STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055374	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Upland Rehabilitation and Care Center	1221 East Arrow Hwy Upland, CA 91786

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44841 Based on observation, interview, and record review, the facility failed to treat a resident in a dignified manner with respect and value for one of three sampled residents (Resident 2) when a staff entered Resident 2 ' s room and removed her oxygen tubing (a plastic tube that carries oxygen from a tank or machine to a person, connecting to a nasal cannula [a tube that goes in the nose] or mask) without requesting permission from Resident 2 on August 19, 2024. This failure compromised Resident 2 ' s dignity, violated her right to respect, and affected her well-being and ability to make choices, which had the potential to cause psychosocial harm (mental distress and suffering) and lead to feelings of upset. Findings: A review of Resident 2's Admission Record (a document containing clinical and demographic data), indicated Resident 2 was admitted to the facility on [DATE], with a diagnosis which included heart failure (a condition in which the heart is unable to pump blood effectively to meet the body's needs), Type 2 diabetes mellitus (a condition that affects how your body uses sugar (glucose), which is an important source of energy) and hypertension (blood pressure that is higher than normal) A review of Resident 2 ' s History and Physical Examination dated June 24, 2024, indicated .capacity: this resident [Resident 2] has the capacity to understand and make decisions. A review of Resident 2 ' s Comprehensive Minimum Data Set (MDS) dated [DATE], indicated Resident 2 was cognitively intact and required maximal assistance - helper does more than half the effort for most activity of daily living. A review of Resident 2 ' s physician order dated June 26, 2024, indicated . continuous oxygen at 2L/min [liters/minute, a measurement of oxygen flow] via nasal canula/mask . A review of State of California Form 341 [Suspected Dependent Adult/Elder Abuse form], dated May 1, 2024, indicated, . It was reported to facility administrator on 8/20/24 [August 20, 2024] at 1:00pm that resident [Resident 2] .[License Vocational Nurse 1 (LVN 1)] turned off her concentrator and pulled her nasal canula on 8/19/24 [August 19, 2024] . (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055374	A. Building B. Wing	09/19/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 2 ' s Social Service notes date August 20, 2024, indicated, . Resident [Resident 2] alleges LVN [LVN1] took off her nasal canula . Patient [Resident 2] reports . just confused and unsure why the event took place She was referred to psychology . A review of Resident 2 ' s IDT (Interdisciplinary Team is a team of professional disciplines, as appropriate, will work together to provide the greatest benefit for the resident) notes dated August 20, 2024, indicated . On August 2024 . [Resident 2 ' s daughter] reported [Resident 2] complained one of the nurse turning off her oxygen concentrator [oxygen machines used as stationary sources to provide long-term oxygen therapy to patients] and pulling on her nasal, nurse than proceeded to walk out the room and did not return. [Resident 2] stated nurse did not explained why the concentrator turned off and her NC [nasal canula] pulled away . During an interview on August 27, 2024, at 3:30 PM with LVN 1, LVN 1 stated that she does not remember if she announced herself before entering Resident 2's room and unsure if Resident 2 was aware of her presence for the routine round. Furthermore, LVN 1 stated that while she was tidying up the area around bed #1, she decided not to announce herself to beds 2 and 3 because she didn ' t want to be stuck longer in the room. She acknowledged that she should have announced herself to respect the residents' rights and personal space, but she did not. During a follow-up interview on August 27, 2024, at 3:40 PM with LVN 1, LVN 1 admitted that she assumed the oxygen concentrator belonged to the resident at bed #1. She pulled the oxygen tubing, which she stored in a bag tied to the concentrator, and then left the room. LVN 1 further stated that she should have checked to whom the oxygen tubing belonged before removing it, but she did not. During concurrent observation and interview on August 27, 2024, at 3:55 PM, with Resident 2, Resident 2 was lying in bed, with a call light next to her. Resident 2 stated that she was aware a staff was in the room doing routine rounds and checking on the residents, and that CNA 1 had left to assist the resident in bed #1 with a shower. Resident 2 further stated she was confused when her oxygen tubing was suddenly pulled from behind her curtain, immediately after that, she saw LVN 1 leaving the room just as CNA 1 returned with the resident from bed #1. Resident 2 then asked CNA 1 to put her oxygen tubing back on her and further stated that she was very upset that day and had told her daughter about it. During a phone interview and concurrent record review with the Director of Nursing (DON), September 18, 2024, at 4:55 PM, the DON reviewed the facility's policy and procedure titled, Resident Rights revised October 4, 2016, indicated As a resident of this nursing facility, you have the right to a dignified existence, self-determination, . Planning and Implementing Care. You have the right to be informed of, and participate in, your treatment, including the right to: be fully informed, . Respect and Dignity. You have the right to be treated with respect and dignity, . The DON stated the policy and procedure was not followed.