using a mechanical lift. RNA 1 stated RNA 1 was supposed to put safety first, make sure there were no accidents, and have the mechanical lift in the right place before lifting a resident. During an interview on 4/15/2025 at 11:22 am, with the Director of Staff Development (DSD), the DSD stated staff were aware that there should be two persons assisting at all times when using a mechanical lift. The DSD stated the mechanical lift could tilt down and cause an accident. The DSD stated one staff member was supposed to be maneuvering the mechanical lift, and the other staff member was supposed to be supporting the resident while on a sling. During a review of the facility ' s P&P titled, Safe Resident Handling/Transfer, revised on 12/19/2022, the P&P indicated it was the policy of the facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure, and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. While manual lifting techniques may be utilized dependent upon the resident ' s condition and mobility, the use of mechanical lifts are a safer alternative and should be used Two staff members must be utilized when transferring residents with a mechanical lift.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687 Based on interview and record review, the facility failed to maintain accurate medical records for one of four sampled residents (Resident 3), according to the facility's policy and procedure (P&P) titled, Documentation in Medical Record, by failing to: Ensure licensed nurses (LNs) documented the redness on and leaking from Resident 3's gastrostomy tube (G-tube- tube inserted through the belly that brings nutrition directly to the stomach) stoma (surgically created opening in the abdomen) in Resident 3's Progress Notes (PN) under Advanced Skilled Evaluation (PN ASE) between 2/17/2025 and 2/20/2025. This failure had the potential for Resident 3 to not receive the care and services needed to appropriately treat the redness and leaking from Resident 3's G-tube stoma, and for Resident 3 to develop further infection. Findings: During a review of Resident 3's Admission Record (AR), the AR indicated the facility initially admitted Resident 3 on 12/20/2022, and readmitted Resident 3 on 3/10/2025, with diagnoses that included encounter for attention to G-tube, encounter for attention to tracheostomy (incision made in the windpipe to relieve an obstruction to breathing), and chronic respiratory failure (serious condition that makes it difficult to breathe on your own) with hypoxia (low level of oxygen in the body that causes confusion, restlessness, and difficulty breathing). During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool) dated 1/27/2025, the MDS indicated Resident 3 had severely impaired cognition (ability to think, remember, and function). the MDS indicated was dependent (helper does all the effort, or the assistance of 2 or more helpers is required) on the staff for oral, toileting, and personal hygiene, showering/bathing self, upper and lower body dressing, putting on/taking off footwear, rolling left and right (in bed), sitting to lying, lying to sitting on the side of the bed, sitting to standing, chair/bed-to-chair transfers, and tub/showers transfers. During a review of Resident 3's eINTERACT/Change in Condition (CIC- a change in the resident's health or functioning that requires further assessment and intervention) Evaluation (CICE) dated 2/17/2025, timed at 6:23 pm, the CICE indicated Resident 2's G-tube was noted with leaking and redness around the G-tube stoma. During a review of Resident 3's six PN ASE dated 2/17/2025 timed at 10:29 pm, 2/18/2025, timed at 2:37 pm, 2/18/2025, timed at 11:23 pm, 2/19/2025, timed at 9:12 am, 2/20/2025, timed at 9:37 am, and 2/20/2025, timed at 10:44 pm, the six PN ASE indicated no documentation about the redness on Resident 3's G-tube stoma and the leaking coming from Resident 3's G-tube stoma. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/16/2025 at 2:29 pm with Licensed Vocational Nurse (LVN) 3, LVN 3 stated (in general) LNs documented the head-to-toe assessment of their assigned residents in the PN ASE. LVN 3 stated skin assessments were documented in the PN ASE. LVN 3 stated redness and leaking from a G-tube stoma should be documented in the skin assessment of the PN ASE. LVN 3 stated if LNs were not documenting skin assessment in the PN ASE, the LNs may not know if the condition was healing or getting worse. LVN 3 stated if skin issues were not appropriately documented, the LNs may not know if treatments were needed and this could lead to a worsening condition for the resident and, could lead to infection or sepsis. During an interview on 4/16/2025 at 3:17 pm with LVN 1, LVN 1 stated (in general) any resident's skin issues documentation in the (nursing) progress notes needed to match the resident's PN ASE documentation for accuracy. LVN 1 stated if skin issues were not documented in the PN ASE, other staff may not know to check on the resident's skin issue and the skin issue may not get better. LVN 1 stated on 2/19/2025 at 9:12 am, LVN 1 should have documented the redness on and leaking from Resident 3's G-tube stoma, under the skin assessment of Resident 3's PN ASE. During a concurrent interview and record review on 4/16/2025 at 3:53 pm with LVN 5, Resident 3's six PN ASE dated 2/17/2025 timed at 10:29 pm, 2/18/2025, timed at 2:37 pm, 2/18/2025, timed at 11:23 pm, 2/19/2025, timed at 9:12 am, 2/20/2025, timed at 9:37 am, and 2/20/2025, timed at 10:44 pm were reviewed. LVN 5 stated (in general) if a resident had a G-tube, the LNs were supposed to be assessing and documenting the skin around the G-tube, even if the resident did not have any skin issue. LVN 5 stated the LNs did not document that Resident 3 had redness on and leaking from Resident 3's G-tube stoma in Resident 3's PN ASE under the skin assessment dated [DATE], timed at 10:29 pm, 2/18/2025, timed at 2:37 pm, 2/18/2025, timed at 11:23 pm, 2/19/2025, timed at 9:12 am, 2/20/2025, timed at 9:37 am, and 2/20/2025, timed at 10:44 pm. LVN 5 stated between 2/17/2025 and 2/20/2025, the LNs were supposed to assess and document Resident 3's skin status once a shift in the PN ASE. LVN 5 stated Resident 3's PN ASEs should have indicated the leaking and the redness to Resident 3's G-tube stoma under the skin assessment section. During an interview on 4/16/2025 at 4:10 pm with the Director of Nursing (DON), the DON stated it was all LNs' responsibility to complete and document residents' (in general) skin issues every shift in residents' PN ASE. The DON stated accurate documentation was important to ensure appropriate patient care and to capture any new issues in a timely manner so the resident's physician could be notified. The DON stated if a skin issue was not being documented in the PN ASE, then it was possible a resident may not receive the appropriate care, that could lead to skin infection and hospitalization . During a review of the facility's P&P titled, Documentation in Medical Record, revised 12/19/2022, the P&P indicated each resident's medical record would contain a representation of the experiences of the resident and include enough information to provide a picture of the resident's progress. The P&P indicated licensed staff and interdisciplinary team (IDT- group of health care professionals with various areas of expertise who work together toward goals of their residents) member shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. The P&P indicated documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46687 Based on observation, interview, and record review, the facility failed to follow its policies and procedures (P&P) titled, Hand Hygiene (procedures that included the use of alcohol-based hand rubs (containing 60%-95% alcohol) and hand washing with soap and water), and Enhanced Barrier Precautions (EBP- set of infection control measures that use personal protective equipment [PPE- equipment worn to minimize exposure to hazards] to reduce the spread of multidrug-resistant organisms [MDRO- organism that is resistant to most antibiotics] by wearing a gown and gloves), for one of four sampled residents (Resident 3) by failing to: 1. Ensure Sitter 1 and Sitter 2 wore gloves while providing care to Resident 3. 2. Ensure Sitter 1 and Sitter 2 performed hand hygiene before donning gloves and providing care to Resident 3. These failures had the potential to transmit and spread infection from staff to residents that could result in widespread infection in the facility. Findings: During a review of Resident 3's Admission Record (AR), the AR indicated the facility initially admitted Resident 3 on 12/20/2022, and readmitted Resident 3 on 3/10/2025, with diagnoses that included encounter for attention to gastrostomy tube (G-tube- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach), encounter for attention to tracheostomy (incision made in the windpipe to relieve an obstruction to breathing), and chronic respiratory failure (serious condition that makes it difficult to breathe on your own) with hypoxia (low level of oxygen in the body that causes confusion, restlessness, and difficulty breathing). During a review of Resident 3's care plan (CP) titled Care Plan Report, initiated 1/23/2025, the CP indicated Resident 3 was on EBP related to tracheostomy and GT. The CP goals indicated the facility would prevent/reduce MDRO transmission through healthcare professional (HCP) use of gowns and gloves while caring for [Resident 3] patients at high risk for MDRO transmission at point of care during specific activities with greatest risk for MDRO contamination of HCP hands, clothes, and the environment. The CP interventions included to apply EBP to prevent the spread of infections for specific care activities such as: morning and evening care, toileting and changing incontinent briefs, caring for devices and giving medical treatment, wound care, mobility assistance, and preparing to leave the room and cleaning and disinfecting the environment as ordered. During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool) dated 1/27/2025, the MDS indicated Resident 3 had severely impaired cognition (ability to think, remember, and function). The MDS indicated Resident 3 was dependent (helper does all the effort, or the assistance of 2 or more helpers is required) on staff for oral, toileting, and personal hygiene, showering/bathing self, upper and lower body dressing, putting on/taking off footwear, rolling left and right (in bed), sitting to lying, lying to sitting on the side of the bed, sitting to standing, chair/bed-to-chair transfers, and tub/showers transfers. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/16/2025 at 11:35 am, at Resident 3's room doorway, the EBP sign next to Resident 3's door was observed. The EBP sign indicated everyone entering the room must perform hand hygiene before entering, and don (to put on) a gown and gloves. During a concurrent observation and interview on 4/16/2025 at 11:37 am with Sitter 1 and Sitter 2, inside of Resident 3's room, Sitter 1 and Sitter 2 were observed caring for Resident 3. Sitter 2 was repositioning Resident 3 in bed while Sitter 1 was holding Resident 3's tracheostomy tubing. Sitter 1 and Sitter 2 were wearing gowns but were not wearing gloves. Sitter 1 and Sitter 2 were unable to state why wearing gloves was important. Sitter 1 and Sitter 2 then donned gloves, but did not perform hand hygiene before donning gloves. Sitter 1 stated Sitter 1 and Sitter 2 did not perform hand hygiene before entering Resident 3's room. Sitter 1 and Sitter 2 were unable to state why performing hand hygiene was important before entering a resident's room who was on EBP. Sitter 1 and Sitter 2 were unable to state what EBP was. During an interview on 4/16/2025 at 4:10 pm with the Director of Nursing (DON), the DON stated staff were supposed to perform hand hygiene before entering residents' rooms, before and after providing care to residents, when exiting rooms, and before donning PPE. The DON stated wearing gloves was important, especially with EBP residents with GT and tracheostomies, because those residents were at high risk for catching infection. The DON stated if staff were not performing hand hygiene and wearing gloves, they may spread infection to the residents. During a review of the facility's P&P titled, Hand Hygiene, revised 12/19/2022, the P&P indicated all staff would perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. The P&P indicated staff would perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. The P&P indicated the use of gloves did not replace hand hygiene. The P&P indicated if the task required gloves, perform hand hygiene prior to donning gloves, and immediately upon removing gloves. During a review of the facility's P&P titled, Enhanced Barrier Precautions, revised 3/10/2025, the P&P indicated the facility would implement EBP for the preventions of transmission of MDRO. The P&P indicated EBP referred to an infection control intervention designed to reduce transmission of MDRO that employed targeted gown and gloves use during high contact resident care activities. The P&P indicated facility staff would receive training on EBP upon hire and at least annually and were expected to comply with all designated precautions. The P&P indicated EBP was indicated for residents with (including but not limited to) feeding tubes (GT) and tracheostomies.