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	05/09/2025

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

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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	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** 44529 Based on observation, interview, and record review, the facility failed to treat one of three sampled residents (Resident 398) with dignity when Certified Nurse Assistant 3 (CNA 3) was standing over the resident while assisting during lunch. This deficient practice had the potential to negatively impact the self-esteem and self-worth of Resident 398. Findings: During a review of Resident 398's Admission Record (AR), the AR indicated Resident 398 was admitted on [DATE], with diagnoses that included unstable angina (a type of chest pain or discomfort caused by reduced blood flow to the heart muscle), atherosclerosis (a condition where plaque builds up inside the arteries, causing them to narrow and potentially harden), hypertension (high blood pressure), and diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing) among others. During a review of the facility's Daily Room Assignment Sheet (DRAS), dated May 5, 2025, the DRAS indicated Resident 398 was on one-on-one meal assist during breakfast and lunch. During a concurrent observation and interview on May 5, 2025, at 12:21 PM, with CNA 3, inside Resident 398's room, CNA 3 was seen standing in front of Resident 398 during feeding. Resident 398 stated they preferred CNA 3 to be seated while feeding them. CNA 3 stated the procedure in assisting residents during feeding was to be seated facing the resident. During an interview on May 7, 2025, at 9:32 AM, with the Director of Staff Development (DSD), the DSD stated the expectation for a CNA when feeding residents was to be seated at eye level. The DSD stated it was a dignity issue for a CNA to stand over residents while feeding them. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on May 7, 2025, at 2:02 PM, with the Director of Nursing (DON), the facility's document titled, Techniques for Safe Swallowing and Feeding, dated 2022, was reviewed. The document indicated, .Feeding Techniques .Sit close to the person so that you can see their face and mouth .Sit next to the person. Never stand above or lean over the person . The DON stated the expectation was for a CNA to be seated at eye level while feeding residents to ensure safe feeding and promotion of dignity. The DON stated CNA 3 did not follow the facility's procedure when feeding Resident 398.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46488 Based on interview and record review, the facility failed to honor the right to formulate an Advance Directive (a legal document indicating resident preference on end-of-life treatment decisions) for five of 37 sampled residents (Residents 50, 147, 153, 175, and 497) when: 1. The Advance Directives Checklist forms did not indicate whether Residents 50, 147, and 153 were provided an opportunity to formulate an Advance Directive. 2. Resident 175's Advance Directives Checklist form was not followed up to ensure their responsible party was given the opportunity to complete an Advance Directive on behalf of the resident. 3. There was no documented evidence indicating Resident 497 was provided with written information to formulate an Advance Directive. This failure had the potential for the residents' decisions regarding their healthcare and treatment options or the decisions made on their behalf not to be honored. Findings: a. A review of Resident 50's Admission Record, (front page of the chart that contains a summary of basic information about the resident), indicated Resident 50 was readmitted to the facility on [DATE]. A review of Resident 50's Advance Directives Checklist form, dated July 3, 2024, indicated Resident 50 acknowledged being provided with written information regarding the right to formulate an Advance Directive and Resident 50 did not currently possess an Advance Directive. The checklist form did not indicate if the resident wished or did not wish to formulate an Advance Directive. During an interview on May 7, 2025, at 08:30 AM, with Resident 50, the resident stated the facility did not offer assistance to formulate an Advance Directive. During a concurrent interview and record review on May 7, 2025, at 9:42 AM, with the Director of Social Services (DOSS), Resident 50's Advance Directives Checklist form, dated July 3, 2024, was reviewed. The DOSS acknowledged the checklist did not indicate if Resident 50 wanted to formulate an Advance Directive. The DOSS stated an Advance Directive would help the family or the healthcare providers make medical decisions for the resident, particularly if the resident became incapacitated. During a follow-up interview and record review on May 8, 2025, at 08:13 AM, with the DOSS, Resident 50's Advance Directives Checklist, dated July 3, 2024, was reviewed. The DOSS acknowledged she was responsible for ensuring a resident's Advance Directive was available in the resident's medical record and the resident was provided information on how to formulate an Advance Directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. A review of Resident 147's Admission Record, indicated Resident 147 was readmitted to the facility on [DATE]. A review of Resident 147's POLST [Physician Orders for Life-Sustaining Treatment], dated April 18, 2025, indicated section D of the form regarding Advance Directive was incomplete. The boxes indicating whether Resident 147 had or did not have an Advance Directive were left unchecked. A review of Resident 147's Advance Directives Checklist, dated April 17, 2025, indicated Resident 147's responsible party was provided with written information regarding the resident's right to formulate an Advance Directive. A checkmark indicated Resident 147 did not currently possess an Advance Directive, but the subcategories were left unchecked and did not indicate whether Resident 147 wished or did not wish to formulate an Advance Directive. During a concurrent interview and record review on May 7, 2025 at 08:40 AM, with Registered Nurse Supervisor (RNS) 1, Resident 147's Advance Directives Checklist dated April 17, 2025 was reviewed. RNS 1 verified the Advance Directives Checklist needed to be completed to indicate whether the resident was provided with written information regarding the right to formulate an Advance Directive and if the resident wished or did not wish to formulate one. RNS 1 further stated that based on Resident 147's Advance Directives Checklist, she was unable to tell whether the responsible party and/or the resident were asked if they wanted to formulate an Advance Directive because the form was incomplete. During an interview on May 7, 2025, at 08:52 AM with Responsible Party (RP) 1, RP 1 was asked about Resident 147's Advance Directive. RP 1 stated they were unsure what an Advance Directive was or if it was offered to formulate one for Resident 147. c. A review of Resident 153's Admission Record, indicated Resident 153 was readmitted to the facility on [DATE]. A review of Resident 153's POLST, dated December 26, 2024, indicated section D of the form regarding Advance Directive was completed. The box indicated Resident 153 did not have an Advance Directive. A review of Resident 153's Minimum Data Set, (MDS- a resident assessment tool) dated March 25, 2025, indicated Resident 153's cognitive skills for decision making were severely impaired. A review of Resident 153's H&P [History and Physical],, dated December 27, 2024, indicated Resident 153 was unable to follow commands. A review of Resident 153's Advance Directives Checklist form, undated, indicated Resident 153 did not currently possess an Advance Directive. The subcategories were left unchecked, the form was unsigned and undated, and it did not indicate whether Resident 153's responsible party was provided with written information regarding the resident's rights to formulate an Advance Directive. d. A review of Resident 175's Admission Record, indicated Resident 175 was readmitted to the facility on [DATE]. A review of Resident 175's MDS, dated [DATE], indicated Resident 175's cognitive skills for decision making were severely impaired. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 175's History and Physical, dated April 18, 2025, indicated Resident 175 did not have the capacity to understand and make decisions. A review of Resident 175's POLST, dated April 18, 2025, was found flagged and attached to a fax Transmission Verification Report, dated April 20, 2025, with a request to Resident 175's responsible party to sign and fax back. A review of Resident 175's Advance Directives Checklist form, dated April 17, 2025, indicated the form was faxed to Resident 175's responsible party to obtain signatures. The form was unsigned, and it did not indicate whether Resident 175's responsible party was provided with written information regarding the resident's right to formulate an Advance Directive. e. A review of Resident 497's Admission Record, indicated Resident 497 was admitted to the facility on [DATE]. A review of Resident 497's POLST, dated April 18, 2025, indicated section D of the form regarding Advance Directive was incomplete. The boxes indicating whether Resident 497 had an Advance Directive or not were left unchecked. A review of Resident 497's MDS, dated [DATE], indicated Resident 497 had a Brief Interview for Mental Status, (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgment status of the resident) score of 15 (highest possible score). A review of Resident 497's History and Physical, dated April 18, 2025, indicated Resident 497 had decision making capacity. During a review of Resident 497's medical record, an Advance Directive Checklist form was not located. During a concurrent interview and record review on May 7, 2025, at 08:18 AM, with the Director of Social Services (DOSS), Resident 153, Resident 175, and Resident 497's Advance Directives Checklist were reviewed. The DOSS was asked to explain the facility's process and policies concerning Advance Directives. The DOSS stated the POLST and Advance Directives Checklist were provided to a resident and/or family representative with the admission packet, and Social Services would follow up to ensure forms were completed. The DOSS verified Resident 153's Advance Directives Checklist was incomplete. The DOSS verified Resident 175's Advance Directives Checklist was incomplete and no follow up was done to ensure the resident's responsible party had received the form. The DOSS verified Resident 497's Advance Directives Checklist was not in the resident's medical record. During an interview on May 7, 2025, at 09:04 AM, with Director of Nursing (DON), the DON was asked to explain the facility's process regarding an Advance Directive and information sent via fax to a resident's responsible party. The DON stated during resident admission a nurse provided information and social services followed up to ensure it was completed within the first 5 days after admission. The DON stated Social Services was ultimately responsible for verifying the Advance Directive Checklist form was completed. The DON stated the expectation for a document sent over fax for a family representative to sign was to follow up the same day to ensure it was received. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedures titled Advance Directives and Associated Documentation, revised December 2023, indicated .1. Prior to, upon, or immediately after admission, a facility staff member shall: a. Provide the resident/family or responsible agent written information .regarding .the right to formulate Advance Directives. b. Document in the resident health record that, at the time of admission, the resident and/or resident representative have been provided with written information regarding advance directives 6 .a. It should be noted that a POLST is not an advance directive.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35335 Based on interview and record review, the facility failed to ensure documentation in the medical record demonstrated the rationale for extending the pro re nata (PRN- as needed) psychotropic (any drug that affects brain activities associated with mental processes and behaviors) anxiety medication for one of five residents (Resident 146). This failure had the potential to increase the risk of clinically significant physical dependence and/or negative clinical outcomes for Resident 146. Findings: A review of the Nursing 2024 DRUG HANDBOOK (a hardcopy drug reference book), obtained from the facility, indicated a Boxed Warning [strongest warning from the Food and Drug Administration (FDA) - a federal agency]. Continued use of benzodiazepines [a category of controlled substance medications which are regulated by the government], including clonazepam [a type of benzodiazepine to manage anxiety], may lead to clinically significant physical dependence. Risk increases with longer treatment duration and higher daily dose. During a review of Resident 146's facesheet (demographics), the facesheet indicated Resident 146 was admitted on [DATE], with a diagnosis of chronic respiratory failure (serious breathing problems). During a review of Resident 146's medical record, a medication order dated June 14, 2024, indicated a telephone order for hydroxyzine (drug to control anxiety) 50 milligrams (mg - a unit of measurement for dose) via Gastrostomy tube (G-Tube- feeding tube) every 6 hours as needed for ITCHING, MILD ANXIETY M/B [manifested by] HYPERVENTILATION [over breathing]. During a review of Resident 146's medical record, a second medication order dated February 27, 2025, indicated a telephone order to change hydroxyzine from prn to 50 mg scheduled two times a day via G-Tube. During a review of Resident 146's medical record, a Care Plan Report revised April 17, 2025, indicated Anti-anxiety medication use (Hydroxyzine r/t [related to] Anxiety disorder .4/17/2025 start on clonazepam prn. During a review of Resident 146's medical record, a progress note, dated April 17, 2025, at 12:42 PM, from the prescriber, indicated Start Clonazepam 0.5 mg Q12H [every 12 hours] PRN via G-tube. During a review of Resident 146's medical record, a medication order dated April 17, 2025, indicated clonazepam 0.5 mg tablet via G-Tube every 12 hours PRN for anxiety MB [manifested by] verbalization/communication of anxious feelings for 14 Days. During a review of Resident 146's medical record, a second medication order dated May 5, 2025, indicated clonazepam 0.5 mg tablet via G-Tube every 12 hours PRN anxiety MB verbalization/communication of anxious feelings for 14 Days. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 146's medical record, the Medication Administration Record indicated the resident received clonazepam 0.5 mg tablet via G-Tube on May 8, 2025, at 12:42 PM. During an observation on May 8, 2025, at 2:11 PM, in Resident 146's room, Resident 146 was observed sleeping with their mouth open. During a concurrent observation and interview on May 8, 2025, at 2:13 PM, in Resident 146's room, Certified Nursing Assistant 5 (CNA 5) stated Resident 146 was sleeping. During a concurrent interview and record review on May 8, 2025, at 3:33 PM, Resident 146's medical record was reviewed with the Director of Nursing (DON). The DON stated the prescribing practitioner did not document in the medical record the rationale for the second PRN clonazepam medication order to extend the PRN order beyond 14 days. During a concurrent interview and record review on May 9, 2025, at 1:45 PM, with the DON, the facility policy and procedure (P&P) titled, PSYCHOACTIVE [affecting the mind] DRUG MONITORING, approved January 2025, was reviewed. The policy indicated, Policy: Residents who receive .anti-anxiety .medications are monitored to evaluate the effectiveness of the medication. Every effort is made to ensure that residents receiving these medications obtain the maximum benefit with the minimum of untoward effects. Procedure: Residents receive a psychoactive medication only if designated medically necessary by the prescriber. The medical necessity is documented in the resident's medical record and in the care planning process. The continued need for the psychoactive medication is reassessed regularly by the prescriber and the care planning team. If continuation is deemed necessary, this is indicated in the medical record. The DON acknowledged the facility's policy. During a concurrent interview and record review on May 9, 2025, at 1:45 PM, with the DON, the facility P&P titled, REFERENCES, approved January 2025, was reviewed. The policy indicated, Policy: The center will have access to reference materials that include current information [on] available medications. Procedures . References that can be used include .Or any other drug reference designed for nurses (for example, Nursing Drug Handbook). The DON acknowledged the facility's policy.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48985 Based on interview and record review, the facility failed to notify the Office of the State Long-Term Care (LTC) Ombudsman (an advocate for residents of nursing homes) before discharge for one of four sampled residents (Resident 70). This deficient practice had the potential to leave Resident 70 unprotected from improper discharge and deny them access to an advocate for their options and rights. Findings: During a review of Resident 70's Admission Record, dated May 7, 2025, the Admission Record indicated Resident 70 was admitted on [DATE], for orthopedic aftercare following left below the knee surgical amputation (surgical removal of the portion of the leg below the knee). During a review of Resident 70's History and Physical (H&P), dated February 28, 2025 , the H&P indicated Resident 70 had the capacity to understand and make decisions. During a review of Resident 70's Progress Note titled Discharge Summary - Nursing, dated May 7, 2025, the Discharge Summary indicated Resident 70 was discharged on [DATE], with a discharge reason of the resident's health has improved sufficiently, resident no longer needs the services of the facility. During a concurrent interview and record review on May 9, 2025, at 8:52 AM, with the Director of Social Services (DOSS), the DOSS presented the fax confirmation page of Resident 70's Notice of Proposed Transfer/Discharge, dated May 5, 2025. The DOSS stated the fax was sent to the Ombudsman's office on May 8, 2025. The DOSS stated the Ombudsman should be notified of a resident's discharge at least 30 days before discharge. The DOSS confirmed the Ombudsman was notified late of Resident 70's discharge. During a concurrent interview and record review on May 9, 2025, at 2:45 PM, with the Director of Nursing (DON) and the Administrator, the facility's policy and procedure (P&P) titled, Criteria for Transfer and Discharge, dated May 9, 2025, was reviewed. The P&P indicated, .a. The facility shall send a copy of the notice to the State Long Term Care Ombudsman . b. The notice shall be made at least 30 days before the resident is transferred or discharged or as soon as practicable before transfer or discharge . The DON and Administrator stated the notice should be sent to the Ombudsman at least 30 days before the resident is transferred or discharged . The DON confirmed the Ombudsman was notified after Resident 70 had been discharged .

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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** 39539 Based on interview and record review, the facility failed to ensure the individualized care plans (the plans showing specific interventions to provide effective and person-centered care to meet a resident's needs) were developed and implemented for three of 37 final sampled residents (Residents 19, 45, and 151) when: 1. Resident 19 did not have a care plan developed for the use of apixaban (a medication used to prevent and treat blood clots). 2. Resident 45 did not have a care plan developed for dental care. 3. Resident 151's care plan intervention to monitor for bruising associated with anticoagulant (medication to prevent blood clot formation) therapy was not implemented. These failures created the risk of health complications and reduced safety from unmonitored conditions for the residents. Findings: 1. A review of Resident 19's Admission Record, indicated Resident 19 was admitted to the facility on [DATE]. A review of Resident 19's History and Physical Examination, dated January 17, 2025, indicated Resident 19's diagnoses included atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). A review of Resident 19's Order Summary Report, dated as of April 30, 2025, indicated an active physician order to administer apixaban 5 milligrams (mg - metric unit of measurement, used for medication dosage and/or amount) by mouth two times a day for atrial fibrillation starting on January 16, 2025. A review of Resident 19's Medication Administration Record, dated April 1, 2025, to April 31, 2025, indicated apixaban was administered to Resident 19 as per the physician's orders. A review of Resident 19's Care Plan Report, (undated), indicated there were no care plan problems developed related to Resident 19's use of apixaban. During a concurrent interview and record review on May 8, 2025, at 11:52 AM, with Licensed Vocational Nurse 1 (LVN 1), Resident 19's Order Summary Report, dated April 30, 2025, and undated Care Plan Report were reviewed. LVN 1 confirmed Resident 19 was receiving apixaban. LVN 1 verified there was no documented evidence indicating a care plan was developed. LVN 1 stated Resident 19 needed to have a care plan developed for apixaban. LVN 1 further stated that the purpose of having a care plan was to ensure the staff knew the resident's plan of care and how to monitor the resident properly. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of Resident 45's Admission Record, indicated Resident 45 was admitted to the facility on [DATE]. A review of Resident 45's Resident Inventory of Personal Effects, dated October 30, 2024, indicated Resident 45 had both upper and lower dentures upon admission. A review of Resident 45's Dental Progress Notes, dated February 12, 2025, indicated Resident 45 was examined by the dentist. The progress notes indicated that the dentist recommended to extract Resident 45's tooth. A review of Resident 45's Order Summary Report, dated as of May 7, 2025, indicated Resident 45 might have an extraction of the tooth and full upper and lower dentures. A review of Resident 45's Minimum Data Set (MDS - a resident assessment tool) - Version 3.0, dated April 24, 2025, indicated the BIMS (Brief Interview for Mental Status - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 15 which meant Resident 45 was cognitively intact. During an interview with Resident 45 on May 6, 2025, at 11:45 AM, Resident 45 stated their dentures were brought to the facility on admission; however, the facility lost the dentures approximately eight months ago, and they still did not have them. Resident 45 further stated they could eat without the dentures but were unable to chew tough meat. A review of Resident 45's Progress Notes, dated March 10, 2025, indicated the Director of Social Services (DOSS) informed Resident 45's responsible party that the resident was provided with the incorrect dentures upon returning from the hospital. The progress notes also indicated the DOSS spoke with Resident 45 who stated they would like to move forward with the tooth extraction and new dentures. A review of Resident 45's Care Plan Report, (undated), indicated there were no care plan problem developed related to Resident 45's dental care. During a concurrent interview and record review on May 7, 2025, at 03:08 PM, with LVN 3, Resident 45's Dental Progress Notes, dated February 12, 2025, Progress Notes, dated March 10, 2025, and undated Care Plan Report were reviewed. LVN 3 confirmed there was documentation indicating Resident 45 did not currently have dentures. When asked why Resident 45 needed a tooth extraction and still did not have dentures, LVN 3 stated they did not know. When asked if there was a care plan problem developed related to Resident 45's dental care, LVN 3 verified there was no documented evidence indicating a care plan was developed. LVN 3 stated a care plan should have been developed as soon as the staff knew about the issue. LVN 3 explained that the purpose of developing a care plan was to determine the type of care to be provided for the resident and to understand the resident's goals. During a concurrent interview and record review on May 7, 2025, at 03:27 PM, with the DOSS, Resident 45's Progress Notes, dated March 10, 2025, were reviewed. The DOSS verified they had been aware of Resident 45's dental issue since March 10, 2025. The DOSS stated Resident 45 complained about not having dentures because they were important for eating and for the resident's appearance. (continued on next page)

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Upland Rehabilitation and Care Center	1221 East Arrow Hwy Upland, CA 91786

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Policy and Procedure, titled Comprehensive Person-Centered Care Planning, (undated), indicated It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment .6. The resident's comprehensive plan of care will be reviewed and/or revised by the IDT after each assessment . 3. A review of Resident 151's Admission Record indicated an admitted [DATE], with diagnoses including history of stroke (damage to the brain due to an interruption in blood supply). A review of Resident 151's care plan for anticoagulant therapy, dated September 6, 2024, indicated interventions including daily skin inspections and to monitor and document any anticoagulant complications, including bruising. A review of Resident 151's medical record, indicated a physician's order, dated October 29, 2024, for Lovenox injection (a medication used to prevent the formation of blood clots), inject 40 milligrams (unit of measure) subcutaneously (under the skin) one time a day for blood clot prevention. During a review of Resident 151's SBAR (Situation, Background, Assessment, and Recommendation) Communication Form, dated April 23, 2025, the SBAR Communication form indicated Resident 151 had a fall. A review of Resident 151's progress notes, dated April 23, 2025, indicated the resident was noted to have discoloration on the right upper back and right hip and thigh. During a review of Resident 151's Medication Administration Record (MAR) for April and May 2025, the MARs indicated Resident 151 did not have signs or symptoms of bleeding. During an observation and interview on May 6, 2025, at 08:57 AM, with Resident 151, in Resident 151's room, the resident stated he had bruises from a fall and a bruise was observed on the resident's right thigh. During a concurrent interview and record review on May 9, 2025, at 09:12 AM, with the Director of Nursing (DON), Resident 151's medical record was reviewed. The DON verified Resident 151 was receiving anticoagulant therapy, sustained a fall on April 23, 2025, and had bruising to the right back, hip, and thigh. The DON stated if a resident had any skin issues, an LVN would be responsible for initiating the skin assessment and should continue to monitor the resident until the problem is resolved. The DON verified Resident 151's bruising should have been monitored. A review of the facility's P&P titled Anticoagulation Therapy, (undated), indicated the facility would ensure the anticoagulation therapy is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person- centered care plan and the residents' goals and preferences . licensed nursing staff will monitor all residents on anticoagulants recognizing signs and symptoms of bleeding, including, but is not limited to bruising, gum bleeding, dark stools, and hematuria [blood in the urine] and document into the medical record.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44529 Based on observation, interview, and record review, the facility failed to provide appropriate grooming services to one of three sampled dependent residents (Resident 47), when Resident 47 was observed with untrimmed and dirty fingernails on the right hand. This had the potential for skin problems and infection around the nail bed for Resident 47. Findings: During a review of Resident 47's Admission Record (AR), the AR indicated Resident 47 was admitted to the facility on [DATE], with diagnoses including functional quadriplegia (paralysis from the neck down, including legs and arms) among others. During a review of Resident 47's Minimum Data Set (MDS - a resident assessment tool), dated March 17, 2025, the MDS indicated Resident 47 had functional limitation in range of motion for both upper and lower extremities. The MDS further indicated Resident 47 was dependent on staff for personal hygiene. During an observation on May 6, 2025, at 2:22 PM, inside Resident 47's room, Resident 47 was observed with untrimmed and dirty fingernails on the right hand. During an observatoin and interview on May 6, 2025, at 2:30 PM, with Certified Nurse Assistant 4 (CNA 4), inside Resident 47's room, CNA 4 looked at Resident 47's right hand fingernails and stated the nails should be trimmed short and clean. CNA 4 stated the expectation was to provide grooming services to Resident 47. During a concurrent interview and record review on May 7, 2025, at 2:39 PM, with the Director of Nursing (DON), the facility's undated policy and procedure (P&P) titled, Nails, Care of Finger and Toe, was reviewed. The P&P indicated, .It is the policy of this facility to perform nail care to: 1. Clean the nail bed 2. Keep nail trimmed 3. Prevent infections .Procedures .7. Nail care includes daily cleaning and regular trimming during ADL (Activities of Daily Living- activities such as bathing, dressing and toileting a person performs regularly) care .8. Proper nail care can aid in the prevention of skin problems around the nail bed . The DON stated the expectation for grooming Resident 47 was not met, and further stated the policy was not followed.

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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** 38764 Based on observation, interview, and record review, the facility failed to provide the necessary services to attain or maintain the highest practicable well-being for 1 of 37 final sampled residents (Resident 4), when Resident 4's wound was not assessed consistently in accordance with the facility's Policy and Procedure (P&P). This failure had the potential to delay identification of wound deterioration for Resident 4. Findings: A review of Resident 4's Admission Record, indicated the resident was admitted to the facility on [DATE]. A review of Resident 4's history and physical note, dated October 10, 2024, indicated the resident had diagnoses including peripheral vascular disease (narrowing of blood vessels) and chronic obstructive pulmonary disease (lung disease that blocks airflow and makes breathing difficult). A review of Resident 4's Physician's Order, dated April 12, 2025, and renewed May 3, 2025, indicated to cleanse Resident 4's moisture-associated skin damage (MASD, inflammation of the skin occurring with or without loss of the outer layer of the skin) on the right buttock extending to the left buttock with normal saline solution, pat the skin area dry, apply barrier cream, and leave the skin area open to air. The order indicated wound care would be performed every day for 21 days then a reevaluation of the skin area would be performed. A review of Resident 4's LN [Licensed Nurse]-Skin Evaluation - PRN [as needed]/weekly did not indicate an assessment of the condition of Resident 4's wound to the buttocks for the weeks of April 25, 2025, and May 2, 2025. During a concurrent interview and record review on May 8, 2025, at 10:42 AM, with Licensed Vocational Nurse 5 (LVN 5), Resident 4's medical record was reviewed. LVN 5 acknowledged Resident 4 was receiving treatment for the wound to the buttocks area. LVN 5 verified the physician's order for the resident's wound treatment. LVN 5 described the wound as redness on the right buttock that extended to the left buttock and stated the wound was moisture-associated skin damage. LVN 5 verified there was no assessment documented in Resident 5's record for the weeks of April 25, 2025, and May 2, 2025. LVN 5 explained the documentation of the assessment findings would guide the other nurses to know whether the condition of the resident's wound was getting worse, or the wound was improving. LVN 5 stated the importance was to ensure Resident 4 would receive the appropriate wound treatment. During a concurrent observation and interview on May 9, 2025, at 9:27 AM, with LVN 5 in the presence of the Director of Staff Development (DSD), LVN 5 was observed providing wound care treatment to Resident 4 in the resident's room. LVN 5 verified there were scattered areas of skin redness on Resident 4's right buttock and extending to the left buttock area. LVN 5 stated the areas were not intact, there was no drainage coming out from the open areas, and the depth of the wound was too shallow for measurement. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's P&P, titled Skin Management System, (undated), indicated residents will have an ongoing head to toe assessment done weekly, incorporated into the weekly summary review by the licensed nursing staff.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38764 Based on observation, interview, and record review, the facility failed to provide respiratory care services for 1 of 37 final sampled residents (Resident 89) when the facility failed to ensure the filter of the Continuous Positive Airway Pressure machine (CPAP- a machine that uses air pressure delivered through tubing and a mask over the mouth or nose to keep the airway open) was replaced in accordance with the manufacturer's guidelines. This failure could potentially result in nasal irritation and/or illness for Resident 89. Findings: A review of Resident 89's Admission Record, indicated the resident was admitted to the facility on [DATE]. A review of Resident 89's Care Plan Report, initiated on March 19, 2025, and revised on May 2, 2025, indicated Resident 89 had a problem of altered respiratory status and difficulty breathing related to Obstructive Sleep Apnea (OSA- a condition where the throat muscle relaxes while sleeping and blocks the airway, leading to lapses in breathing). A review of Resident 89's physician's order, dated May 2, 2025, indicated to use a CPAP machine at bedtime for OSA. During an observation and interview on May 5, 2025, at 10:30 AM, with Resident 89, in Resident 89's room, a machine was observed on the resident's nightstand and tubing was connected and hanging at the bedside. Resident 89 stated the machine was a CPAP machine Resident 89 used to help with breathing at night during sleep. Resident 89 acknowledged the facility staff would come by and check the machine; however, the resident was not able to describe what the staff would check on the machine. During a concurrent observation and interview on May 8, 2025, at 11:20 AM, with Licensed Vocational Nurse 8 (LVN 8), in Resident 89's room, LVN 8 acknowledged Resident 89 used a CPAP machine at night to help the resident with breathing. During an inspection of the machine, LVN 8 opened the compartment of the filter located on the right side of the CPAP machine. The color of the filter was observed to be a mixed light grey and dark grey. LVN 8 acknowledged the grey color of the filter. LVN 8 stated they were not sure who was responsible for checking and replacing the filter of the CPAP machine. During a concurrent observation and interview on May 8, 2025, at 11:34 AM, with the Assistant Director of Nursing (ADON) and Respiratory Therapy Supervisor (RTS), in Resident 89's room, the ADON and RTS acknowledged the color of the filter of Resident 89's CPAP machine was light grey and dark grey. The RTS stated a new filter was white in color and CPAP machine filters should be replaced routinely. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview and record review on May 8, 2025, at 2:40 PM, with the RTS, the CPAP machine manufacturer's user guide, (undated), was reviewed. The RTS stated the user guide indicated to check the CPAP air filter and replace the filter at least every six months and replace the filter more often if there were any holes or blockages with dirt or dust. The RTS stated there was no documentation indicating an inspection was conducted on Resident 89's CPAP machine, including a filter change for the machine. The RTS stated the purpose of the filter in a CPAP machine was to ensure the resident would be breathing clean air while the resident was using the machine at nighttime. During a follow-up interview on May 8, 2025, at 2:58 PM, with the ADON, the ADON acknowledged there was no documentation the licensed nursing staff changed the filter of Resident 89's CPAP machine. During a concurrent interview and record review on May 9, 2025, at 11:05 AM, with the Director of Nursing (DON), the CPAP machine manufacturer's user guide, (undated), was reviewed. The DON stated the nursing staff were responsible to ensure the CPAP machine was working and the Respiratory Department would ensure the machine had the correct settings, as ordered by the physician. The DON acknowledged the facility should have followed the manufacturer's user guide for filter replacement for Resident 89's CPAP machine.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44529 Based on observation, interview, and record review, the facility failed to ensure the provision of care and services for dialysis (a treatment to cleanse the blood of waste and extra fluids through a machine when the kidney(s) have failed) when a bandage was left on the dialysis site for more than four hours for one of two sampled residents (Resident 49). This had the potential to prevent appropriate monitoring for complications including potential for infection and malfunction of Resident 49's dialysis access site . Findings: During a review of Resident 49's Admission Record (AR), the AR indicated Resident 49 was admitted on [DATE], with diagnoses that included end stage renal disease (irreversible kidney failure) among others. During a review of Resident 49's Order Listing Report (OLR), dated May 6, 2025, the OLR indicated Resident 49 had an active order for dialysis every Monday, Wednesday, and Friday. During a concurrent observation and interview on May 6, 2025, at 8:39 AM, with Licensed Vocational Nurse 2 (LVN 2), inside Resident 49's room, Resident 49 was seen with a bandage on the left arm. LVN 2 stated she would check records to be sure but thought the bandage might be from the previous dialysis treatment. During a concurrent observation and interview on May 6, 2025, at 9:05 AM, with the Director of Nursing (DON), inside Resident 49's room, the DON stated Resident 49 received dialysis treatment. The DON removed the bandage on Resident 49's arm and stated it was from the dialysis treatment from May 5, 2025. During a concurrent interview and record review on May 6, 2025, at 9:10 AM, with the DON, the Facility/Dialysis Center Nursing Communication Record (CR) signed and dated May 5, 2025, was reviewed. The CR indicated Resident 49 had dialysis on May 5, 2025, and the resident had a bandage in place upon return to the facility. The DON stated the bandage in place referenced in the document was for the dialysis access site on the left arm. The DON stated the bandage on Resident 49's arm should have been removed within four hours following dialysis treatment. During a concurrent interview and record review on May 9, 2025, at 2:10 PM, the facility's Lesson Plan .Pre and Post Care for Dialysis Inservice, dated November 20, 2024, was reviewed. The lesson plan indicated, . Objective .Clearly define guidelines in providing pre and post care for dialysis .Post Dialysis Care .Bandages should be removed within three to four hours after treatment . The DON stated the bandage remained on Resident 49's dialysis access site for more than four hours.

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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** 38764 Based on observation, interview, and record review, the facility failed to ensure the side rail (also called bedrail) assessment was accurate and side rail use was indicated to meet the needs of one of 37 final sampled residents (Resident 66), who was unable to use the side rails due to functional limitations in both upper extremities. This failure had the potential for injury related to improper use of side rails for Resident 66. Findings: A review of Resident 66's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 66's physician's order, dated February 8, 2023, indicated an order for half (1/2) side rails up in bed to aid in bed mobility. A review of Resident 66's Minimum Data Set (MDS, a standardized assessment tool), dated June 13, 2024, indicated Resident 66 had impaired range of motion in both upper extremities. A review of Resident 66's OT [Occupational Therapy] Evaluation and Plan of Treatment, dated July 9 to August 5, 2024, indicated Resident 66 had functional limitations due to contractures (shortening or tightening of muscles causing deformity or loss of movement of the affected extremity) of both upper extremities. A review of Resident 66's Functional Abilities and Goals form, dated March 6, 2025, indicated the resident was dependent on staff for mobility, including rolling side to side in bed. In addition, the form indicated Resident 66 was dependent on staff when moving from sitting on the side of the bed to lying flat on the bed. A review of Resident 66's Bed Rail Safety Evaluation, dated March 6, 2025, indicated Resident 66 could have two (2) 1/2 siderails up to aid the resident in bed mobility. In addition, the evaluation indicated Resident 66 was able to move freely in bed and did not exhibit signs or symptoms of impaired and restricted mobility. During an initial tour observation on May 5, 2025, at 11:55 AM, in Resident 66's room, Resident 66 was observed with eyes closed while lying in bed. The resident's bed was observed to have both upper side rails raised above the mattress level of the bed and both side rails were covered with soft material. During an interview on May 7, 2025, at 2:02 PM, with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated Resident 66 was dependent on staff for care, including with the activities of daily living (ADLs- for example, bathing, personal hygiene and repositioning). CNA 2 explained Resident 66 was unable to reposition independently due to contractures of both upper and lower extremities. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on May 7, 2025, at 3:05 PM, with Registered Nurse Supervisor 2 (RNS 2), Resident 66's Bed Rail Safety Evaluation, dated March 6, 2025, was reviewed. RNS 2 acknowledged there was inconsistency between Resident 66's documented functional abilities in the medical record and the assessment findings on the safety evaluation regarding the mobility of Resident 66. RNS 2 stated the Bed Rail Safety Evaluation should show Resident 66 was assessed to have exhibited signs or symptoms of impaired and restricted mobility. During a concurrent observation and interview on May 9, 2025, at 8:33 AM with CNA 1, CNA 1 was observed providing a bed bath to Resident 66 inside the resident's room. Resident 66 was observed lying in bed with arms crossed over the resident's chest area. Resident 66's arms remained bent at the elbows while CNA 1 was removing the shirt of the resident. When CNA 1 rolled Resident 66 towards the left side, the CNA instructed the resident to grab on to the left side rail. Resident 66's arms remained bent, and the resident did not reach over and grab on to the side rail. CNA 1 acknowledged Resident 66 did not reach for and hold onto the side rail. During a concurrent interview and record review on May 9, 2025, at 9:00 AM, with the Director of Rehabilitation Services (DRS), Resident 66's OT Evaluation and Plan of Treatment, dated July 9 to August 5, 2024, was reviewed. The DRS stated the rehabilitation services department would evaluate a resident's mobility and the need for assistive devices. The DRS stated side rails would aid a resident in repositioning their body while in bed. The DRS stated the assessment findings for Resident 66 included functional limitations of both upper extremities due to the presence of contractures. The DRS stated the side rails of Resident 66's bed could no longer aid the mobility of the resident due to the functional limitations of the resident's upper extremities. A review of the facility's Policy and Procedure (P&P), titled Resident Assessment- Bedrail Assessment, (undated), indicated the need for ongoing monitoring and supervision for the use of side rails, which would include an ongoing assessment to assure that the bed rail is used to meet the resident's needs.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35335 Based on interview and record review, the facility failed to ensure safe and effective pharmaceutical services when an order was not clarified before a medication was held for one of five residents (Resident 112). This failure had the potential to result in preventable medication errors resulting from incomplete or unclear orders for Resident 112. Findings: During a review of Resident 112's facesheet (demographics), the facesheet indicated the resident was readmitted on [DATE], and had diagnoses of dependence on renal (kidney) dialysis (procedure for filtering blood when kidneys stop working) and hypertension (high blood pressure). During a review of Resident 112's SNF [Skilled Nursing Facility] H&P [History & Physical], the H&P indicated Resident 112 was diagnosed with chronic (persistent) congestive heart failure (CHF- when the heart does not pump blood normally). During a review of Resident 112's medical record, an order dated April 28, 2025, indicated a medication order for furosemide (diuretic - water pill) 80 milligrams (mg - a unit of measurement for dose) tablet by mouth two times a day for CHF. During a review of Resident 112's medical record, an order dated April 29, 2025, indicated to HOLD ALL B/P [blood pressure] MEDS [medications] ON THE MORNING OF DIALYSIS DAYS. During an interview on May 7, 2025, at 8:14 AM, with Licensed Vocational Nurse 6 (LVN 6), LVN 6 stated they were going to hold Resident 112's furosemide because the resident was going to dialysis. During a concurrent interview and record review on May 7, 2025, at 2:15 PM, with LVN 6, Resident 112's medical record was reviewed. LVN 6 stated they did not administer the furosemide to Resident 112 that morning. LVN 6 acknowledged the order dated April 29, 2025, indicated to HOLD ALL B/P MEDS ON THE MORNING OF DIALYSIS DAYS. LVN 6 reviewed the furosemide medication order dated April 28, 2025. LVN 6 acknowledged the furosemide was indicated for CHF and not blood pressure. LVN 6 stated furosemide was categorized as a diuretic and water pill. LVN 6 stated the order to hold blood pressure medications on dialysis days dated April 29, 2025, and the furosemide medication order dated April 28, 2025, should have been clarified. During a concurrent interview and record review on May 9, 2025, at 1:45 PM, with the Director of Nursing (DON), the facility policy and procedure (P&P) titled, PRESCRIBER MEDICATION ORDERS, approved January 2025, was reviewed. The policy indicated, Any dose or order that appears inappropriate considering the resident's age, condition, or diagnosis is verified with the attending physician before processing. The DON acknowledged the facility's policy.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 35335 Based on observation, interview, and record review, the facility failed to ensure medications were stored at an appropriate temperature range, in accordance with drug manufacturers' requirements, in one of three medication rooms (Station 2 Med Room). This failure had the potential for residents to be given deteriorated (reduced quality) medications which could result in suboptimal treatment. Findings: During a review of the Station 2 Daily Record of Medication Room Temperature, the log indicated the Station 2 Medication Room temperature was recorded as 78 degrees Fahrenheit (F - a temperature scale) on May 4, 2025, and May 5, 2025. During a concurrent observation and interview on May 5, 2025, at 9:41 AM, with the Assistant Director of Nursing (ADON), an inspection of the Station 2 Medication Room was conducted. When the medication room cabinet was opened, multiple medications were observed stored inside. The ADON acknowledged the product labeling for the following six (6) drug products indicated to store the medications at a maximum of 77 degrees F. a. Three (3) bottles of Extra Strength acetaminophen (pain relief medication) 500 milligrams (mg - a unit of measurement for dose) b. Two (2) bottles of acetaminophen 325 mg c. One bottle of senna (laxative to manage constipation) syrup 237 milliliters (ml - a unit of measurement for volume) d. One carton of twenty-four (24) caplets (pills) of loperamide (drug to control diarrhea) 2 mg e. Two (2) bottles of docusate sodium (stool softener) 100 mg f. Two (2) bottles of Extra Strength docusate sodium 250 mg During a concurrent interview and record review on May 9, 2025, at 1:45 PM, with the Director of Nursing (DON), the facility policy and procedure (P&P) titled MEDICATION STORAGE IN THE FACILITY .STORAGE OF MEDICATIONS approved January 2025, was reviewed. The policy indicated, Medications and biologicals are stored safely, securely, and properly, following the manufacturer's recommendations or those of the supplier. The DON acknowledged the facility's policy.

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	05/09/2025

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 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. 46110 Based on observation, interview, and record review the facility failed to store food in accordance with professional standards for food safety when employees' food was found inside 1 of 3 residents' refrigerators (Station 1 RR). This failure had the potential to expose 50 highly susceptible residents from Station 1, who were on an oral diet, to cross-contaminated (the transfer of harmful substances or disease- causing microorganisms) food. Findings: During a review of the facility's Station 1 Daily Census, dated May 4, 2025, the census indicated there were 56 residents in Station 1. During a review of the Station 1 Dietary Order Tally Report, (undated), the Dietary Order Tally Report indicated there were six residents who were not receiving an oral diet. During a concurrent observation tour and interview, on May 5, 2025, at 9:34 AM, inside the room where the ice machine and Station 1 RR were located, with the Maintenance Director (MD), the MD stated each station had a refrigerator for residents. The Station 1 RR door had a post on it which indicated, Resident's Food Only .This fridge is for RESIDENTS' FOOD ONLY. No Employees food can be stored inside . When the refrigerator was opened, a box of sponge cakes with a name and date written on it was found inside. During an interview on May 6, 2025, at 9:42 AM, with Station 1 Licensed Vocational Nurse (LVN 4), LVN 4 stated they were not sure if the name written on the box of sponge cakes was a resident or not. During an interview on May 6, 2025, at 10:28 AM, with the Clinical Resource (CR), the CR confirmed the food inside Station 1 RR belonged to the Housekeeper (HK) working at night. During an interview on May 7, 2025, at 8:20 AM, with the Administrator (ADM), the ADM acknowledged it was not appropriate to keep staff food inside Station 1 RR. The ADM stated a licensed nurse or housekeeper at each station should check the refrigerator daily. The ADM further stated staff should have understood not to put their food inside the residents' refrigerator to prevent cross-contamination. During a concurrent interview and record review on May 8, 2025, at 2:03 PM, with the ADM, the ADM reviewed and confirmed the facility's revised policy titled, Resident/Personal Food Storage, dated 11/2016 indicated, .refrigeration units, or personal/resident room refrigeration units will be monitored by designated facility staff for food safety . The ADM confirmed the finding, and stated the policy was not followed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Food and Drug Administration Food Code 2022, 3-701.11, indicated, Discarding or Reconditioning Unsafe, Adulterated, or Contaminated Food .(C) READY-TO-EAT FOOD that may have been contaminated by an EMPLOYEE who has been RESTRICTED or EXCLUDED as specified under S 2-201.12 shall be discarded.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39210 Based on interview and record review, the facility failed to ensure complete and accurate documentation for one of 37 final sampled residents (Resident 151), when Restorative Nursing Assistant (RNA) services were not documented. This failure had the potential for Resident 151's care needs to go unmet due to inaccurate information in the record. Findings: A review of Resident 151's Admission Record, indicated Resident 151 was admitted to the facility on [DATE], with diagnoses including osteoarthritis (a disease where joint tissue breaks down) to both knees and history of stroke (brain damage due to an interruption in blood flow). A review of Resident 151's Physician Orders, dated October 14, 2024, indicated RNA services daily five times a week for ambulation (walking) with front wheel walker, as tolerated, to be conducted every Monday, Tuesday, Wednesday, Thursday, and Friday. A review of the Point of Care Audit Report for March 2025, indicated four RNA entries in Resident 151's medical record for March. A review of the Point of Care Audit Report for April 2025, failed to show RNA entries were made in Resident 151's medical record for April. During a concurrent interview and record review on May 9, 2025, at 8:22 AM, with the Director of Nursing (DON) and RNA 1, Resident 151's medical record was reviewed. RNA 1 stated after working with the resident, they would document their entries into the computer. RNA 1 further stated, it should be documented in the medical record if Resident 151 was provided or refused RNA services. The DON acknowledged and verified there was no documentation of RNA services for Resident 151 from March 9, 2025, through the end of April 2025. A review of the facility's Policy and Procedure (P&P), titled ROM [Range of Motion] and Contracture Prevention, (undated), indicated appropriate documentation is completed to address goals of the program and resident tolerance to the program. A review of the facility's P&P titled Charting Guide- General, (undated), indicated the purpose of proper charting and documentation is to provide a complete account of the resident's care, treatment, and response to the care, signs, symptoms, etc., as well as the progress of the resident's care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 39539 Based on observation, interview, and record review, the facility failed to implement infection control and prevention measures when: 1. One single-dose container of acetic acid (solution to prevent blockage in tubes connected to the resident's body) was not discarded after being opened. This failure had the potential for cross contamination (unintentional transfer of germs) to residents or residents to be treated with deteriorated treatments which could negatively impact their clinical condition. 2. One non-laundry staff entered the restricted clean area of the laundry department and obtained items from a linen cart. This failure had the potential for cross contamination and spread of infection which could adversely affect the health and wellbeing of residents and staff. Findings: 1. During a concurrent observation and interview on May 5, 2025, at 12:08 PM, an inspection of Treatment Cart 1 near Nursing Station 1 was conducted with Licensed Vocational Nurse 5 (LVN 5). LVN 5 stated she was the Treatment Nurse (nurse specializing in wound care). When Treatment Cart 1 was opened, one container of [Manufacturer] 0.25% (concentration) of acetic acid was observed stored and labeled with handwritten black ink D/O 5/2/25. LVN 5 stated the acetic acid container was opened on May 2, 2025. During an interview on May 5, 2025, at 12:22 PM, with the Director of Nursing (DON), the DON was requested to provide literature from [Manufacturer] supporting the extended beyond-use-dating (written documentation from the manufacturer regarding the longer duration of the opened container) for NDC [National Drug Code - unique number assigned to each medication] 0264-2304-10 acetic acid observed stored in Treatment Cart 1. During an interview on May 7, 2025, at 11:58 PM, with the DON, the DON stated the drug manufacturer verbally told the facility the acetic acid container was single-dose. During an interview on May 7, 2025, at 12:10 PM, with the DON, the DON acknowledged the acetic acid container was labeled Sterile [clean] .Single-dose container. The DON acknowledged the opened acetic acid container had labeling which indicated it was opened on May 2, 2025, and should not have been stored in the treatment cart on May 5, 2025. During a concurrent interview and record review on May 7, 2025, at 3:22 PM, with the Infection Preventionist (IP), the [Manufacturer] package insert (document on how to safely use medications) dated August 2023, obtained from the facility, for the acetic acid container NDC 0264-2304-10 was reviewed. The IP acknowledged the package insert indicated, WARNINGS .After opening container, the contents should be used promptly in order to minimize the possibility of bacterial growth or pyrogen [fever-inducing substance] formation. Discard unused portion of irrigating [referring to the acetic acid] solution since it contains no preservative [to protect against decay]. The IP stated the unused portion of the acetic acid container should have been discarded because don't want bacterial growth. The IP stated the acetic acid solution did not contain preservatives. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on May 9, 2025, at 1:45 PM, with the DON, the facility policy and procedure (P&P) titled MEDICATION STORAGE IN THE FACILITY .STORAGE OF MEDICATIONS approved January 2025, was reviewed. The policy indicated, Medications and biologicals are stored safely, securely, and properly, following the manufacturer's recommendations or those of the supplier. The DON acknowledged the facility's policy. 2. During a concurrent observation and interview on May 7, 2025, at 2:20 PM, with the Environmental Services Supervisor (EVSS), in the presence of the Infection Preventionist (IP), in the laundry department, the EVSS stated laundry staff would have to dispose of their Personal Protective Equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) and perform hand hygiene prior to coming into the clean area. The EVSS explained that after removing the dried items from the dryer, the laundry staff would place the items on the sorting table in the clean area of the laundry department. The EVSS further explained that once the items were sorted and folded, they were then placed inside the clean linen carts for the laundry staff to take to each station's clean utility rooms. It was observed that a non-laundry staff took clean items, including towels and socks, from the linen cart in the clean sorting area and placed the items inside a clear plastic bag. When the EVSS was asked if non-laundry staff were allowed to be at the laundry department's clean area near the sorting table and remove items from the linen cart, the EVSS stated no. The EVSS stated only laundry staff were allowed to handle clean items in the laundry department. During an interview on May 8, 2025, at 11:15 AM, with the IP, the IP stated non-laundry staff could not enter and were to remain outside of the clean area of the laundry department. The IP stated only laundry staff could handle clean linens and place them inside a plastic bag to provide to non-laundry staff. During an interview on May 8, 2025, at 3:35 PM, with the DON, the DON stated non-laundry staff needed to call the laundry department should they need additional clean items for the residents. The DON verified non-laundry staff were not allowed to enter the clean area or handle the clean items in the laundry department. A review of the facility's Policy and Procedures (P&P) titled Infection Prevention - Control of Transmission of Infection, (undated), indicated It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions . A review of the facility's Policy and Procedures (P&P) titled Laundry Services, (undated), indicated It is the policy of this facility that careful precautionary procedures must be followed by laundry personnel to prevent the spread of infectious diseases to other staff members, residents, and visitors .2. The supervisor of laundry services will work closely with the infection control designee to establish and maintain consistent high standards .