

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 03/06/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781</p> <p>Based on observation, interview, and record review, the facility failed to ensure a call light was kept within reach for one of one sampled resident (Residents 55) in accordance with the facility's policy and procedure (P&P), titled, Call Lights: Accessibility and Timely Response.</p> <p>This failure had the potential for Resident 55 to receive delayed care and services necessary to meet the residents' needs.</p> <p>Findings:</p> <p>During a review of Resident 55's Admission Record (AR), the AR indicated Resident 55 was admitted to the facility on [DATE] with diagnoses that included difficulty with walking and chronic respiratory failure (condition that occurs when the lungs cannot get enough oxygen) with hypoxia (low levels of oxygen in the body tissues).</p> <p>During a review of Resident 55's Fall Risk assessment (FR- method of assessing a patient's likelihood of falling), dated 1/10/2025, the FR indicated Resident 55 was at risk for falls due to being chair bound, taking three or more medications, and due to the presence of three or more predisposing disease conditions.</p> <p>During a review of Resident 55's Minimum Data Set (MDS - a resident assessment tool) dated 1/15/2025, the MDS indicated, Resident 55 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated, Resident 55 was dependent (helper does all of the effort) to staff for toileting hygiene, showering, lower body dressing, and personal hygiene.</p> <p>During a review of Resident 55's Care Plan (CP), revised 1/16/2025, the CP indicated Resident 55 was at risk for falls related to confusion. The CP's interventions indicated for the nursing staff to place Resident 55's call light within reach and encourage Resident 55 to use the call light for assistance as needed and Resident 55 needed prompt response to all requests for assistance.</p> <p>During a concurrent observation and interview on 3/3/2025 at 1:32 PM, Resident 55 was awake and lying on bed. Resident 55's call light was hanging on a pole located next to Resident 55's head of the bed. Resident 55 stated, I could not find my call light.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 3/3/2025 at 1:35 PM, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated, Resident 55's call light was hanging on the pole and Resident 55 was unable to reach the call light. LVN 1 stated call lights needed to always be within reach of Resident 55 for safety and in case Resident 55 needed anything from the staff.</p> <p>During an interview on 3/5/2025 at 11:27 AM with the facility's Director of Nursing (DON), the DON stated resident call lights needed to always be within reach for residents to use the call lights when staff assistance was needed.</p> <p>During a review of the facility's P&P, titled, Call Lights: Accessibility and Timely Response, date implemented and revised 12/19/2022, the P&P indicated the facility staff will ensure call lights were within reach of residents and secured, as needed.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781</p> <p>Based on interview and record review, the facility failed to ensure information regarding an Advance Directive (AD, a written preferences regarding treatment options, a process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions) was provided to one of one sampled resident's (Resident 20) Responsible Party (RP) 1 in accordance with the facility's policy and procedure (P&P), titled, Residents' Rights Regarding Treatment and Advance Directives.</p> <p>This deficient practice had the potential to result in lack of knowledge regarding care and treatment decision making and in result in provision of medical treatment that was against RP 1's wishes.</p> <p>Findings:</p> <p>During a review of the Letter of Conservatorship, dated 1/22/2020, the letter indicated RP 1 was Resident 20's Conservator (a court-appointed person responsible for managing the financial and personal affairs of a person who is incapacitated).</p> <p>During a review of Resident 20's Admission Record (AR), the AR indicated Resident 20 was admitted to the facility on [DATE] with diagnoses that included encounter for attention to gastrostomy (creation of an artificial external opening into the stomach for nutritional support) and dysphagia (swallowing difficulty).</p> <p>During a review of Resident 20's Minimum Data Set (MDS - a resident assessment tool), dated 1/10/2025, the MDS indicated, Resident 20 had severe impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated, Resident 20 was dependent (helper does all of the effort) on staff for oral hygiene, toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear, and personal hygiene.</p> <p>During a review of the AD Acknowledgement Form (found in Resident 20's medical record), dated 2/3/2025, the form indicated Resident 20 executed an AD.</p> <p>During an interview and concurrent record review on 3/3/2025 at 4:16 PM, with the Social Worker (SW), of Resident 20's AD Acknowledgement Form. The SW stated, AD Acknowledgement form indicated Resident 20 executed an AD. The SW stated, Resident 20 and/or Resident 20's Responsible Party (RP), did not execute an AD. The SW stated the Form was filled up incorrectly. The SW stated, AD needed to be discussed and explained to the RP upon admission.</p> <p>During an interview on 03/03/2025 at 4:27 PM with RP 1, RP 1 stated, I had no idea what an advanced directive is, they [the facility] have not discussed advanced directives to me.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/4/2025 at 8:51 AM, with the facility's Director of Nursing (DON), the DON stated, the SD needed to discuss the AD Acknowledgement forms with the RPs (in general) or residents (in general) upon admission. The DON stated, RP 1 needed to understand what an AD was about. The DON stated, the AD Acknowledgement form needed to be filled out properly because it indicated the residents wants and wishes.</p> <p>During a review of the facility's P&P, titled, Residents' Rights Regarding Treatment and Advance Directives, date revised 12/19/2022, the P&P indicated in the event the resident is unable to formulate an AD due to cognitive impairment or deemed by the medical doctor that the resident is incapable of making decisions on his or her own, the facility will provide information and education to the resident representative. The P&P indicated the facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive. The P&P indicated, upon admission, should the resident have an advance directive, copies will be made and placed on the chart as we as communicated to the staff.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45553</p> <p>Based on observation, interview, and record review, the facility failed to maintain a clean, safe, sanitary, and homelike environment for the following:</p> <ul style="list-style-type: none"> a. 1 of 1 kitchen affecting 31 of 64 residents, who received food from the kitchen. b. 2 resident rooms affecting 4 residents (Resident 54, Resident 14, Resident 43, and Resident 45) c. Bathroom [ROOM NUMBER] affecting 4 residents (Resident 16, Resident 34, Resident 166, and Resident 167). <p>This practice had the potential for residents to be exposed to dirt, mold, rust and drywall dust, which can lead to a decline in the residents' health and result in irritation of the eyes, skin, nose, throat, and lungs. This deficient practice could result in prolonged exposure that could cause serious problems such as acute (sudden) respiratory illness, persistent coughing, and asthma (narrowed airways in the lungs that make it difficult to breath).</p> <p>Findings:</p> <ul style="list-style-type: none"> a. During an observation on 3/3/25 at 8:41 a.m., two areas of the kitchen ceiling near the food preparation were observed with plaster that was cracked/bubbled. <p>During an interview on 3/3/25 at 8:45 a.m., in the kitchen, with the Dietary Supervisor (DS), the DS stated the ceiling was not currently leaking. The DS stated the Maintenance Department fixed the ceiling area a few months ago.</p> <p>During an observation on 3/3/25 at 8:50 a.m., in the kitchen, the floor adjacent to the sink area and stove, was observed with white tiles worn with black marks and cracks, with the floor tile raised. The floor area near the rack for plates was observed with cracked/missing tile area and chipped (3 inches by 1.5 inches) and the floor area near the stainless-steel food prep table was missing tile and chipped (1 inch by 4 inches).</p> <p>During an interview on 3/3/25 at 8:55 a.m., in the kitchen, with the DS, the DS stated the floor were cleaned daily, but the black marks remained, and staff were unable to remove the marks. The DS stated she informed the Maintenance Department and had asked for a new floor in this kitchen area.</p> <p>During an interview on 3/5/25 at 9:45 a.m. with the Maintenance Supervisor (MS), the MS acknowledged the kitchen needed repairs due to the conditions posed a hazard to the health of the residents. The MS acknowledged that cracked plaster and the chipped tile had dust and could make the food prep area in the kitchen unsanitary. The MS stated he would start all repairs immediately.</p> <ul style="list-style-type: none"> b. During an observation on 3/3/25 at 10:27 a.m., in Room A, a wall area of unpainted plaster (15 inches by 20 inches) was observed under the window and to the right of Resident 54's bed. <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/3/25 at 10:35 a.m., in Room A, with Certified Nursing Assistant (CNA) 6, CNA 6 stated she reported room repairs to the Maintenance Department via a log at the nursing station. CNA 6 stated she did not know if the unpainted plaster near Resident 54's bed was reported to the Maintenance Department.</p> <p>During an interview on 3/3/25 at 11:25 a.m., in the hallway near Room A, with the MS, the MS stated he previously repaired the wall by Resident 54's bed because staff hit and damaged the wall with the Hoyer lift (a mechanical device used by nurses to safely lift and transfer patients with limited mobility). The MS stated he did not paint the plastered area. The MS stated he should have painted the plastered wall after he made the repair.</p> <p>During an observation on 3/3/25 at 11:33 a.m., in Room B (Resident 14, Resident 43 and Resident 45's room), a wall area (4 inches by 25 inches) of unpainted plaster with peeling paint, directly below the air conditioning unit, was observed.</p> <p>During an interview on 3/3/25 at 11:35 a.m., in Room B, with Licensed Vocational Nurse (LVN) 8, LVN 8 stated she would report the wall repair issue to maintenance and record the issue in the logbook at the nursing station. LVN 8 stated she did not know if the wall repair issue was reported, and she would have to check the logbook. LVN 8 stated the unpainted wall was a health risk for all 3 residents (Resident 14, Resident 43, and Resident 45) in the room because of the possibility of plaster dust blowing in the room when the air conditioner was turned on.</p> <p>During a review of the Maintenance Department's logs titled, Wall Penetration, dated January 2024 to December 2024, the logs did not indicate any repairs were made to Room A or Room B nor were Room A or Room B listed on the logs as needing repairs.</p> <p>During a review of the Maintenance Department's logs titled, Maintenance Checklist, dated December 2024 to February 2025, the logs did not indicate any wall, painting, caulking or plastering repairs for Room A or Room B.</p> <p>c. During an observation on 3/3/25 at 12:45 p.m., in Bathroom [ROOM NUMBER] (shared bathroom between Resident 16, Resident 34, Resident 166 and Resident 167), the following were observed:</p> <ol style="list-style-type: none"> 1. On the left corner and right corner of the toilet and along the baseboard was a dark black substance. 2. On the left and right side of the toilet the baseboard along the wall was warped. 3. Around the water shut off valve on the left side of the toilet there was a brown substance, and the wall area was cracked and peeling. 4. On the right side of the toilet, the tile floor had a 3-inch crack with a 1/4 inch groove in the tile. 5. The safety grab bar by the left side of the toilet had cracked and peeling plaster with an exposed screw where the grab bar was fastened to the wall. <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6. On the right side of the bathroom sink there was a 3-inch crack and black substance where the sink met the wall.</p> <p>7. Under the bathroom sink and on/around the plumbing cleanout (an accessible plug or fitting that allows you to access the drain line for cleaning and unclogging) there was a brown color substance and cracked/peeling plaster.</p> <p>8. Under the bathroom sink along the baseboard was crack/unpainted plaster.</p> <p>During a review of the Maintenance Department's logs titled, Wall Penetration, dated January 2024 to December 2024, the logs did not indicate any repairs were made to Bathroom [ROOM NUMBER] nor were Bathroom [ROOM NUMBER] listed on the logs as needing repairs.</p> <p>During a review of the Maintenance Department's logs titled, Maintenance Checklist, dated December 2024 to February 2025, the logs did not indicate any bathrooms listed as part of the maintenance checklist.</p> <p>During an interview on 3/5/25 at 10:30 a.m., in Bathroom #,1 with the MS, the MS acknowledged Bathroom [ROOM NUMBER], and other residents' rooms and bathrooms that were reviewed by a walk-through, needed repairs due to the conditions pose a hazard to the health of the residents. The MS acknowledged the conditions of the rooms and bathrooms were not home-like for the residents. The MS stated he would start all repairs immediately.</p> <p>During a review of Resident 14's Admission Record (AR), the AR indicated, Resident 14 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included chronic respiratory failure (when your blood has too much carbon dioxide or not enough oxygen), encounter for attention to tracheostomy (artificial opening requiring attention or management), and dependence on respirator [ventilator] status (unable to breathe independently and require a mechanical ventilator to support their breathing).</p> <p>During a review of Resident 16's AR, the AR indicated, Resident 16 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included metabolic encephalopathy (a change in how your brain functions), chronic respiratory failure (when your blood has too much carbon dioxide or not enough oxygen), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing).</p> <p>During a review of Resident 34's AR, the AR indicated, Resident 34 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included chronic respiratory failure with hypoxia (when your blood does not have enough oxygen), encounter for attention to tracheostomy, and dependence on respirator [ventilator] status.</p> <p>During a review of Resident 43's AR, the AR indicated, Resident 43 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included chronic respiratory failure with hypercapnia (when your blood has too much carbon dioxide), encounter for attention to tracheostomy, and dependence on respirator [ventilator] status.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 45's AR, the AR indicated, Resident 45 was admitted to the facility on [DATE], with diagnoses that included chronic respiratory failure with hypoxia, encounter for attention to tracheostomy, and dependence on respirator [ventilator] status.</p> <p>During a review of Resident 54's AR, the AR indicated, Resident 54 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included metabolic encephalopathy (a change in how your brain functions), chronic respiratory failure with hypoxia , and traumatic subdural hemorrhage without loss of consciousness (when blood collects in the space between the brain and the membrane surrounding the brain after a head injury).</p> <p>During a review of Resident 166's AR, the AR indicated, Resident 166 was originally admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of larynx (a type of cancer that develops in the voice box), chronic respiratory failure with hypoxia (when your blood does not have enough oxygen), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing).</p> <p>During a review of Resident 167's Admission Record (AR), the AR indicated, Resident 167 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included chronic respiratory failure with hypoxia, encounter for attention to tracheostomy, and dependence on respirator [ventilator] status.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Maintenance Inspection, revised 12/19/22, the P&P indicated, It is the policy of this facility to utilize a maintenance inspection checklist in order to assure a safe, functional, sanitary, and comfortable environment for residents, staff and the public. The P&P indicated, Policy Explanation and Compliance Guidelines: The Director of Maintenance Services will perform routine inspections of the physical plant using the Maintenance Checklist. The Administrator, or designee, will perform random inspections of the physical plant using the Maintenance Checklist . The facility shall establish quality/compliance thresholds as a benchmark for QA purposes.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Safe and Homelike Environment, revised 12/19/22, the P&P indicated, In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment . The P&P further indicated, Policy Explanation and Compliance Guidelines: . Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45553</p> <p>Based on observation, interview, and record review, the facility failed to ensure the assessment entries on the Minimum Data Set (MDS - a resident assessment tool) related to active diagnoses was accurately documented to reflect the resident's health status for one of two sampled residents (Resident 168).</p> <p>This deficient practice resulted in an inaccurate MDS assessment for Resident 168. Resident 168 received Aripiprazole (medication to treat psychosis [mental health condition characterized by a loss of touch with reality]) for 5 days for schizophrenia (a mental illness that is characterized by disturbances in thought, perception, emotions, and social interactions) with no documented diagnosis of schizophrenia.</p> <p>Findings:</p> <p>During a review of Resident 168's Admission Record (AR), the AR indicated, Resident 168 was admitted to the facility on [DATE], with diagnoses that included metabolic encephalopathy (a change in how your brain functions), acute and chronic respiratory failure (a condition where you don't have enough oxygen in the tissues in your body) with hypercapnia (when you have too much carbon dioxide in your blood), depression (persistent low mood, loss of interest or pleasure in activities), and unspecified psychosis, not due to a substance or known physiological condition (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). Resident 168's AR did not list schizophrenia under the Diagnosis Information section.</p> <p>During a review of Resident 168's History and Physical (H&P) dated 2/28/25, the H&P indicated Resident 168 had the capacity to understand and make own decisions.</p> <p>During a review of Resident 168's Minimum Data Set (), dated 3/3/25, the MDS indicated Resident 168's cognition (ability to understand and process information) was cognitively intact, and Resident 168's mood interview indicated a total severity score of 10 (a score of 10 to 14 indicates moderate depression). Resident 168's potential indicators of psychosis indicated none of the above for Hallucinations (seeing, hearing, or smelling things that are not real) and Delusions (unshakable beliefs in something untrue).</p> <p>The MDS indicated Resident 168's active diagnoses selected under Psychiatric/Mood Disorder were Depression (other than bipolar) and Psychotic Disorder (other than schizophrenia). Schizophrenia (e.g., schizoaffective and schizophreniform disorders) was not selected as an active diagnosis.</p> <p>During a review of Resident 168's Medication Administration Record (MAR) for the month of March 2025, the MAR indicated Resident 168 was given Aripiprazole Oral Tablet 20 milligrams (mg- unit of measurement), one time a day for schizoaffective disorder at 9:00 a.m. on 3/1/25, 3/2/25, 3/3/25, and 3/4/25. The MAR indicated the Aripiprazole's start date was 2/28/25 at 9:00 a.m. and the discontinued date was 3/4/25 at 8:03 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 168's care plan (CP) titled, Care Plan Report, revised on 3/5/2025, the CP indicated resident used psychotropic medications related to Aripiprazole Oral Tablet 20 mg for psychosis manifested by lack of motivation to improve medical condition. The CP goal indicated, The resident will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through 5/28/25.</p> <p>During a concurrent interview and record review on 3/6/25 at 3:26 p.m. Re with the Minimum Data Set Coordinator (MDS C), Resident 168's medical record was reviewed. The MDS C stated Resident 168 had received Aripiprazole for a total of 5 days based on the hospital notes indicating she had schizophrenia. The MDS C reviewed Resident's 168's MDS, dated [DATE], and acknowledged there was no schizophrenia selected as an active diagnosis.</p> <p>During a concurrent interview and record review on 3/6/25 at 5:27 p.m. with the Director of Nursing (DON), Resident 168's electronic medical record was reviewed. The DON stated when Resident 168 was admitted to the facility, the hospital notes indicated, Problem List/Past Medical History: Ongoing: Schizophrenia (Patient Stated). The DON stated, The current MDS assessment should be a Yes for schizophrenia based on the hospital notes and by the fact that Resident 168 received antipsychotic medication from 2/28/25 to 3/4/25. The DON stated currently the MDS indicated No on schizophrenia. The DON acknowledged the MDS assessment, dated 3/3/25 was incorrect for Resident 168. The DON stated it was important for the MDS assessment to be accurate because it's the medical record for Resident 168, and an incorrect assessment can lead to an incorrect diagnosis and the wrong medications given.</p> <p>During a review of the facility's policy and procedure (P&P) titled, MDS 3.0 Completion, revised 12/19/22, the P&P indicated, Policy: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. The P&P indicated, Coding of Assessment: All disciplines shall follow the guidelines in Chapter 3 of the current RAI [Resident Assessment Instrument, a tool that helps nursing home staff assess a resident's needs and strengths] Manual for coding each assessment.</p> <p>During a review of the Long-Term Care Facility Resident Assessment Instrument User's Manual (RAI - manual for the MDS), revised October 2024, the manual indicated the steps for assessment of active diagnoses include:</p> <p>Step 1: Diagnosis identification is a 60-day look-back period. Medical record sources for physician diagnoses include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/problem list, and other resources available. If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered. Diagnostic information, including past history obtained from family members and close contacts, must also be documented in the medical record by the physician to ensure validity and follow-up.</p> <p>Step 2: Diagnosis status: Active or Inactive is a 7-day look back period. Once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnosis are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look back period. Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look back period, as these would be considered inactive diagnoses.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781</p> <p>Based on interviews and record review, the facility failed to develop a care plan (CP), for one of one sampled resident (Resident 52), that included management of intravenous (IV, the administration of substances, such as fluids, medications, or blood products, directly into the vein) therapy for Resident 52.</p> <p>This failure had the potential to result in unmet individualized needs for Resident 52 and the potential to affect the resident's physical well-being.</p> <p>Findings:</p> <p>During a review of Resident 52's MDS dated [DATE], the MDS indicated, Resident 52 had severe impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 52 was dependent (helper does all of the effort) on staff for toileting hygiene, showering, lower body dressing, and putting on/taking off footwear. The MDS indicated, Resident 52 needed maximum assistance (helper does more than half the effort) for oral hygiene, upper body dressing, and personal hygiene.</p> <p>During a review of Resident 52's Admission Record (AR), the AR indicated Resident 52 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure (a condition when the lungs cannot get enough oxygen into the blood) with hypercapnia (presence of excessive amounts of carbon dioxide in the blood) and pneumonia (an infection/inflammation in the lungs), unspecified organism.</p> <p>During a review of Resident 52's Order Summary Report (OSR), dated active as of 3/4/2025, the OSR included a physician order, dated 3/1/2025, to restart intravenous 96 hours and as needed for complications. The order indicated to change the [IV] dressing with site change and as needed.</p> <p>During a concurrent interview and record review on 3/4/2025 at 8:38 AM with Registered Nurse 1 (RN 1), Resident 52's medical records were reviewed. RN 1 stated there was no clinical documentation indicating a CP was initiated or implemented for the management of IV therapy. RN 1 stated [developing CPs was important to] ensure Resident 52 received the proper care and effective interventions from the nursing staff.</p> <p>During a concurrent interview and record review of Resident 52's medical record on 3/5/2025 at 11:12 AM with the facility's Director of Nursing (DON), the DON stated comprehensive CPs needed to be developed and implemented to provide proper treatment to the residents.</p> <p>During a review of the facility's Policy and Procedure (P&P), titled, Comprehensive Care Plans, revised 12/19/2022, the P&P indicated to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental, and psychosocial needs that are identified in the resident's comprehensive assessment.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>48729</p> <p>Based on interview and record review the facility failed provide supervision, consistent with the needs of one of one sampled resident (Resident 18), and implement interventions indicated in the facility's policy and procedure (P&P) titled, Fall Prevention Program.</p> <p>This deficient practice resulted in Resident 18 experiencing an unwitnessed fall on 2/27/2025 and had the potential to result in injury to Resident 18.</p> <p>Findings:</p> <p>During a review of Resident 18's Admission Record (AR), the AR indicated Resident 18 was initially admitted to the facility 2/6/2025 with multiple diagnoses including Alzheimer's disease (a condition that occurs late in life and worsens with time in which brain cells degenerate; it is accompanied by memory loss, physical decline, and confusion) and rheumatoid arthritis (persistent joint inflammation).</p> <p>During a review of Resident 18's Minimum Data Set (MDS - a resident assessment tool) dated 2/12/2025, the MDS indicated Resident 18's cognition (ability to understand and process information) was moderately impaired and Resident 18 required maximal assistance (helper does more than half the effort) from facility staff for moving from a sit to stand position and used a walker.</p> <p>During a review of Resident 18's Fall Risk (FR) assessment, dated 2/16/2025, the FR assessment indicated Resident 18 had a fall risk score of 17 which indicated Resident 18 was at risk for falls. The FR assessment further indicated Resident 18 had a history of three or more falls in the past three months and had a balance problem while standing.</p> <p>During a review of Resident 18's Change in Condition Evaluation (COC, a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains), dated 2/16/2025, the COC indicated Resident 18 had a history of falls and a behavior of getting up unassisted. The COC further indicated Resident 18 was found sitting on the floor mat located on the left side of Resident 18's bed. The COC indicated Resident 18 stated Resident 18 had somewhere to be and that was why Resident 18 got up without asking for help.</p> <p>During a review of Resident 18's Change in Condition Evaluation (COC) dated 2/27/2025, timed at 6:40 AM, the COC indicated Resident 18 was noted sitting on the floor with a walker in front of Resident 18. The COC indicated Resident 18 stated Resident 18 lost Resident 18's balance while getting ready for work. The COC further indicated this condition, symptom or sign had occurred before and the treatment for the last episode indicated a sitter at Resident 18's bedside.</p> <p>During a concurrent interview on 3/6/2025 at 1:17 PM with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Resident 18's current fall risk score of 19 and stated the higher the number, the higher the risk for falls. LVN 3 stated Resident 18 was at risk for falls and a sitter (caregiver who supervises residents requiring constant supervision) was implemented after Resident 18 fell a second time on 2/16/2025.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/6/2025 at 1:51 PM with the Director of Staff Development (DSD), the DSD stated the facility implemented a sitter for Resident 18 on 2/16/2025 during the 11 PM to 7 AM shift after Resident 18 fell a second time.</p> <p>During an interview on 3/6/2025 at 2:26 PM with the DSD, the DSD stated the facility had not discontinued Resident 18's sitter from 2/16/2025 to 2/27/2025 and there should have been a sitter for Resident 18 during the night shift. The DSD stated there was no documentation indicating a sitter being present on 2/27/2025 when Resident 18 fell . The DSD stated without documentation [the facility could not prove] a sitter was present at the time of the fall on 2/27/2025. The DSD stated, if a sitter was present, Resident 18 should not have fallen.</p> <p>During an interview on 3/6/2025 at 2:27 PM with Certified Nurse Assistant (CNA) 7, CNA 7 stated Resident 18 had fallen around shift change at 6:30 AM and there was no staff watching Resident 18 when CNA 7 started CNA 7's shift.</p> <p>During an interview on 3/6/2025 at 4:36 PM with the Director of Nursing (DON), the DON stated Resident 18's fall could have been prevented if someone had been monitoring [supervising] Resident 18.</p> <p>During a review of the facility's P&P titled, Fall Prevention Program, revised 12/19/2022, the P&P indicated the nurse and/or interdisciplinary team will initiate interventions on the resident's care plan, in accordance with the resident's level of risk. The P&P further indicated to provide additional interventions as directed by the resident's assessment including but not limited to: iii. Sitter, if indicated.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45553</p> <p>Based on observation, interview, and record review, the facility failed to follow appropriate infection control guidelines related to a urinary catheter bag lying on the floor for a resident with an indwelling urinary catheter for 1 of 2 sampled residents (Resident 167).</p> <p>This deficient practice had the potential to result in urinary tract infections for Resident 167.</p> <p>Findings:</p> <p>During a review of Resident 167's Admission Record (AR), the AR indicated, Resident 167 was initially admitted to the facility on [DATE], and then readmitted on [DATE] with diagnoses that included anoxic brain damage (where the brain is deprived of oxygen for a prolonged period, leading to damage or death of brain cells), chronic respiratory failure with hypoxia (the lungs cannot deliver enough oxygen to the body over time, leading to chronic oxygen deficiency), Moyamoya disease (certain arteries in the brain are constricted), dependence on ventilator status (a serious medical condition that occurs when a patient is unable to breathe independently), encounter for attention to tracheostomy, (routine care for a surgical procedure that creates an opening in the front of the neck and inserts a tube into the windpipe), and neuromuscular dysfunction of bladder (bladder muscles and nerves responsible for urine control are not functioning properly due to damage to the nervous system).</p> <p>During a review of Resident 167's History and Physical (H&P), dated 2/25/25, the H&P indicated Resident 167 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 167's care plan (CP) titled, Care Plan Report, initiated on 2/25/25 and revised 3/3/25, the CP indicated Resident 167 had indwelling catheter due to neurogenic bladder/urinary retention. The CP goal indicated, The resident will show no s/sx (signs/symptoms) of urinary infection through review date (5/24/25). The CP indicated, The resident will be/remain free from catheter-related trauma through review date (5/24/25). The CP interventions included to position the catheter bag and tubing below the level of the bladder and away from entrance room door.</p> <p>During a review of Resident 167's Treatment Administration Record (TAR)for March 2025, the TAR indicated, Indwelling Foley Catheter 16F/10CC (16 French size [used to size catheters by their outer circumference], 10CC [10 milliliters of sterile water, balloon size to hold the catheter in place in the bladder]) maintenance change every day shift starting on the 20th and ending on the 20th every month for urinary retention.</p> <p>During an observation on 3/5/25 at 10:15 a.m. in Resident 167's room, Resident 167's foley catheter bag was observed lying on the floor.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 3/5/25 at 10:17 a.m., in Resident 167's room, with the Infection Preventionist Nurse (IPN), the IPN stated, the foley catheter bag should not be lying on the floor because it is a potential source of infection for the resident. The IPN stated, All staff (Registered Nurses, Licensed Vocational Nurses [LVNs], and Certified Nursing Assistants [CNAs]) are able to see the foley catheter bag in that position and should be able to place it in the correct height.</p> <p>During an observation on 3/5/25 at 10:20 a.m., in Resident 167's room, LVN 5 was observed raising Resident 167's bed to a height where the foley catheter bag was no longer lying or touching the floor.</p> <p>During an interview on 3/5/25 at 10:25 a.m. with CNA 2, CNA 2 stated he was the CNA assigned to Resident 167. CNA 2 stated he received in-services such as patient care, positioning, and foley catheter every other week. CNA 2 was shown a picture of Resident 167's foley catheter bag lying on the floor next to the bed, and CNA 2 stated, The foley bag should not touch or lie on the floor because it is unclean, and you don't know what is on the floor; it could cause an infection to the resident. CNA 2 acknowledged the foley bag lying on the floor was an infection control issue, and CNA 2 stated if he saw any foley bags touching or lying on the floor in the other resident rooms, he would make sure to raise them to the proper height.</p> <p>During a follow up interview on 3/5/25 at 10:43 a.m. with LVN 5 regarding Resident 167's foley bag, LVN 5 stated she noticed the foley bag lying on the floor when LVN 5 went to check on Resident 167. LVN 5 stated, That is why I raised the bed, so the foley bag would be off the floor. LVN 5 acknowledged that the foley bag should not be touching or lying on the floor because the bag and tubing were a direct line to the resident and may cause an infection if it was contaminated or result in an injury to the resident if someone were to trip on the foley bag.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Appropriate Use of Indwelling Catheters, revised 12/19/22, the P&P indicated, Policy Explanation and Compliance Guidelines: . Indwelling urinary catheters (urethral or suprapubic) will be utilized in accordance with current standards of practice, with interventions to prevent complications to the extent possible. The plan of care will address the use of an indwelling urinary catheter, including strategies to prevent complications.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729</p> <p>Based on observation, interview, and record review, the facility failed to ensure adequate gastrostomy tube (GT, a tube inserted into the stomach through a surgical incision used for feeding and administration of medications for a resident unable to swallow) treatment and services were provided for two of two sampled residents (Resident 40 and Resident 20), who were receiving enteral feedings (liquid nutrition, delivery of nutrients through a feeding tube directly into the stomach) when:</p> <p>A. On 3/5/2025, Resident 40's GT was observed disconnected from the GT feeding pump with enteral feeding spilling on the floor.</p> <p>B. On 3/3/2025, the facility failed to follow infection control precautions to minimize the risk of GT contamination, Resident 20's GT tip touched the floor. Additionally, the facility failed to utilize feeding tubes in accordance with current clinical standards of practice by failing to ensure Certified Nursing Assistant 1 (CNA 1) did not disconnect or turn Resident 20's GT feeding pump off/on as indicated in the facility's policy and procedure (P&P) titled, Care and Treatment of Feeding Tube.</p> <p>These deficient practices had the potential to result in unmet nutritional needs to Resident 40 and the potential for GT complications to Resident 20.</p> <p>Findings:</p> <p>A. During a review of Resident 40's Admission Record (AR), the AR indicated Resident 40 was initially admitted to the facility 6/25/2024 with multiple diagnoses including chronic respiratory failure (condition that occurs when the lungs cannot get enough oxygen) and dysphagia (swallowing difficulties) with GT.</p> <p>During a review of Resident 40's Minimum Data Set (MDS - a resident assessment tool) dated 1/8/2025, the MDS indicated Resident 6 had severely impaired cognition (ability to understand and process information) and was dependent (helper does all of the effort) on facility staff for bathing and toileting.</p> <p>During a review of Resident 40's Medication Review Report (MRR) with date range from 3/1/2025 to 3/31/2025, the MRR indicated Resident 40 had a physician order, start date 3/1/2025, for continuous enteral feeding (uninterrupted administration of enteral formula over extended periods of time) formula: Fibersource HN 1.2 (a nutritionally tube feeding formula with fiber) at a rate of 60 milliliters (mL - unit of volume) per hour for 20 hours until 1200 mLs were infused.</p> <p>During a concurrent observation and interview on 3/5/2025 at 4:12 PM with Licensed Vocational Nurse (LVN) 7, Resident 18's GT feeding pump was powered on and was observed disconnected from Resident 18 with formula spilling from the GT to the floor. LVN 7 stated LVN 7 had powered off the GT feeding pump and disconnected Resident 18 from the GT feeding pump around 3 PM so CNA 1 could give Resident 18 a bed bath.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/5/2025 at 4:16 PM with CNA 4, CNA 4 stated CNA 4's shift began at 3 PM and CNA 4 had received bedside shift report from CNA 1 but was not told Resident 18 was disconnected from the GT feeding machine. CNA 4 stated CNA 4 had not seen when the enteral feeding was disconnected but CNA 4 was not the staff who disconnect Resident 18, and CNA 4 did not know how long the enteral feeding had been spilling on the floor.</p> <p>During an interview on 3/5/2025 at 11:21 AM with the Director of Nursing (DON), the DON stated staff (in general) could lose track of how much enteral feeding a resident had received if a resident was disconnected from the GT feeding pump and a resident could lose weight.</p> <p>During a review of the facility's P&P, titled, Care and Treatment of Feeding Tubes, dated 12/19/2022, the P&P indicated, 9. Direction for staff regarding nutritional products and meeting the resident's nutritional needs will be provided: e. Ensuring that the administration of enteral nutrition is consistent with and follows the practitioner's orders. 10. Direction for staff regarding how to manage and monitor the rate of flow will be provided: c. Periodic evaluation of the amount of feeding being administered for consistency with practitioner's orders.</p> <p>42781</p> <p>B. During a review of Resident 20's AR, the AR indicated Resident 20 was admitted to the facility on [DATE] with diagnoses that included encounter for attention to gastrostomy (creation of an artificial external opening into the stomach for nutritional support) and dysphagia (swallowing difficulty).</p> <p>During a review of Resident 20's MDS, dated [DATE], the MDS indicated Resident 20 had severe impaired cognition for daily decision making. The MDS indicated, Resident 20 was dependent on staff for oral hygiene, toileting hygiene, showering, upper and lower body dressing, putting on/taking off footwear, and personal hygiene.</p> <p>During a review of Resident 20's Order Summary Report (OSR), dated active as of 3/4/2025, the OSR included a physician's order, dated 1/23/2025, the order indicated, to administer Isosource 1.5 (nutritional formula) rate at 63 cubic centimeter (cc, unit of measurement) per hour (cc/hr) for 20 hours. The order indicated a start time of 12 noon and an off time of 8 AM or until 1260 cc was infused.</p> <p>During an observation on 3/3/2025 at 9:18 AM, Resident 20 was awake, lying in bed, and CNA 1 was at Resident 20's bedside. The tip of Resident 20's feeding tube was touching the floor.</p> <p>During an interview on 3/3/2025 at 9:24 AM, with LVN 1, LVN 1 stated, the tip of Resident 20's GT tubing was touching the floor. LVN 1 stated, GT tubing should not touch the floor because the floor was dirty.</p> <p>During an interview on 3/3/2025 at 9:25 AM, with CNA 1, CNA 1 stated, I disconnected the GT feeding from the resident and hung the tubing on the GT machine. I turned off and on the machine.</p> <p>During an interview on 3/5/2024 at 11:21 AM, with the facility's DON, the DON stated, CNAs (in general) were not allowed to [disconnect] turn on/off resident GT feedings. The DON stated GT tubing should not touch the floor for infection control [purposes].</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's P&P, titled, Care and Treatment of Feeding Tube, revised 12/19/2022, the P&P indicated, it is the policy of the facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. The P&P indicated the use of infection control precautions and related techniques to minimize the risk of contamination.</p>

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781</p> <p>Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Resident 52 and Resident 116) received care and services for the provision of peripheral IV (intravenous, the administration of substances, such as fluids, medications, or blood products, directly into the vein) site (a thin, flexible tube is inserted through the skin into a small vein in the periphery such as the hand, elbow, or foot and can remain in place for several days) in accordance to facility's policy and procedure (P&P), titled, Intravenous Therapy, when,</p> <p>A and B. On 3/3/2025, Resident 52 and Resident 116's IV sites were not labeled with a date and time, to indicate when the IV dressings were changed.</p> <p>These failures had the potential to result in IV complications and infections to Residents 52 and Resident 116 and the potential to affect the resident's well-being.</p> <p>Findings:</p> <p>A. During a review of Resident 52's MDS dated [DATE], the MDS indicated, Resident 52 had severe impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 52 was dependent (helper does all of the effort) on staff for toileting hygiene, showering, lower body dressing, and putting on/taking off footwear. The MDS indicated, Resident 52 needed maximum assistance (helper does more than half the effort) for oral hygiene, upper body dressing, and personal hygiene.</p> <p>During a review of Resident 52's Admission Record (AR), the AR indicated Resident 52 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure (a condition when the lungs cannot get enough oxygen into the blood) with hypercapnia (presence of excessive amounts of carbon dioxide in the blood) and pneumonia (an infection/inflammation in the lungs), unspecified organism.</p> <p>During a review of Resident 52's Order Summary Report (OSR), dated active as of 3/4/2025, the OSR included a physician order, dated 3/1/2025, to restart intravenous every 96 hours and as needed for complications. The order indicated to change the [IV] dressing with site change and as needed.</p> <p>During a review of Resident 52's Order Summary Report (OSR), dated active as of 3/4/2025, the OSR included a physician order, dated 3/1/2025, the order indicated to administer Zosyn (medication used to kill bacteria and to treat infections) Intravenous solution, 3-0.375 gram (gm, unit of measurement) per 50 millimeter (ml, unit of measurement) IV every six hours for pneumonia (an infection/inflammation in the lungs) for seven days.</p> <p>During an observation on 3/3/2025 at 8:35 AM, Resident 52 was lying in bed and awake. Resident 52's left arm had a peripheral IV site; the dressing was unlabeled and did not indicate a date.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 3/3/2025 at 8:37 AM with the Infection Prevention Nurse (IPN), Resident 52 was awake lying in bed and had an IV site on the left arm. The IV site was not labeled with a date or time to indicate when the dressing was last changed. The IPN stated Resident 52's IV site needed to be labeled with a date by the licensed nurse (in general) who inserted the IV line and a time to know when the dressing was last changed for infection control [purposes].</p> <p>B. During a review of Resident 116's AR, the AR indicated Resident 116 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure with hypoxia (body or a region of the body is deprived of adequate oxygen supply) and pneumonia, unspecified organism.</p> <p>During a review of Resident 116's MDS dated [DATE], the MDS indicated Resident 116 had moderately impaired cognition for daily decision making. The MDS indicated, Resident 116 was dependent on staff for oral hygiene, toileting hygiene, showers, upper and lower body dressing, putting on/taking off footwear, and personal hygiene.</p> <p>During a review of Resident 116's Order Summary Report (OSR), dated active as of 3/4/2025, the OSR included a physician order, dated 2/24/2025, indicating to insert a peripheral IV and rotate the site used for medication every 7 days and as needed.</p> <p>During a concurrent observation and interview on 3/3/2025 at 8:41 AM, with the IPN, at Resident 116's bedside, Resident 116 was awake lying in bed with a peripheral IV site on Resident 116's left hand. The site was not dated to when the dressing was changed.</p> <p>During an interview with facility's Director of Nursing (DON) on 3/5/2025 at 11:12 AM, the DON stated IV sites should be labeled with a date, time of IV insertion, and the licensed nurse's initial to identify who and when the IV was changed and to prevent infections.</p> <p>During a review of the facility's P&P, titled, Intravenous Therapy, revised 12/19/2022, the P&P indicated, IV sites are changed every 72 hours unless otherwise ordered by the physician. The P&P indicated in the event an IV site is left in place longer than 72 hours, IV site will be checked for any infiltration (when fluids or medications leak out of the vein and into the surrounding tissues often due to dislodged or a punctured catheter, causing swelling, pain, or burning at the IV site).</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of three sampled resident's (Resident 50) nasal cannula tubing (a medical device, a soft tubing, used to deliver supplemental oxygen, the tube's ends splits into two prongs) was place properly by placing both nasal prongs in the Resident 50's nostrils in accordance with the facility's policy and procedure (P&P), titled, Oxygen administration.</p> <p>This deficient practice placed Resident 50 at risk for shortness of breath and/or hypoxia (low levels of oxygen in the body tissues) and had the potential to result in a physical decline to Resident 50.</p> <p>Findings:</p> <p>During a review of Resident 50's Admission Record (AR), the AR indicated Resident 50 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure (a condition where the lungs cannot get enough oxygen into the blood) with hypoxia (the body's tissues do not receive enough oxygen), dependence on supplemental oxygen, and encounter for attention to tracheostomy (surgical opening in the throat in which a tube is placed for the resident's breathing).</p> <p>During a review of Resident 50's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 1/9/2025, the MDS indicated, Resident 50 had severe impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated, Resident 50 was dependent (helper does all of the effort) on staff for oral hygiene, toileting hygiene, showers, upper/lower body dressing, putting on/taking off footwear, and personal hygiene.</p> <p>During a review of Resident 50's Order Summary Report (OSR), dated active as of 3/4/2025, the OSR included a physician order, dated 1/26/2025, the order indicated to apply oxygen via nasal cannula at one liter (L, unit of measurement) per minute (L/min), may titrate oxygen to maintain oxygen saturation (is a measure of how much oxygen the blood is carrying as a percentage of the maximum it could carry) greater or equal to 92 percent (%) every shift.</p> <p>During a review of Resident 50's care plan (CP), revised on 1/26/2025, the CP indicated Resident 50 had history of chronic respiratory failure with hypoxia. The CP's interventions indicated for staff to administer oxygen as ordered [by the physician] to Resident 50.</p> <p>During an observation on 3/3/2025 at 11:45 AM, Resident 50 was asleep, lying in bed. The nasal cannula was located on Resident 50's forehead.</p> <p>During a concurrent observation and interview on 3/3/2025 at 11:48 AM with the facility's Infection Prevention Nurse (IPN), the IPN stated, the nasal cannula was not placed in Resident 50's nostrils. The IPN stated, nasal cannulas needed to be inside both nostrils to ensure proper oxygen delivery that was ordered by the medical doctor. The IPN stated, if the nasal cannula was not placed in both nostrils, Resident 50's oxygen saturation would drop.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/5/2025 at 11:15 AM with the facility's Director of Nursing (DON), the DON stated nasal cannulas needed to be inside the nostrils for Resident 50 to get the right amount of oxygen therapy needed. The DON stated, if nasal prongs were not placed in both nostrils, it could result in shortness of breath and poor oxygenation to Resident 50.</p> <p>During a review of the facility's P&P, titled, Oxygen Administration, revised 5/20/2024, the P&P indicated, oxygen is administered to residents who need it, consistent with professional standards of practice. The P&P indicated oxygen is administered under order of a physician.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of one sampled staff (Certified Nurse Assistant 1 [CNA 1]) was competent with providing gastrostomy tube (GT, a tube inserted through the abdomen that delivers nutrition directly to the stomach) care for one of two sampled residents (Resident 20) in accordance with the facility's policy and procedure (P&P), titled Care and Treatment of Feeding Tube.</p> <p>This failure had the potential to place the residents with GTs, under the care of CNA 1, at risk for not having their needs met safely and in a manner that promoted each resident's physical well-being.</p> <p>Cross Reference F693</p> <p>Findings:</p> <p>During a review of Resident 20's Admission Record, the AR indicated Resident 20 was admitted to the facility on [DATE] with diagnoses that included encounter for attention to gastrostomy (creation of an artificial external opening into the stomach for nutritional support) and dysphagia (swallowing difficulty).</p> <p>During a review of Resident 20's Minimum Data Set (MDS, resident assessment tool), dated 1/10/2025, the MDS indicated Resident 20 had severe impaired cognition for daily decision making. The MDS indicated, Resident 20 was dependent on staff for oral hygiene, toileting hygiene, showering, upper and lower body dressing, putting on/taking off footwear, and personal hygiene.</p> <p>During a review of Resident 20's Order Summary Report (OSR), dated active as of 3/4/2025, the OSR included a physician's order, dated 1/23/2025, the order indicated, to administer Isosource 1.5 (nutritional formula) rate at 63 cubic centimeter (cc, unit of measurement) per hour (cc/hr) for 20 hours. The order indicated a start time of 12 noon and an off time of 8 AM or until 1260 cc was infused.</p> <p>During an observation on 3/3/2025 at 9:18 AM, Resident 20 was awake, lying in bed, and CNA 1 was at Resident 20's bedside. Resident 20's GT tubing was hanging on a pole and was disconnected from Resident 20.</p> <p>During an interview on 3/3/2025 at 9:25 AM, with CNA 1, CNA 1 stated, I disconnected the GT feeding from the resident [Resident 20] and hung the tubing on the GT machine. I turned [the machine] off and on.</p> <p>During an interview on 3/3/2025 at 9:26 AM, Licensed Vocational Nurse 1 (LVN 1) stated, the GT feedings should not be disconnected from the residents [by CNAs]. LVN 2 stated, CNAs should not turn on or off the GT machine because they were not licensed to do it.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/5/2024 at 11:21 AM, with the facility's DON, the DON stated, CNAs (in general) were not trained or allowed to [disconnect] turn on/off resident GT feedings. The DON stated, this action was outside of CNAs scope of practice (specific types of activities and tasks that a healthcare professional is legally allowed and qualified to perform, based on their training, education, and license).</p> <p>During a review of the facility's P&P, titled, Care and Treatment of Feeding Tube, revised 12/19/2022, the P&P indicated, it is the policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729</p> <p>Based on interview and record review, the facility failed to ensure accurate acquiring and dispensing of medications by failing to:</p> <p>A. Ensure accountability of the narcotic (medications that have compounds with paralyzing [causing a person or part of the body to become partly or wholly incapable of movement] or numbing properties) medications stored in one of two medication carts (Med Cart #2) between the off-going nurse and the on-coming nurse on 3/1/2025 for the morning (AM) and the evening (PM) shifts.</p> <p>B. Ensure, the correct dose of Polyvinyl Alcohol Ophthalmic Solution (eyedrops, medication used to relieve eye dryness an soreness, particularly where the dryness is caused by a reduced flow of tears) was administered as ordered by the physician for one of one sampled resident (Resident 50).</p> <p>This deficient practice had the potential to lead to diversion (illegal distribution of abuse of prescription drugs or their use for unintended purposes) of narcotic medications and resulted in an inadequate eyedrop dose administered to Resident 50 with a potential for worsening of Resident 50's eye condition.</p> <p>Findings:</p> <p>A. During an interview on 3/6/2025 at 7:31 AM with Licensed Vocational Nurse (LVN) 6, LVN 6 stated at the beginning of each shift change, the off-going nurse and on-coming nurse counted all the narcotics for the residents designated to the nurse's assigned medication cart. [This was important] to ensure there were no missing medications. LVN 6 stated each nurse signed a log titled, Controlled Substances Shift Count Log (SCL). LVN 6 stated, the signature indicated the licensed nurse had reviewed all the narcotics in the cart and all narcotics from that medication cart were accounted for.</p> <p>During a concurrent interview and record review on 3/6/2025 at 4:38 PM with the Director of Nursing (DON), the facility's SCL for Med Cart #2 was reviewed. The SCL indicated a space for signatures from the off-going nurse and on-coming nurse from 3/1/2025 to 3/31/2025. The DON stated on 3/1/2025 the off-going nurses' signatures (for AM and PM shifts) were missing, and the off-going nurse should have signed the SCL but did not. The DON stated the nurse's signature showed that the narcotics were counted and without the off-going nurse's signature, it was certain if both nurses counted the narcotics together which could lead to the diversion of narcotic medications.</p> <p>During a review of the facility's in-service titled, Medication Administration, dated 2/10/2025. The in-service indicated controlled drug quantities will be verified and reconciled at the change of each nursing shift and this count needed to be documented.</p> <p>42781</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>B. During a review of Resident 50's Admission Record, the AR indicated Resident 50 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure (a condition where the lungs cannot get enough oxygen into the blood) with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), and dependence on supplemental oxygen (colorless, odorless gas) and encounter for attention to tracheostomy (surgical opening in the throat in which a tube is placed for the resident's breathing).</p> <p>During a review of Resident 50's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/9/2025, the MDS indicated, Resident 50 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated, Resident 50 was dependent (helper does all of the effort) on staff for oral hygiene, toileting hygiene, shower, upper/lower body dressing, putting on/taking off footwear and personal hygiene.</p> <p>During a review of Resident 50's Order Summary Report (OSR), dated active as of 3/4/2025, the OSR indicated a physician's order, dated 7/31/2024, the order indicated to instill two (2) drops of Polyvinyl Alcohol Ophthalmic Solution on both eyes every 12 hours for dry eyes.</p> <p>During a medication administration observation on 3/5/2025 at 9:08 AM, Licensed Vocational Nurse 2 (LVN 2) administered one drop of Polyvinyl Alcohol Ophthalmic Solution to Resident 50's left eye.</p> <p>During a medication pass observation on 3/5/2025 at 9:11 AM, LVN 2 administered one drop of Polyvinyl Alcohol Ophthalmic Solution to Resident 50's right eye.</p> <p>During a concurrent interview and record review on 3/5/3035 at 9:21 AM of Resident 50's Medication Administration Record (MAR) with LVN 2. The MAR indicated to instill 2 drops of Polyvinyl Alcohol Ophthalmic Solution in both eyes to Resident 50. LVN 2 stated, I administered 1 [eye]drop [to] each eye. LVN 2 stated, Resident 50 would not get the adequate dose of the medication as ordered by the physician.</p> <p>During a concurrent interview and record review on 3/5/2025 at 11:28 AM with the facility's Director of Nursing (DON), Resident 50's electronic medical records (PointClickCare - PCC, a cloud-based software used in long-term and post-acute care facilities) was reviewed. The DON stated, medications would not have the maximum expected effect if the physician's order was not followed correctly.</p> <p>During a review of the facility's policy and procedure (P&P), titled, Medication Administration, revised 12/19/2022, the P&P indicated, medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state as ordered by the physician and in accordance with professional standards of practice. The P&P indicated to review the MAR to identify the medication to be administered.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781</p> <p>Based on interview and record review, the facility failed to ensure specific indication for the use of Ativan (medication used to treat anxiety [group of mental disorders characterized by feelings of anxiety [an unpleasant state of inner turmoil] and fear]) for one of five sampled residents (Resident 55) as indicated in the facility's policy and procedure (P&P), titled Use of Psychotropic [medications that affect the brain and nervous system, used to treat mental health conditions], Medications.</p> <p>This deficient practice had the potential to result in the use of unnecessary psychotropic drugs and result in an adverse drug event (injuries resulting from medication use including physical and mental harm, or loss of function) to Resident 55.</p> <p>Findings:</p> <p>During a review of Resident 55's Admission Record (AR), the AR indicated Resident 55 was admitted to the facility on [DATE] with diagnoses that included difficulty with walking and chronic respiratory failure (a condition where the lungs cannot get enough oxygen into the blood) with hypoxia (low levels of oxygen in the body tissues).</p> <p>During a review of Resident 55's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/15/2025, the MDS indicated Resident 55 had moderate impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 55 was dependent (helper does all of the effort) on staff for toileting hygiene, showers, lower body dressing, and personal hygiene.</p> <p>During a review of Resident 55's Order Summary Report (OSR), dated active as of 3/4/2025, the OSR included a physician order, dated 2/24/2025, the order indicated Ativan 1 milligram (mg, unit of measurement) via gastrostomy tube (GT, a tube inserted into the stomach through a surgical incision used for feeding and administration of medications for a residents who are unable to swallow) every six hours as needed for agitation for 14 days manifested by constant fidgeting.</p> <p>During a concurrent interview and record review on 3/5/2025 at 11:09 AM with the facility's Director of Nurses (DON), Resident 55's medical records were reviewed. The DON stated Resident 55's indication for use [agitation] for Ativan was not a specific diagnosis. The DON stated, to administer Ativan, the medication needed to have a proper and specific diagnosis with symptoms. The DON stated, agitation is not a specific diagnosis or indication for Ativan use.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's P&P, titled, Use of Psychotropic Medications, revised 12/19/2022, the P&P indicated, residents are not given psychotropic drugs (psychiatric medicines that alter chemical levels in the brain which impact mood and behavior) unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident. The P&P indicated, PRN (given as needed or requested) orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45553</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper food handling practices by one of three dietary staff observed during lunch tray line.</p> <p>This deficient practice had the potential for cross-contamination of food that could result in food borne illness (any illness resulting from eating contaminated/spoiled foods) for 31 of 64 residents who received food from the kitchen.</p> <p>Findings:</p> <p>During an observation of the kitchen tray line on 3/5/25 at 12:03 p.m., the cook, who was assisting the dietary assistant (DA) with plating lunch food, was observed wearing blue nitrile gloves and using silver oven mittens to hold plates, and then passing the plates to the DA who was placing food on the plates. The cook was observed using silver oven mittens to remove hot plates from the oven. The cook was observed touching the top of table with blue gloves, then touching the top of the oven mittens that were lying off to the side on the table. Next, the cook was observed slicing bread (to be served with lasagna); the cook holding the knife in her right hand (with the blue glove) and holding the bread as it was sliced with her left hand (with the blue glove). The cook did not change gloves before touching the bread (after touching the oven, the table, and then touching the top of the silver mitten). The cook was also observed wearing on the left hand (silver oven mitten) and on the right hand (with blue glove) receiving a plate with food on it from the DA, then the cook placed the plate cover over the food and gave the plate to another dietary staff to place on the food rack.</p> <p>During an interview on 3/5/25 at 12:15 p.m. with the Dietary Supervisor (DS), the DS stated the cook should change her gloves before touching the bread because of cross-contamination from touching other areas in the kitchen. The DS stated when handling ready-to-eat foods like bread, staff should not transfer potential bacteria from surfaces like tables to the food directly, which can lead to a food borne illness for the residents.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Personal Hygiene-Safety Food Handling-Infection Control, revised 12/19/22, the P&P indicated, Policy: Guidelines for personal hygiene to promote a safe and sanitary department must be followed. Gloves should be used when touching ready-to-eat (RTE) foods. RTE foods are foods that will not receive additional cooking. Examples of RTE foods are sandwiches, salads, ice, and similar foods. Utensils such as scoops, tongs, or ladles can also be used to handle RTE foods. Ice is considered an RTE food and must be handled accordingly. When retrieving ice from the ice machine, use a scoop or gloves. If using gloves, the gloves have to be changed if staff touch equipment or other items that might cause cross-contamination of the ice.</p> <p>(continued on next page)</p>		

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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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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Food Safety and Food Storage, revised 11/4/24, the P&P indicated, Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety. The P&P indicated, Policy Explanation and Compliance Guidelines: Food safety practices shall be followed throughout the facility's entire food handling process. This process begins when food is received from the vendor and ends with delivery of the food to the resident . Preparation of food, including thawing, cooking, cooling, holding and reheating . Distribution and service of food to the resident, including transportation, set up, and assistance. The P&P indicated, When preparing food, staff shall take precautions in critical control points in the food preparation process to prevent, reduce, or eliminate potential hazards . Foods and beverage shall be distributed and served to residents in a manner to prevent contamination and maintain food at the proper temperature and out of the Danger Zone. The P&P indicated, Staff shall adhere to safe hygienic practices to prevent contamination of foods from hands or physical objects . Additional strategies to prevent foodborne illness include, but are not limited to . Preventing cross contamination of foods.</p> <p>During a review of the U.S. Food and Drug Administration Food Code, dated 2017, the food code indicated, 3-304.15 Gloves, Use Limitation. (A) If used, SINGLE-USE gloves shall be used for only one task such as working with READY-TO-EAT FOOD or with raw animal FOOD, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. (B) Except as specified in (C) of this section, slash-resistant gloves that are used to protect the hands during operations requiring cutting shall be used in direct contact only with FOOD that is subsequently cooked as specified under Part 3-4 such as frozen FOOD or a PRIMAL CUT of MEAT. (C) Slash-resistant gloves may be used with READY-TO-EAT FOOD that will not be subsequently cooked if the slash-resistant gloves have a SMOOTH, durable, and nonabsorbent outer surface; or if the slash-resistant gloves are covered with a SMOOTH, durable, nonabsorbent glove, or a SINGLE-USE glove. (D) Cloth gloves may not be used in direct contact with FOOD unless the FOOD is subsequently cooked as required under Part 3-4 such as frozen FOOD or a PRIMAL CUT of MEAT.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729</p> <p>Based on observation, interview, and record review, facility staff failed to implement infection control practices to reduce and/or prevent the spread of infection when:</p> <p>A. One of two staff (Respiratory Therapist, RT) failed to properly wear an isolation (staying away/kept away from others) gown during tracheostomy care (procedure performed routinely to keep tracheostomy [surgical opening created through the neck into the windpipe to allow air to fill the lungs] and the surrounding area clean and reduce the induction of bacteria [living organism that can cause an infection] into the windpipe and lungs) for one of six sampled residents (Resident 6) who was under enhanced barrier precaution (EBP-infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO, bacteria that are resistant to three or more classes of antimicrobial drugs] that employs targeted gown and gloves use during high contact resident care activities).</p> <p>B. One of two staff (Certified Occupational Therapy Assistant, COTA) failed to wear proper personal protective equipment (PPE, protective clothing or equipment, designed to protect the wearer from injury or the spread of infection or illness) while assisting one of six sampled residents (Resident 117), who was on contact isolation.</p> <p>This deficient practice had the potential to result in the spread infections throughout and affect the health of the residents and/or facility staff.</p> <p>Findings:</p> <p>A. During a review of Resident 6's Admission Record (AR), the AR indicated Resident 6 was initially admitted to the facility 3/22/2011 and the resident was readmitted on [DATE] with multiple diagnoses including chronic respiratory failure (condition that occurs when the lungs cannot get enough oxygen) and quadriplegia (paralysis below the neck that affects all of a person's limbs [arms or legs]).</p> <p>During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool) dated 1/31/2025, the MDS indicated Resident 6 had severely impaired cognition (ability to understand and process information) and was dependent (helper does all the effort) on facility staff for bathing and toileting.</p> <p>During a review of Resident 6's Medication Review Report (MRR), dated 3/6/2025, the MRR indicated Resident 6 had a physician's order with a start date of 9/4/2024, for EBP related to tracheostomy, gastrostomy tube (feeding tube inserted through the abdomen directly into the stomach), CRE (carbapenem-resistant Enterobacterales, a type of bacteria resistant to most available antibiotics) and a history of ESBL (extended spectrum beta lactamase - enzymes produced by some bacteria that may make them resistant to some antibiotics).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 3/6/2025 at 3:30 PM with the RT, outside Resident 6's room, the RT donned (put on) an isolation gown but failed to secure the ties located on the back of the gown. The RT did not fully cover the RT's clothing and the RT's scrubs (sanitary clothing worn by healthcare workers) touched Resident 6's bed. The RT stated the RT forgot to secure the back ties of the gown. The RT stated the isolation gown was required for infection control purposes and a loose gown could lead to contamination and potential spread of infection to other residents.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, dated, 2024, the P&P indicated it is the policy of this facility to implement enhanced barrier precautions for the prevention of multidrug-resistant organisms. The P&P indicated, EBP was defined as an infection control intervention designed to reduce transmission of MDROs that employs gown, and gloves use during high contact resident care activities.</p> <p>42781</p> <p>B. During a review of Resident 117's AR, the AR indicated the facility initially admitted Resident 117 on 2/19/2025 with diagnoses that included type 2 diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine) and Urinary tract infection (UTI- infection that affects part of the urinary tract).</p> <p>During a review of Resident 117's MDS, dated [DATE], the MDS indicated, Resident 117 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated, Resident 117 required maximum (helper does more than half of the effort) assistance with toileting hygiene, upper body/lower body dressing and putting on/taking off footwear. The MDS indicated Resident 117 required moderate (helper does less than half of the effort) assistance for oral hygiene, and personal hygiene.</p> <p>During a review of Resident 117's Situation-Background-Assessment-Recommendation (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents), dated 3/4/2025, timed at 3:15 PM, the SBAR indicated Resident 117 was noted with two episodes of loose stool. The SBAR indicated, to collect stool to rule out Clostridium difficile (C. diff, a type of bacteria that can cause diarrhea and inflammation of the colon).</p> <p>During a review of Resident 117's care plan initiated on 3/5/2025, the care plan indicated Resident 117 was placed on contact isolation. The care plan's interventions included for staff to observed good hand hygiene, to provide education on the importance of maintaining contact precautions and provide an isolation cart in Resident 117's room.</p> <p>During a concurrent observation and interview on 3/6/2025 at 8:18 AM, with the COTA, the COTA was inside Resident 117's room and was not wearing gloves or a gown while assisting Resident 117 with upper body therapy. The COTA stated, he needed to wear [proper PPE] gown and gloves while assisting Resident 117 because Resident 117 was on contact isolation. The COTA stated, proper PPE must be worn to avoid the spread of infections to other residents and staff.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/6/2025 at 9:34 AM with the facility's Infection Preventionist Nurse (IPN), the IPN stated, Resident 117 was still on contact isolation to rule out C-diff. The IPN stated, in a contact isolation room, staff needed to wear a gown, gloves, and a mask before and while performing activities of daily living (ADL, term used in healthcare that refers to self-care activities) or when in contact with the resident to prevent the spread of infections to other residents and staff.</p> <p>During a record review of the facility's P&P, titled, Transmission - Based (Isolation) Precautions, revised 7/18/2023, the P&P indicated contact precautions - donning PPE upon room entry and discarding before exiting the room is done to contain pathogens (an organism that causes disease), especially those that have been implicated in transmission through environmental contamination (e.g. C-diff). The P&P indicated, recommendations included wearing PPE, gloves and gowns for contact precaution.</p>

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729</p> <p>Based on observation, interview, and record review, the facility failed to ensure 11 of 32 resident rooms (rooms 115, 116, 117, 118, 119, 120, 129, 130, 131, 132, 133) met the minimum requirement of 80 square feet (sq.ft. - unit of measure) per resident in bedrooms with more than one resident.</p> <p>This deficient practice had the potential to result in inadequate space for nursing care or resident care devices.</p> <p>Findings:</p> <p>During a review of the facility's Census List, (CL) dated 3/2/2025, the CL indicated rooms 115, 116, 117, 118, 119, 120, 129, 131, 132 and 133 had three beds occupying each room.</p> <p>During a review of the facility's Client Accommodation analysis, (CAA) dated, 3/3/2025 the CAA indicated the following rooms were less than 80 sq.ft. per resident:</p> <p>Room No. No. of beds: Room Size: Floor Area:</p> <p>115 3 190 sq.ft. 10 ft. x 19 ft.</p> <p>116 3 190 sq.ft. 10 ft. x 19 ft.</p> <p>117 3 190 sq.ft. 10 ft. x 19 ft.</p> <p>118 3 190 sq.ft. 10 ft. x 19 ft.</p> <p>119 3 190 sq.ft. 10 ft. x 19 ft.</p> <p>120 3 190 sq.ft. 10 ft. x 19 ft.</p> <p>129 3 190 sq.ft. 10 ft. x 19 ft.</p> <p>130 3 190 sq.ft. 10 ft. x 19 ft.</p> <p>131 3 190 sq.ft. 10 ft. x 19 ft.</p> <p>132 3 190 sq.ft. 10 ft. x 19 ft.</p> <p>133 3 190 sq.ft. 10 ft. x 19 ft.</p> <p>During a review of the facility's room waiver request letter, dated 3/3/2025 the room waiver request letter indicated the facility was in accordance with the special needs of the residents and maintained the residents' best interest.</p> <p>(continued on next page)</p>

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 3/6/2025 at 3:50 PM with Certified Nursing Assistant (CNA) 5, room [ROOM NUMBER] was observed with three residents. CNA 5 stated the room was tight and felt the smallest, but CNA 5 was still able to provide care to the residents. CNA 5 stated resident care devices such as a hooyer lift (mechanical device that assists caregivers in safely transferring individuals with limited mobility, using a sling to lift and support the person) could still be brought into the room for residents if needed.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45553</p> <p>Based on observation, interview, and record review, the facility failed to maintain a safe and sanitary bathroom (Bathroom [ROOM NUMBER]) for 4 of 4 sampled residents (Resident 16, Resident 34, Resident 166 and Resident 167).</p> <p>This deficient practice had the potential for residents to be exposed to dirt, mold, rust and drywall dust, which can cause respiratory/breathing problems.</p> <p>Cross Reference F584</p> <p>Findings:</p> <p>During an observation on 3/3/25 at 12:45 p.m., in Bathroom [ROOM NUMBER] (shared bathroom between Residents 16, 34, 166, and 167) the following were observed:</p> <ol style="list-style-type: none"> 1. On the left corner and right corner of the toilet and along the baseboard was a dark black substance. 2. On the left and right side of the toilet the baseboard along the wall was warped. 3. Around the water shut off valve on the left side of the toilet there was a brown substance, and the wall area was cracked and peeling. 4. On the right side of the toilet, the tile floor had a 3-inch crack with a 1/4 inch groove in the tile. 5. The safety grab bar by the left side of the toilet had cracked and peeling plaster with an exposed screw where the grab bar was fastened to the wall. 6. On the right side of the bathroom sink there was a 3-inch crack and black substance where the sink met the wall. 7. Under the bathroom sink and on/around the plumbing cleanout (an accessible plug or fitting that allows you to access the drain line for cleaning and unclogging) there was a brown color substance and cracked/peeling plaster. 8. Under the bathroom sink along the baseboard was crack/unpainted plaster. <p>During a review of the Maintenance Department's logs titled, Wall Penetration, dated January 2024 to December 2024, the logs did not indicate any repairs were made to Bathroom [ROOM NUMBER] nor were Bathroom [ROOM NUMBER] listed on the logs as needing repairs.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the Maintenance Department's logs titled, Maintenance Checklist, dated December 2024 to February 2025, the logs did not indicate any bathrooms listed as part of the maintenance checklist.</p> <p>During an interview on 3/5/25 at 10:30 a.m. in Bathroom [ROOM NUMBER] with the Maintenance Supervisor (MS), the MS acknowledged Bathroom [ROOM NUMBER], needed repairs due to the conditions pose a hazard to the health of the residents. MS acknowledged the conditions of the bathroom was not home-like for the residents. The MS stated he would start all repairs immediately.</p> <p>During a review of Resident 16's, Resident 34's, Resident 43's, and Resident 45's Admission Record (AR), the ARs indicated, all four residents were admitted to the facility with a respiratory diagnoses such as chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) or chronic respiratory failure with hypoxia (when your blood does not have enough oxygen), which placed the residents in a vulnerable state of health.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Maintenance Inspection, revised 12/19/22, the P&P indicated, It is the policy of this facility to utilize a maintenance inspection checklist in order to assure a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>During a review of the facility's P&P titled, Safe and Homelike Environment, revised 12/19/22, the P&P indicated, In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment . The P&P further indicated, Policy Explanation and Compliance Guidelines: . Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment.</p>		