STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055247	A. Building B. Wing	05/08/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure to prevent accident for three of three sampled residents' (Resident 28, Resident 1, and Resident 9) by failing to maintain Resident 28, Resident 1 and Resident 9's beds at a low position at all times. Resident 28, Resident 1, and Resident 9 were assessed at risk for falls on admission. This failure could have potentially caused Resident 28 to fall on 5/1/2026 resulting in Resident 28's laceration (a cut, tear or rip somewhere on or in your body) above Resident 28's left eyebrow and could potentially result in Resident 28, Resident 1 and Resident 9 who had history of multiple falls to sustain another fall.a. During review of Resident 1's admission Record (AR), the AR indicated the resident was admitted on [DATE], with diagnoses that include metabolic encephalopathy (sudden change in brain function like confusion, severe drowsiness, or memory loss), abnormal posture, muscle weakness and bilateral osteoarthritis (cartilage cushioning the ends of bones wears down) of hip. During review of Resident 1's Fall Risk Assessment, dated 2/6/2026, the Fall Risk Assessment indicated resident's level of conscious as intermittent confusion, decreased muscle coordination, with 3 or more present predisposing diseases. The resident is at risk for falls. During review of Resident 1's Minimum Data Set (MDS- standardized, comprehensive assessment form used to record a resident's physical, mental, and social health status) dated 2/12/2026, the MDS indicated Resident 1 has moderate cognitive impairment. During review of Resident 1's Care Plan (CP) dated 4/12/2026, the CP indicated Resident 1's bed is to be in lowest position in order to provide safety. During review of Resident 9's admission Record (AR), the AR indicated the resident was admitted on [DATE], with the diagnosis the include metabolic encephalopathy (sudden change in brain function like confusion, severe drowsiness, or memory loss), contracture of left knee, amputation of right lower extremity, rhabdomyolysis (rapid breakdown of damaged skeletal muscle tissue) and other seizures. During review of Resident 9's Care Plan (CP) dated 11/23/2025, the CP indicated Residents 9's bed is to be in lowest position. During review of Resident 9 's MDS dated [DATE], the MDS indicated Resident 1 has severe cognitive impairment. During review of Resident 9's Fall Risk assessment dated [DATE], the Fall Risk Assessment indicated residents' level of conscious as confused and cannot correctly identify three key aspects of (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	their reality: who they are, where they are, and what time it is at all times, with 1-2 falls in the past 3 month. During review of Resident 9's nursing progress notes dated 4/23/2026, 4/27/2026 and 5/4/2026, the progress notes indicated Resident 9 has fallen a total of three times. During a concurrent observation and interview on 5/5/2026 at 11:15 AM with License Vocational Nurse (LVN) 2 in Resident 1's room, Resident 1 was lying in bed with the head of the bed elevated at a 45 degree angle, with their head slumped toward the right side, and the bed positioned above waist level. LVN 2 stated Resident 1's bed should have been maintained in a lower position to reduce the risk of injury. Keeping the bed at a lower height would help prevent more serious harm in the event of a fall, as falling from an elevated height increases the likelihood of neurological injury. During a concurrent observation and interview on 5/7/2026 at 9:08 AM with LVN 3 in Resident 9's room, Resident 9 was lying in bed with the head of the bed elevated at a 45 degree, with their bed positioned above waist level. LVN 3 stated, the resident is at high risk for falls and that the bed should be kept at a lower level. Failure to do so could result in sprains, fractures, or potential head injuries. During an interview on 5/7/2026 at 9:59 AM with the DON, the DON stated that the bed should be kept in a lower position because the resident attempts to get out of bed and maintaining the bed at a higher height could result in more severe injuries. During an interview on 5/7/2026 at 11:40 AM with Director of Nursing (DON), DON stated, resident's beds should be maintained in a low position to reduce the potential risk of injury in the event of a fall During a review of the facility's policy and procedures (P&P) title, Fall Prevention Program, dated 12/19/2022, the P&P indicated residents beds are to be locked and lowered to a level that allows the residents feet to be flat on the floor when resident is sitting on the edge of the bed. b. During a review of Resident 28's AR, the AR indicated Resident 28 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including hemiplegia (paralysis on one side of the body), unspecified affecting left nondominant side, other seizures (sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and history of falling. During a review of Resident 28's History and Physical Examination (H&P), dated 8/1/2025, the H&P indicated, Resident 28 did not have the capacity to understand and make decisions. During a review of Resident 28's Fall Risk (FR) (assessments), dated 12/4/2025, 3/19/2026 and 5/1/2026, the FR indicated Resident 28 was at risk for falls. During a review of Resident 28's MDS, dated [DATE], the MDS indicated Resident 28's cognitive skills (ability to think and process information) for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated Resident 28 required substantial/maximal assistance (helper does more than half the effort) for setup or clean-up assistance (helper sets up or cleans up; resident completes activity) for activities of daily living (ADL – routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 28 had two (2) or more falls without injury since (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admission/reentry. During a review of Resident 28's CP, titled, initiated 2/19/2026, the CP's focus indicated Resident 28 was at risk for falls. The CP's interventions indicated to keep Resident 28's bed at the lowest position at all times when Resident 28 was in bed. During a review of Resident 28's Change in Condition Evaluation (COC), dated 5/1/2026, timed at 11:07 PM, the COC indicated Resident 28 had an unwitnessed fall (found on the floor) and a laceration (cut) on the left eyebrow. The COC indicated Resident 28 was sent to the General Acute Care Hospital (GACH). During a review of the facility's untitled list of fall incidents, the list indicated Resident 28 had ten (10) fall incidents since 11/11/2024 with the latest incident dated 5/1/2026. During an observation on 5/5/2026 at 10:29 AM, Resident 28 was lying in bed, awake and confused (talking to self in Spanish). Resident 28's bed was in a high position, about three (3) feet off the floor. There was brown colored long floor mats placed on both sides of Resident 28's bed. Resident 28 had an old bruise below the left eye and a dry laceration with 2 steri-strips (thin adhesive bandages that help seal minor wounds) above the left eyebrow. During a concurrent observation and interview on 5/5/2026 at 10:45 AM with Certified Nursing Assistant (CNA) 2, Resident 28 was in bed, awake, confused, and Resident 28's bed was about three (3) feet off the floor. CNA 2 stated Resident 28's bed was not in a low position and staff (unnamed) might have forgotten to lower Resident 28's bed after Resident 28 had breakfast. CNA 2 stated Resident 28 had a bruise on the left eye and steri-strips above the left eyebrow from a [previous] fall, I heard he fell. CNA 2 stated keeping Resident's 28 bed in a low position always was important because Resident 28 was a fall risk, confused at times, and had tried to get up [from bed]. During an interview on 5/5/2026 at 12:55 PM with Resident 28's Responsible Party (RP), the RP stated Resident 28 fell on 5/1/2026 and [this incident] was not the first time Resident 28 had fallen at the facility. The RP stated the RP had noticed Resident 28's bed was not always in a low position. During a concurrent interview and record review on 5/8/2026 at 11:44 AM with the DON, Resident 28's CP, date initiated 5/1/2026, the CP's focus indicated Resident 28 had an unwitnessed fall with minor injury. The CP's interventions indicated to consider moving Resident 28 to a room closer to nurse's station. The DON stated Resident 28 was in a spot where Resident 28 was not near the nursing station. The DON stated, the DON had given Resident 28's RP some room options and the RP would consider the options. The DON stated Resident 28 was a fall risk and had the tendency to get out of bed. The DON stated always keeping Resident 28's bed in a low position was important because a low bed helped minimize falls for Resident 28. During a review of the facility's P&P titled, Fall Prevention Program, date revised 4/20/2026, the P&P indicated each resident would be assessed for fall risk and would receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The P&P indicated providing additional fall prevention interventions as directed by the resident's assessment included but not limited to a low bed. During a review of the facility's P&P titled, Incidents and Accidents, date reviewed/revised 12/19/2022, the P&P indicated, incidents/accidents included falls.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain safe and proper storage of food practices in accordance with the facility's policy and procedures (P&P) by failing to:1. Ensure one of one kitchen staff's (Cook [CK]) personal food item was not stored inside one of three freezers (Freezer 1) located in the facility's kitchen.2. Discard two-week old personal food items, brought to the facility from outside for one of one sampled resident (Resident 17), stored at Resident 17's bedside.These deficient practices could result in cross contamination (the process by which microorganisms are unintentionally transferred from one area/object to another with a harmful effect) of food items stored in Freezer 1 and cause foodborne illness (illness caused by the ingestion of contaminated food or beverage) and serious health complications to the residents (in general) consuming food from Freezer 1 and to Resident 17.Findings:1. During a concurrent observation and interview on 5/5/2026 at 9:08 AM with the CK, in the presence of the Dietary Supervisor (DS), during the initial walkthrough of the kitchen, there was an unlabeled bottle with a green colored cover lid with half (1/2) contents of a light chocolate colored drink stored at the bottom shelf of Freezer 1. The CK stated the unlabeled bottle belonged to the CK and the content was a protein shake. The CK stated the CK stored the bottle of protein shake inside Freezer 1 because the CK's protein shake, got a little warm. The CK stated staff (in general) had a refrigerator in the employee lounge where staff stored personal food items. The CK stated not storing staff personal food items in the facility's kitchen freezers was important for infection control.During a review of the facility's policy and procedure (P&P) titled, Food Safety and Food Storage, date revised 11/4/2024, the P&P indicated food would be stored, prepared, distributed and served in accordance with professional standards for food service safety. The P&P indicated additional strategies to prevent foodborne illness included but not limited to preventing cross-contamination of foods.During a review of the facility's P&P titled, Designated Area for Employee Personal Belongings, date reviewed 6/23/2025, the P&P indicated guidelines for promoting an area for the safe retention of personal belongings. The P&P indicated personal belongings, beverages, and/or food may be stored in the designated area such as the DS office, dry storage area, or any designated separate employee personal belongings area with signage.2. During a review of Resident 17's admission Record (AR), the AR indicated Resident 17 was admitted to the facility on [DATE] with multiple diagnoses including Huntington's disease (an inherited, progressive brain disorder that causes nerve cells in the brain to break down), and immunodeficiency (any condition, illness or sickness that deteriorates the usual functioning parts of the body) due to conditions classified elsewhere.During a review of Resident 17's Minimum Data Set (MDS - a resident assessment tool), dated 2/26/2026, the MDS indicated Resident 17's cognitive skills (ability to think and process information) for daily decision making were intact (decisions consistent/reasonable). The MDS indicated Resident 17 was independent (resident completes the activity by themselves with no assistance) to requiring setup or clean-up assistance (helper sets up or cleans up; resident completes activity) for activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 17's History and Physical Examination (H&P), dated 3/3/2026 the H&P indicated Resident 17 had the capacity to understand and make decisions.During a concurrent observation and interview on 5/5/2026 at 9:56 AM with Resident 17, inside Resident 17's room, Resident 17's bedside had multiple personal food items, including a container of Sweet P's (brand name) chocolate cupcakes with a manufacturer's sticker indicating 4/21/26 Bakery $5.99 with two (2) cupcakes left inside and a container of Sweet P's unicorn cupcakes with a manufacturer's sticker indicating 4/20/26 Bakery $5.99 with six (6) cupcakes left inside the container. Resident 17 stated, Resident 17's daughter (unnamed) brought the cupcakes to the facility.During a concurrent observation and interview on (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/6/2026 at 3:46 PM, with the Restorative Nurse Assistant (RNA, nurse assistants with extra training to help residents regain or maintain mobility, strength, and independence with activities of daily living), in Resident 17's room, there were Sweet P's unicorn cupcakes with a manufacturer's sticker indicating 4/20/2026 Bakery $5.99 with six (6) cupcakes left inside. The RNA stated the RNA discarded the other container that had chocolate cupcakes dated 4/21/2026 because Resident 17 no longer wanted the cupcakes. The RNA stated the unicorn cupcakes with a manufacturer's sticker indicating 4/20/2026 located at Resident 17's bedside were more than 2 weeks old and were older than the chocolate cupcakes discarded by the RNA. The RNA stated checking and monitoring resident rooms for food brought from outside was important because residents could be poisoned from food getting rotten, and food could attract bugs, like flies.During an interview on 5/7/2026 at 10:18 AM with the Registered Nurse Supervisor (RN), the RN stated food brought from outside should be dated and timed to indicate when the food was delivered (received) since food brought from outside was usually thrown away after three days. The RN stated the RN had seen Resident 17's bedside with food brought from outside and had seen Resident 17 share the food with other residents (unidentified). The RN stated the RN did not know who brought food from outside to Resident 17. The RN stated Resident 17's cupcakes dated 4/20/2026 and 4/21/2026 were over 2 weeks old. The RN stated discarding food brought from outside that became old was important to prevent mold, that could cause diarrhea, stomach upset, or foodborne illness, from growing.During an interview on 5/8/2026 at 10:27 AM with the Registered Dietician (RD), the RD stated the facility had designated areas for staff to store personal food items located in the DS's office and in the facility's staff breakroom. The RD stated staff storing food items in the designated areas [was important] to reduce the potential risk of contamination to the residents. The RD stated staff were supposed to discard resident's food brought from outside after 3 days of receipt and staff should be monitoring and checking the beside for foods brought from outside to prevent food-borne illness to the residents. The RD stated Resident 17 should not have been allowed to share Resident 17's food brought from outside with other residents.During a review of the facility's P&P titled, Use and Storage of Food Brought in by Family or Visitors, date reviewed 9/14/2023, the P&P's policy indicated it was the right of the residents of the facility to have food brought in by family or other visitors; however, the food must be handled in a way to ensure the safety of the resident. The P&P indicated all food items brought in that were manufactured and did not require refrigeration, may be kept in the resident room inside a lock tight container that was provided by the resident. The P&P indicated all food items brought in must be approved per Nursing.labeled with [food] content and dated. The P&P indicated if not consumed within 3 days, the food will be thrown away by facility staff.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection (the invasion and growth of germs in the body) prevention and control practices by failing to label and properly store personal care items found in two of five sampled [NAME] & [NAME] restrooms ([a shared restroom situated between two bedrooms with direct access from both rooms], Restroom [ROOM NUMBER] and Restroom [ROOM NUMBER]). Restroom [ROOM NUMBER] was situated between Resident 50 and Resident 20's double-occupancy (two people sharing a single room) room and Resident 65 and Resident 6's double-occupancy room. Restroom [ROOM NUMBER] was situated between Resident 48 and Resident 45's double-occupancy room and Resident 40 and Resident 67's double-occupancy room. This deficient practice had the potential to result in cross contamination (the process by which microorganisms are unintentionally transferred from one area/object to another with a harmful effect) and/or the development and transmission of disease (an illness or sickness) and infections to Residents 50, 20, 65, 6, 48, 45, 40 and 67.Findings:During an observation on 5/5/2026 at 11:51 AM, Resident 50 and Resident 20's double-occupancy room had Enhanced Barrier Precaution (EBP - an infection-control practice to prevent the spread of bacteria in nursing homes) signage posted outside of the room. During a concurrent observation and interview on 5/5/2026 at 12:11 PM with Certified Nurse Assistant (CNA) 3, inside Restroom [ROOM NUMBER], an unlabeled hair comb and an unlabeled eight (8) fluid ounce (fl oz - a measurement of volume) of Remedy (brand name) Essential Cleanse Shampoo & Body Wash were stored on the sink. CNA 3 stated CNA 3 did not know what resident the hair comb and shampoo body wash belonged to and [the personal items] should have been labeled with the resident's name (in general) for staff to know and not to use on another resident and to prevent cross contamination.During a concurrent observation and interview on 5/5/2026 at 1:23 PM with CNA 4, Resident 40 and Resident 67's double-occupancy room had EBP signage posted outside of the room. Restroom [ROOM NUMBER] had an unlabeled 10 fl oz Vaseline (brand name) Advanced Repair Body Lotion tucked away horizontally behind the sink faucet. CNA 4 stated CNA 4 thought the body lotion may belong to Resident 40. CNA 4 stated the body lotion should have been labeled with Resident 40's name so other residents would not use the body lotion and for infection control.During an interview on 5/7/2026 at 7:52 AM with the Infection Preventionist Nurse (IP), the IP stated the comb, body wash, and lotion were considered personal care items. The IP stated labeling personal care items with resident names and room numbers and storing the personal care items at the resident's bedside or closet was important for residents and staff to know who the resident care items belonged to and for infection control.During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, date reviewed 12/19/2022, the P&P indicated the facility had established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.During a review of the facility's P&P titled, Resident Personal Belongings, date reviewed 12/19/2022, the P&P indicated the facility would ensure resident belongings were kept in a neat and orderly fashion and maintained in each resident's room.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure three of 24 sampled residents (Resident 8, 23, and 84) had their call light within reach.This failure had the potential to affect the residents' ability to request assistance when needed.During a review of Resident 8's Face Sheet, the Face Sheet indicated the resident was admitted on [DATE], with the diagnosis that include sequelae of cerebral infarction (when a blood clot blocks blood flow to the brain), abnormalities of gait (natural pattern or style of walking), lack of coordination, retention of urine, contracture (permanent tightening or shortening of muscles, tendons, skin, or joint capsules) of right elbow and right hand.During a review of Resident 8's Minimum Data Set (MDS- standardized, comprehensive assessment form used to record a resident's physical, mental, and social health status) dated 3/10/2026, the MDS indicated the resident has severe cognitive impairment.During a review of Resident 23's Face Sheet, the Face Sheet indicated the resident was admitted on [DATE], with the diagnosis that include dementia (decline in memory, thinking, and reasoning), dysphagia (difficult swallowing) and psychosis.During a review of Resident 23's MDS dated [DATE], the MDS indicated the resident has severe cognitive impairment. During a review of Resident 84's Face Sheet, the Face Sheet indicated the resident was admitted on [DATE], with the diagnosis that include abnormal posture, psychosis (difficulty distinguishing what is real from what is not) and signs and symptoms involving cognitive awareness.During a review of Resident 84's MDS dated [DATE], the MDS indicated the resident has severe cognitive impairment. During a concurrent observation and interview on 5/5/2026 at 10:06 AM with Director of Staff Development (DSD) in Resident 8,23, and 84's (shared) room, Residents were positioned on their in their beds. The residents' call lights were on the floor and out of their reach. The DSD stated, not having the call light within reach could prevent residents from requesting assistance, potentially worsening their existing condition.During an interview on 5/7/2026 at 10:03 AM with the Director of Nursing (DON), DON stated, that having the call light on the floor could create an infection control concern due to the floor being dirty, and it could also place the resident at risk of injury if they attempt to retrieve the call light from the floor.During a review of the facility's policy and procedure (P&P) titled Call Lights: Accessibility and Timely Response, dated 12/19/2022, the P&P indicated Staff will ensure the call light is within reach of resident and secured, as needed. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop or implement individualized person-centered care plans (CP) for two of two sampled residents (Resident 4 and Resident 26) when:a. For Resident 4, the facility failed to implement a CP addressing bipolar disorder (mental health condition that causes extreme mood swings).b. For Resident 26, the facility failed to create a CP addressing impaired hearing and the use of hearing aids.These deficient failures had the potential to result in unmet individualized needs for Resident 4 and Resident 26 and the potential to affect the resident's physical and psychosocial well-being.a. During a review of Resident 4's admission Record (AR), the AR indicated Resident 4 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder, depression (sadness, loss of interest, and decreased energy) and morbid obesity (excess body fat). During a review of Resident 4's History and Physical (H&P), dated 3/10/2926, the H&P indicated Resident 4 had the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 3/14/2026, the MDS indicated Resident 4 was cognitively (the ability to think and process information) intact, had clear speech, and had the ability to understand and be understood by others. The MDS indicated Resident 4 was dependent (helper does all the work), with oral and toilet hygiene, upper and lower body dressing, and from sit-to-lay positions and bed to chair transfers. During an interview and concurrent record review on 5/8/2026 at 9:45 AM, Resident 4's paper and electronic medical record was reviewed with the Medical Records Director (MRS), the MRS stated Resident 4 did not have a CP for bipolar disorder. During an interview and concurrent record review on 5/8/2026 at 9:49 AM Resident 4's paper and electronic medical record was reviewed with the Director of Nursing (DON), the DON stated Resident 4 had a diagnosis of bipolar disorder. The DON stated Resident 4 did not have a CP for bipolar disorder. The DON stated [creating a CP was important] to be aware and address Resident 4's needs and complications that could arise from this disorder. b. During a review of Resident 26's AR, the AR indicated Resident 26 was admitted to the facility on [DATE] with diagnoses that included a urinary tract infection (UTI- an infection in the bladder/urinary tract) and Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic neuropathy (nerve damage caused by diabetes). During a review of Resident 26's Progress Notes, dated 4/22/2026, the progress note indicated Resident 26 received a pair of hearing aids. During a review of Resident 26's MDS, dated [DATE], the MDS indicated Resident 26 had had intact cognition and indicated Resident 26 used a hearing aid or other hearing appliance. During a concurrent interview and record review on 5/7/2026 at 2:45 PM with Licensed Vocational Nurse (LVN) 1, Resident 26's current CPs were reviewed, the CPs did not indicate a CP that addressed Resident 26's hearing impairment. LVN 1 stated, Resident 26 had hearing issues and used hearing aids. LVN 1 stated CPs provided a focus, goals, and interventions to achieve resident (continued on next page)

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	055247	A. Building B. Wing	05/08/2026

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Country Oaks Care Center	215 W Pearl St Pomona, CA 91768

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	improvement. LVN 1 stated Resident 26 needed a CP for impaired hearing to make nursing staff aware of his hearing aids and of their proper use. During an observation on 5/7/2026 at 4:10 PM in Resident 26's room, Resident 26 was sitting up in bed and had hearing aids in both ears. During an interview on 5/8/2026 at 9:07 AM with the DON, the DON stated CPs needed to be comprehensive and encompass all the residents' needs and were used to ensure all staff followed the same interventions for the resident's best outcome. The DON stated residents with hearing impairments needed a CP to recognize those needs and provide them with the best interventions. During a review of the facility's policy and procedure (P&P) titled Comprehensive Care Plans, dated revised 12/19/2022, the P&P indicated it is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the resident's comprehensive assessment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure their process for over the counter (OTC) product self-administration (the process where patients manage and take their own medications) was followed, for one of one sampled resident (Resident 45) when on 5/5/2026 Resident 45 had a non-legend (drug that can be purchased OTC without a prescription) product at Resident 45's bedside without a self-administration assessment or a physician's order.This deficient practice had the potential to result in misuse and side effects (SE - an unwanted, unintended, or secondary effect that occurs in addition to the desired therapeutic effect of a drug) of the OTC product to Resident 45 and the potential for OTC product sharing with other residents (in general) by Resident 45.Findings:During a review of Resident 45's admission Record (AR), the AR indicated Resident 45 was admitted to the facility on [DATE] with multiple diagnoses including unspecified atrial fibrillation (an irregular and often very rapid heartbeat), and type 2 diabetes mellitus (DM II - adult-onset disorder characterized by difficulty in blood sugar control and poor wound healing) with unspecified complications.During a review of Resident 45's History and Physical Examination (H&P), dated 2/27/2026, the H&P indicated, Resident 45 had the capacity to understand and make decisions.During a review of Resident 45's Care Plan (CP), titled, date initiated 3/1/2026, the CP's focus indicated Resident 45 was at risk for re-hospitalization. The CP's interventions indicated medications as ordered.During a review of Resident 45's Minimum Data Set (MDS - a resident assessment tool), dated 3/3/2026, the MDS indicated Resident 45's cognitive skills (ability to think and process information) for daily decision making were intact (decisions consistent/reasonable). The MDS indicated Resident 45 was dependent (helper does all of the effort) and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 45's Order Summary Report (OSR), dated active as of 5/5/2026, the OSR did not indicate an order for Australian Dream (brand name) Arthritis (a condition that causes inflammation, pain, stiffness, and swelling in one or more joints) Pain Relief Cream.During a concurrent observation and interview on 5/5/2026 at 1:10 PM with Resident 45 in Resident 45's room, Resident 45 had a four (4) oz (ounce - a unit of weight) of Australian Dream Arthritis Pain Relief Cream at Resident 45's bedside. Resident 45 stated, Resident 45 brought the cream from Resident 45's home and the cream worked for Resident 45's arthritis. During an interview on 5/7/2026 at 10:18 AM with the Registered Nurse Supervisor (RN), the RN stated Resident 45's arthritis pain relief cream was an OTC medication. The RN stated residents (in general) were allowed to keep OTC medications at their bedside with a physician's order and [after] the risks [were] explained to the resident. The RN stated not keeping an OTC medication at the bedside was important to avoid residents from overdosing (overusing), reactions and allergies, and to prevent residents from sharing the OTC medication with other residents. The RN stated staff should be checking resident's bedside for OTC medications and, whatever family brings.During an interview on 5/8/2026 at 11:44 AM with the Director of Nursing (DON), the DON stated Resident 45's OTC arthritis pain relief cream was a medication and should have been ordered by Resident 45's physician [after] a self-administration assessment was conducted. The DON stated following the facility's self-administration process was important to prevent the risk of Resident 45 applying the cream incorrectly or in the wrong areas causing injury and to prevent Resident 45 from sharing OTC products with other residents.During a review of the facility's policy and procedure (P&P) titled, Resident Self-Administration of Medication, date reviewed/revised 12/19/2022, the P&P indicated a resident may only self-administer medications after the facility's interdisciplinary team (IDT - a group of healthcare professionals from various disciplines who collaborate, assess, coordinate, and manage each resident's comprehensive (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	health care, including his or her medical, psychological, social, and functional needs) had determined which medications may be self-administered safely. The P&P indicated, all nurses and aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage. The P&P indicated, medications stored at the bedside were reordered in the same manner as other medications.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to ensure that two of eight sampled residents (Resident 1 and 72) with active skin breakdown were repositioned frequently in accordance with their individualized care plans.This failure had the potential to cause the residents' existing pressure injuries to worsen.During review of Resident 1's Face Sheet, the Face Sheet indicated the resident was admitted on [DATE], with the diagnoses that included metabolic encephalopathy (sudden change in brain function like confusion, severe drowsiness, or memory loss), abnormal posture, muscle weakness and bilateral osteoarthritis (cartilage cushioning the ends of bones wears down) of hip.During review of Resident 1's care plan, dated 1/14/2026, the care plan indicated Resident 1 is to be reposition every 2 hours and as needed.During review of Resident 1's Minimum Data Set (MDS- standardized, comprehensive assessment form used to record a resident's physical, mental, and social health status) dated 2/12/2026, the MDS indicated Resident 1 has moderate cognitive impairment.During review of Resident 1s's skin assessment, dated 3/4/2026, the skin assessment indicated that Resident 1 has active skin breakdown on her front left leg, perineum (small patch of sensitive skin and flesh located between the sex organs (vagina or scrotum) and the anus), sacrococcygeal (the area at the very base of the spine), front right leg and her left heel.During review of Resident 72's Face Sheet, the Face Sheet indicated the resident was admitted on [DATE], with the diagnoses that included metabolic encephalopathy, type 2 diabetes (chronic condition where the body cannot properly use or make enough insulin, leading to high levels of sugar (glucose) in the blood, difficulty walking and lack of coordination.During review of Resident 72's MDS, dated [DATE], the MDS indicated Resident 72 has severe cognitive impairment.During review of Resident 72's care plan, dated 3/16/2026, the care plan indicated resident is to be repositioned frequently due to active skin breakdown and immobility.During review of Resident 72's Skin Assessment, dated 4/1/2026, the skin assessment indicated that Resident 72 has active skin breakdown on the left outer arm, right outer forearm, coccyx (small, triangle-shaped bone located at the very bottom of the spine), and perineum.During multiple observations on 5/5/2026 at 10:46 AM, 12:05 PM, 3:14 PM and on 5/7/2026 at 8:17 AM, 11:00 AM and 1:50 PM, in Resident 72's room, Resident 72 was lying in bed on her back with the head of the bed elevated at a 45 degrees angle. During multiple observations on 5/5/2026 at 11:05 AM, 5/7/2026 8:22 AM, 9:33 AM, 3:20 PM, 5/8/2026 1:37 PM and 1:54 PM, in Resident 1's room, Resident 1 was lying in bed on her back with the head of the bed elevated at a 45 degrees angle.During a concurrent observation and interview on 5/5/2026 at 3:10 PM with Resident 72 in Resident 72's room, Resident 72 was lying in bed on her back with the head of the bed elevated at a 45 degrees angle. Resident 72 stated, they are often left lying on their back and must request to be repositioned.During an observation on 5/5/2026 at 3:14 PM. in Resident 72's room, Resident 72 was lying in bed on her back with the head of the bed elevated at a 45 degrees angle. Resident 72 informed the Treatment Nurse (TN) that they wished to be repositioned. The TN stated the resident was scheduled to get out of bed soon and did not reposition the resident. During a concurrent observation and interview on 5/7/2026 at 9:33 AM, with Certified Nurse Assistant (CNA) 1 in Resident 1's room, Resident 1 was lying in bed on her back with the head of the bed elevated at a 45degree angle. Resident 1 stated she would like to be repositioned. CNA 1 repositioned Resident 1. CNA 1 stated, that residents are to be repositioned in accordance with the facility's Turning and Repositioning Schedule, and that failure to follow the schedule could result in existing wounds worsening.During an interview on 5/7/2026 at 10:01 AM, with Director of Nursing (DON), the DON stated there is no formal log used to track residents' repositioning times, and that failure to reposition residents could result in worsening wounds.During a concurrent interview and record review on 5/7/2026 at 11:50 AM with DSD, the Turning & Repositioning Schedule (job aid), was reviewed. The Turning & Repositioning Schedule indicated, the residents are to be positioned on their back from 12:00-2:00, facing the door (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from 2:00-4:00, facing the window from 4:00-6:00, on their back 6:00-8:00, facing the door 8:00-10:00 and facing the window 10:00-12:00. The DSD stated that residents who are at risk for, or who have existing skin breakdown, should be repositioned every two hours and as needed, and that staff follow the turning schedule displayed on their badges. The DSD added that failure to reposition residents as required could cause active skin breakdown to worsen.During an interview on 5/8/2026 at 2:00 PM with the DON, the DON stated, it is important to reposition residents because skin breakdown can develop or worsen over bony areas of the body.During review of the facility's policy and procedure (P&P) titled, Pressure Injury Prevention and Management, dated 12/19/2022, indicated, the facility shall establish and utilize a systemic approach for pressure injury prevention and management.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to ensure that the Bed Rail Assessment (a safety check to determine if side rails are needed, if they are safe, and if they pose more risks than benefits) was completed for one of eight sampled residents (Resident 1) with bedrails in use.This failure had the potential to result in entrapment and/or injuries to the resident.During review of Resident 1's Face Sheet, the Face Sheet indicated the resident was admitted on [DATE], with the diagnoses that included metabolic encephalopathy (sudden change in brain function like confusion, severe drowsiness, or memory loss), abnormal posture, muscle weakness and bilateral osteoarthritis (cartilage cushioning the ends of bones wears down) of hip.During review of Resident 1's Minimum Data Set (MDS- standardized, comprehensive assessment form used to record a resident's physical, mental, and social health status) dated 6/29/2025, the MDS indicated Resident is cognitively intact.During review of Resident 1's care plan, dated 1/21/2026, the care plan indicated Resident 1 is to have bilateral 1/4 side rails up while in bed as enabler for transferring, repositioning and during ADL care.During review of Resident 1's Standard Assessments, the Standard Assessments indicated the Bed Rail Assessment was past due as of 2/6/2026.During an on observation on 5/7/2026 at 8:22 AM in Resident 1's room, Resident 1 was lying in bed on her back with the head of the bed elevated at a 45 degrees angle, with bilateral 1/4 Side Rails up.During an interview on 5/7/2026 at 3:25 AM with Registered Nurse (RN), RN stated Bed Rail Assessments are to be completed by the Minimum Data Set Coordinator (MDSC), Licensed Vocational Nurse (LVN) or a Registered Nurse (RN) prior to implementing bedrails on a resident's bed.During an interview on 5/7/2026 at 3:41 PM with MDSC, MDSC stated, that Bed Rail Assessments are completed upon admission and annually for residents who use bed rails and stated that a Bed Rail Assessment had not been completed for Resident 1. Failing to complete required bed rail assessments could result in resident entrapment and injuries.During a review of the facility's policy and procedure (P&P) titled, Proper Use of Bed Rails, dated 12/19/2022, the P&P indicated the resident assessment should assess the residents' risks of entrapment between the mattress and bed rail or in the bed rail itself. The facility will assess to determine if the bed rail meets the definition of a restraint.