

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055598	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024
NAME OF PROVIDER OR SUPPLIER The Bradley Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 980 West Seventh Street San Jacinto, CA 92582	
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 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. 36038 Based on interview and record review, the facility failed, for one of 12 sampled residents (Resident 38), to ensure the resident or resident representative was informed and provided a written information regarding the formulation of an advance directive (written instruction such as living will or durable power of attorney for health care about the provision of care and services the resident preferred when he is no longer able to decide for himself) upon admission to the facility. This failure had the potential for the residents to have inappropriate treatment and services in the event of a medical emergency. Findings: A review of Resident 38's document titled, Physician Orders for Life Sustaining Treatment (POLST- form completed by the resident and/or legal representative that records the resident's treatment preferences in the event of a medical emergency), dated January 31, 2024, indicated, Resident 38 did not provide information regarding advance directive. A review of Residentn 38's document titled, Residents Receipt of Self-Determination Act Information, dated February 1, 2024, indicated, .Please have the appropriate category checked as to whether or not an Advance Directive has been executed by this resident .No .THE SOCIAL SERVICES DESIGNEE WILL FOLLOW-UP WITH YOU FOR ANY CARE DIRECTIVES YOU DESIRE . Further review of Resident 38's records indicated Resident 38 was not provided with information regarding formulating an advance directive. During a concurrent interview and review of Resident 38's POLST, on March 27, 2024, at 3:54 p.m., with the Social Service Director, she stated the POLST dated January 31, 2024, did not indicate that Resident 38 nor the resident representative were asked about the advance directive. The SSD stated, the admitting nurse should have asked the resident about the advance directive. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and review of Resident 38's Residents Receipt of Self Determination Act Information, on March 29, 2024, at 9:35 a.m., with the Business Office Manager (BOM), she stated the document, Residents Receipt of Self Determination Act Information, dated February 1, 2024, indicated that Resident 38 responded No, when asked whether an advance directive was executed. The BOM stated there was no documentation showing the facility offered assistance in formulating an advance directive. The BOM stated, the facility should have assisted in formulating an advance directive. A review of the facility policy titled, Advance Directives, dated December 2016, indicated .Prior to or upon admission of a resident, the Social Service Director or Designee will inquire of the resident, his/her family members and/or his or her legal representative about existence of any written advance directives . Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record .If the resident indicates that he has not established advance directives, the facility staff will offer assistance in establishing advance directives .		

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48240 Based on interview and record review, the facility failed to ensure a written notice of bed-hold policy (reserving a resident's bed while resident is out of the facility for therapeutic leave or hospitalization) was provided to the resident/and or resident representative, for one of one resident reviewed for hospitalization (Resident 34) when Resident 34 was transferred to the acute hospital. This failure had the potential for the resident or resident representative not to be informed of their right to hold the bed while out of the facility and the right to be readmitted back to the facility. Findings: On March 29, 2024, Resident 34's record was reviewed. Resident 34 was admitted to the facility on [DATE], with diagnoses which included osteomyelitis (bone infection), end stage renal disease (a permanent kidney failure that requires a regular course of dialysis-a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). Further review of Resident 34's document titled, BEDHOLD INFORMED CONSENT, dated February 22, 2024, indicated, .CONFIRMATION OF TRANSFER & (and) BEDHOLD PROVISION .Copy of Bedhold Notice sent with resident .blank (no answer) .Notice given to Responsible Party at time of transfer .blank (no answer) . A review of Resident 34's LICENSED NURSES PROGRESS NOTES, dated March 22, 2024, at 4:00 p.m., indicated that Resident 34 was transferred to (name of hospital) from the dialysis center for blood transfusion. A review of Resident 34's Notice of Proposed Transfer/Discharge, dated March 22, 2024, indicated Resident 34 was transferred to (name of hospital) on March 22, 2024. There was no documented evidence Resident 34 or resident representative were provided with information of the facility's bed hold notice at time of transfer. On March 29, 2024, at 1:29 p.m., a concurrent interview with Licensed Vocational Nurse (LVN) 1 and review of Resident 34's records were conducted. LVN 1 stated, Resident 34 was receiving dialysis and that the dialysis center transferred the resident to the hospital for a blood transfusion. LVN 1 stated, the bed hold notice for transfer was done by the Social Services Designee (SSD) or Admissions Representative. LVN 1 stated, there was no documentation indicating that the bed hold notice was discussed with the resident or resident representative at the time of transfer. On March 29, 2024, at 1:55 p.m., a concurrent interview and review of Resident 34's BEDHOLD INFORMED CONSENT, were conducted with the SSD. The SSD stated, the bed hold notice was not completed upon transfer and should have been completed upon transfer. The SSD stated, the licensed nurse progress note did not indicate any discussion of the bed hold notice with the resident or resident representative. (continued on next page)		

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 29, 2024, at 3:08 p.m., a concurrent interview and review of Resident 34's BEDHOLD INFORMED CONSENT, were conducted with the Director of Nursing (DON). The DON stated, the bed hold notice was not completed upon resident's transfer. The DON stated, there was no written information indicating that a bed hold notice was provided to the resident or resident representative upon transfer. The DON stated, there was no documentation in the licensed nurse progress notes regarding Resident 34's bedhold. The facility's policy and procedure titled, Bed-Holds and Returns, dated March 2022, was reviewed. The policy indicated, .all residents/representatives are provided written information regarding the facility bed hold policies . residents are provided written information about these policies at least twice .well in advance of any transfer .at the time of transfer .(or, if the transfer was an emergency, within 24 hours) .		

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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** 44270 Based on observation, interview, and record review, the facility failed to ensure one of one resident reviewed (Resident 24) received care and treatment to maintain their highest practicable physical well-being when a dietitian recommendation for a diet upgrade was not made known to the physician by the licensed nurses. This failure resulted in the resident remaining on her current diet, which could potentially lead to a decline in resident's overall condition. Findings: On March 28, 2024, a review of Resident 24's Face Sheet, indicated, Resident 24 was admitted to the facility on [DATE], with a diagnosis which included, cerebral infarction (lack of oxygen to the brain), and dementia (memory loss). A review of Resident 24's, Minimum Data Set, (a standardized assessment for the management of care) dated, December 17, 2023, indicated, .BIMS (Brief Interview for Mental Status- screening tool to assess mental capability) Summary Score . 3 .(severe cognitive impairment). A review of Resident 24's document titled, Resident Meet and Greet, dated June 9, 2023, indicated, . Daughter asking when (name of Resident) can upgrade to mech. (mechanical) soft diet . A review of Resident 24's document titled, Nutrition Screening Form, dated June 8, 2023, indicated, Resident 34's family requested on June 14, 2023, an upgrade of the resident's diet. A review of Resident 24's document titled, Nutrition Recommendations, dated June 22, 2023, indicated, . Recommendations .Refer to MD (physician) or ST (speech therapy) .Reason .Family desires food texture upgrade from puree . A review of Resident 24's document titled, Nutrition Risk Assessment Summary, dated June 22, 2023, indicated, .Refer texture upgrade to MD (physician), Hospice . A review of Resident 24's document titled, Care conference note, dated June 22, 2023, indicated, .Dietary . puree diet c (with) thickened liquids .(name of family member) only concerns is diet texture . Further review of Resident 24's Dietary, Nursing, and Hospice progress notes from June 2023 to March 2024, indicated there was no upgrade for Resident 24's diet. In addition, the hospice physician was not made aware of the family request or the nutrition recommendations. A review of Resident 24's plan of care, dated September 23, 2023, indicated, .Resident problems/concerns . potential for altered nutrition .interventions .review food likes and dislikes .fortified pureed diet with nectar thick liquids. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 28, 2024, at 2:54 p.m., the Dietary Supervisor (DSS) was interviewed. The DSS stated, she was aware of the family's request to upgrade the diet texture in June 2023. The DSS stated, the Registered Dietitian (RD) made a recommendation to hospice. On March 28, 2024, at 3:01 p.m., the RD was interviewed. The RD stated, she made a referral to the hospice MD. The RD stated, when a referral is made, the nursing staff should communicate the recommendations with hospice and process the recommendations. On March 29, 2024, at 5:01 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated when dietary recommendations are made, she would review them and make the hospice teams aware if residents were on hospice. The DON stated the licensed nurses were responsible for informing the hospice team about dietary recommendations. The DON stated she was not aware of the dietary preferences upgrade request made in June 2023 for Resident 24. The DON stated, the physician was not made aware of the recommendation and should have been informed of the dietary upgrade request. The facility policy and procedure titled Resident Examination and Assessment, dated January 2018, was reviewed. The policy indicated, .it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs .communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day .to ensure quality of care for the resident and family .ensuring that the LTC facility communicates with the hospice medical director, the resident's attending physician, and other practitioners participating in the provision of care to the resident as needed to coordinate the hospice care with the medical care provided by other physicians .		

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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. 46393 Based interview and record review, the facility failed to ensure accurate accountability of controlled medications (those with high potential for abuse or addiction) when random controlled medication use audits did not reconcile for two out of three residents (Residents 23 and 27). There was a total of 4 unaccounted controlled medications. This failure had the potential for misuse or abuse of controlled medications. Findings: The controlled drugs record (CDR, an inventory count sheet that keeps record of the usage of controlled medications) for three random residents receiving controlled medications were reviewed during the survey. 1. Resident 27 had a physician's order, dated February 3, 2024, for hydrocodone-acetaminophen (a potent controlled medication for pain) 10/325 milligrams (mg, unit of measurement) tablet, take 1 tablet by mouth every 6 hours as needed for moderate pain 4-6. During a concurrent interview and record review on March 26, 2024 at 3:09 p.m. with licensed vocational nurse (LVN) 2, Resident 27's CDR for hydrocodone-acetaminophen 10/325 mg and the Medication Administration Records (MAR) dated March 2024 were reviewed. a. The CDR for hydrocodone-acetaminophen 10/325 mg indicated the nursing staff removed one tablet on March 1, 2024 at 6:11 p.m. and on March 10, 2024 at 8:50 a.m. from the medication cart and documented on the CDR (meaning they removed the medication from the locked controlled medication compartment in the medication cart). The MAR indicated, on March 1, 2024 for the 6:11 p.m. administration and on March 10, 2024 for the 8:50 a.m. administration, there were no nursing staff initials in the box for Resident 27's hydrocodone-acetaminophen 10/325 mg, to demonstrate the medication was administered. LVN 2 stated, there was no documentation on the MAR that indicated Resident 27 received the hydrocodone-acetaminophen 10/325 mg on March 1, 2024 at 6:11 p.m and on March 10, 2024 at 8:50 a.m., and she said, there should have been. b. The CDR for hydrocodone-acetaminophen 10/325 mg did not indicate the nursing staff removed one tablet of hydrocodone-acetaminophen 10/325 mg on March 8, 2024 at 1:30 p.m. The MAR indicated, on March 8, 2024 for the 1:30 p.m. administration, the nursing staff wrote their initials in the box for Resident 27's hydrocodone-acetaminophen 10/325 mg to demonstrate the medication was administered. Additionally, the nursing staff documented on the back page of the MAR: 3/8 Norco [brand name for hydrocodone-acetaminophen] 10/325 mg at [1:30 p.m.] . and signed with their signature (meaning they administered the medication to Resident 27). LVN 2 acknowledged, there was no documentation on the CDR to indicate the nurse removed the hydrocodone-acetaminophen 10/325 mg tablet from the locked controlled medication compartment in the medication cart. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on March 27, 2024 at 3:09 p.m. with the Director of Nursing (DON), a review of Resident 27's CDR for the hydrocodone-acetaminophen 10/325 mg and MAR dated March 2024 reflected the nursing staff signed the hydrocodone-acetaminophen 10/325 mg tablet out of the CDR but did not document the respective administration on the MAR on March 1, 2024 at 6:11 p.m. and on March 10, 2024 at 8:50 a.m. Additionally the nurse documented the administration of 1 tablet of hydrocodone-acetaminophen 10/325 mg on the MAR on March 8, 2024 at 1:30 p.m. but did not document the removal of the medication from the medication cart on the CDR. The DON verified this finding and acknowledged 3 hydrocodone-acetaminophen 10/325 mg tablets were not accounted. The DON acknowledged the nurse should have documented in both places, on the CDR and on the MAR. 2. Resident 23 had a physician's order, dated February 24, 2024 for Percocet (oxycodone-acetaminophen, a potent controlled medication for pain) 10/325 mg tablet, take 1 tablet by mouth every 6 hours as needed for moderate (4-6) pain or severe (7-10) pain. During a concurrent interview and record review on March 27, 2024 at 11:20 a.m. with licensed LVN 1, Resident 23's CDR for Percocet 10/325 mg and the MAR dated March 2024 were reviewed. The CDR for Percocet 10/325 mg indicated the nursing staff removed one tablet on March 24, 2024 at 8:30 p.m. from the medication cart and documented on the CDR (meaning they removed the medication from the locked controlled medication compartment in the medication cart). The MAR indicated, on March 24, 2024 for the 8:30 p.m. administration, there were no nursing staff initials in the box for Resident 23's Percocet 10/325 mg, to demonstrate the medication was administered. LVN 1 stated, there was no documentation on the MAR that indicated Resident 23 received the Percocet 10/325 mg on March 24, 2024 at 8:30 p.m. During a concurrent interview and record review on March 27, 2024 at 3:22 p.m. with the DON, a review of Resident 23's CDR for the Percocet 10/325 mg and MAR dated March 2024 reflected the nursing staff signed the Percocet 10/325 mg tablet out of the CDR but did not document the respective administration on the MAR on March 24, 2024 at 8:30 p.m. The DON verified this finding and acknowledged 1 Percocet 10/325 mg tablet was not accounted. When asked why it is important to follow the process for controlled substance documentation of administrations, the DON stated, so we don't overdose, if not documenting right the next person could give a medication when a resident already received it. The DON added, it is also important for tracking usage to prevent diversion. During a review of the facility's policy and procedures (P&P) titled, Controlled Substances, revised April 2019, the P&P indicated, An individual resident controlled substance record is made for each resident who is receiving a controlled substance .Upon administration: The nurse administering the medication is responsible for recording: Name of resident receiving the medication; name, strength and dose of the medication; time of administration; method of administration, quantity of the medication remaining; and signature of the nurse administering the medication. During a review of the facility's P&P titled, Medication Administration, revised November 2017, the P&P indicated, Each dose administered to a resident shall be properly recorded in the resident's medical record . Each dose of PRN [as needed] medication that is administered must be explained as to time, dose, reason given, and effectiveness of the dose .The initials of the nurse must be recorded on the front of the med sheet .in the proper column for the correct date and time of the administration; Date, time, drug name, dose, route . reason given and effectiveness (result) must be indicated whenever a PRN med [medication] is administered. Documentation of PRN use is recorded on the back of the med sheet which shall include the nurse's signature .		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46393 Based on interview, and record review, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported irregularities during the monthly medication regimen review (MRR) for one of five sampled residents (Resident 4) when Resident 4 was administered Seroquel (an antipsychotic medication for bipolar disorder, depression, and schizophrenia) without manufacturer specified monitoring. This failure had the potential for the medication not being optimized for best possible health outcome, and unnecessary or prolonged use of the medication which could lead to adverse effects and unidentified risks associated with the use of psychotropic medications that included but not limited to sedation, respiratory depression, constipation, anxiety, agitation, and memory loss. Finding: During a review of Resident 4's Physician's Orders, dated June, 9, 2021, the Physician's Orders indicated, Resident 4 was admitted to the facility on [DATE] under the care of Hospice (focused on the care, comfort, and quality of life for person with a serious illness approaching the end of life), and had diagnoses including dementia. During a review of Resident 4's Face Sheet, dated October 12, 2023, the Face Sheet indicated, Resident became off from .Hospice effective date on 11/30/22 . During a review of Resident 4's Physician Progress Note, dated December 8, 2022, the Physician's Progress Note indicated, .new patient .now off hospice .[diagnosis] dementia .[medications] Seroquel . Resident 4's medical record indicated she had been receiving Seroquel in various doses since June 16, 2021. Her current Physician's Orders, dated July 14, 2023, indicated provider orders for: Quetiapine (Seroquel) 25 milligram (mg, unit of measurement) tab, take 1 tablet by mouth daily for dementia with psychotic features manifested by continuous yelling out .; Quetiapine (Seroquel) 50 mg tab, take 1 tablet by mouth at bedtime for dementia with psychotic features manifested by continuous yelling out .; and Monitor Side Effects of Seroquel (Quetiapine) .blood abnormalities . During a review of Resident 4's Medication Administration Record (MAR), dated March 1, 2024 through March 31, 2024, the MAR indicated, Monitor side effects of Seroquel (quetiapine) .blood abnormalities . (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on March 29, 2024 at 1:20 p.m. with the Director of Nursing (DON), Resident 4's medical record was reviewed. When asked if manufacturer specified monitoring for blood abnormalities, such as high cholesterol and high blood sugar, during the use of Seroquel was completed for Resident 4, the DON stated, I don't see any orders for labs [manufacturer specified monitoring]. The DON added, usually when a resident comes off hospice, doctor orders baseline labs or pharmacist recommends to order labs. The DON said, she will check with medical records. During a follow-up interview on March 29, 2024 at 4:02 p.m. with the DON, the DON stated, no documentation was found in Resident 4's medical record that labs were ordered or monitored during the use of Seroquel while admitted to the facility under hospice care on June 2021 and no labs ordered when the resident was taken off hospice care since November 2022. The DON added, it is important to monitor (the labs specified by the manufacturer) for adverse reactions to see if the medication needs to be discontinued. The DON verified there were no recommendations by the Consultant Pharmacist (CP) during monthly MRRs between January 1, 2023 to February 29, 2024 related to manufacturer specified monitoring for labs related to metabolic abnormalities during use of Seroquel for Resident 4. During a telephone interview on March 29, 2024 at 5:44 p.m. with the Consultant Pharmacist (CP), the CP stated, the antipsychotic use monitoring process included monitoring for behaviors and side effects. When asked regarding Resident 4 receiving Seroquel since June 2021 without manufacturer specified monitoring for labs related to metabolic abnormalities such as high cholesterol and high blood sugar, the CP acknowledged the resident should have been monitored and stated, Should monitor for lipids [cholesterol] and hyperglycemia [blood sugar]]. A review of the CP's monthly MRRs for Resident 4 from January 1, 2023 to February 29, 2024 indicated there were no recommendations from the CP related to the need for monitoring of manufacturer specified labs related to metabolic abnormalities during use of Seroquel for Resident 4. During a review of the facility's policy and procedures (P&P), titled Pharmacy Medication Regimen Review, revised November 2017, the P&P indicated, The consultant pharmacist performs the review of each resident's medication regimen monthly, which shall include but are not limited to all psychotropic .medication orders (active and discontinued) used since previous review .The consultant pharmacist documents in a separate written report any found irregularities .the procedure is as follows: .based on information gathered during mediation monitoring, the pharmacist evaluates (but not limited to): .recommended labwork . During a review of the facility's P&P titled, Antipsychotic Medication Use, dated December 2016, the P&P indicated, .Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the attending physician .increase in total cholesterol/triglycerides, unstable or poorly controlled blood sugar . A review of the Prescribing Information (PI, detailed description of a drug's uses, dosage range, side effects, drug-drug interactions, and contraindications that is available to clinicians) for Seroquel, revised January 2022, indicated, Warnings and Precautions .antipsychotic drugs have been associated with metabolic changes that include hyperglycemia [high blood sugar]/diabetes mellitus, dyslipidemia [high cholesterol] .Any patient treated with atypical antipsychotics should be monitored for symptoms of hyperglycemia . Dyslipidemia: Undesirable alterations have been observed in patients treated with atypical antipsychotics. Appropriate clinical monitoring .including fasting blood lipid testing at the beginning of, and periodically, during treatment .		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46393 Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 4) was free from unnecessary psychotropic (drugs that affects brain activities associated with mental processes and behavior) medications when Resident 4 was administered Seroquel (quetiapine, an antipsychotic medication for bipolar disorder, depression, and schizophrenia) without manufacturer specified monitoring. This failure had the potential for the medication not being optimized for best possible health outcome, and unnecessary or prolonged use of the medication which could lead to adverse effects and unidentified risks associated with the use of psychotropic medications that included but not limited to sedation, respiratory depression, constipation, anxiety, agitation, and memory loss. Finding: During a review of Resident 4's Physician's Orders, dated June, 9, 2021, the Physician's Orders indicated, Resident 4 was admitted to the facility on [DATE] under the care of Hospice (focuses on the care, comfort, and quality of life for person with a serious illness approaching the end of life), and had diagnoses including dementia. During a review of Resident 4's Face Sheet, dated October 12, 2023, the Face Sheet indicated, Resident became off from .Hospice effective date on 11/30/22 . During a review of Resident 4's Physician Progress Note, dated December 8, 2022, the Physician's Progress Note indicated, .new patient .now off hospice .[diagnosis] dementia .[medications] Seroquel . Resident 4's medical record indicated she had been receiving Seroquel in various doses since June 16, 2021. Her current Physician's Orders, dated July 14, 2023, indicated provider orders for: Quetiapine (Seroquel) 25 milligram (mg, unit of measurement) tab, take 1 tablet by mouth daily for dementia with psychotic features manifested by continuous yelling out .; Quetiapine (Seroquel) 50 mg tab, take 1 tablet by mouth at bedtime for dementia with psychotic features manifested by continuous yelling out .; and Monitor Side Effects of Seroquel (Quetiapine) .blood abnormalities . During a review of Resident 4's Medication Administration Record (MAR), dated March 1, 2024 through March 31, 2024, the MAR indicated, Monitor side effects of Seroquel (quetiapine) .blood abnormalities . (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on March 29, 2024 at 1:20 p.m. with the Director of Nursing (DON), Resident 4's medical record was reviewed. When asked if manufacturer specified monitoring for blood abnormalities, such as high cholesterol and high blood sugar, during the use of Seroquel was completed for Resident 4, the DON stated, I don't see any orders for labs [manufacturer specified monitoring]. The DON added, usually when a resident comes off hospice, doctor orders baseline labs or pharmacist recommends to order labs. The DON said, she will check with medical records. During a follow-up interview on March 29, 2024 at 4:02 p.m. with the DON, the DON stated, no documentation was found in Resident 4's medical record that labs were ordered during the use of Seroquel while admitted to the facility under hospice care on June 2021 and no labs ordered when the resident was taken off hospice care since November 2022. The DON added, it is important to monitor (the labs specified by the manufacturer) for adverse reactions to see if the medication needs to be discontinued. During a telephone interview on March 29, 2024 at 5:44 p.m. with the Consultant Pharmacist (CP), the CP stated, the antipsychotic use monitoring process included monitoring for behaviors and side effects. When asked regarding Resident 4 receiving Seroquel since June 2021 without manufacturer specified monitoring for labs related to metabolic abnormalities such as high cholesterol and high blood sugar, the CP acknowledged the resident should have been monitored and stated, Should monitor for lipids [cholesterol] and hyperglycemia [blood sugar]]. During a review of the facility's policy and procedure (P&P) titled, Antipsychotic Medication Use, dated December 2016, the P&P indicated, .Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the attending physician .increase in total cholesterol/triglycerides, unstable or poorly controlled blood sugar . A review of the Prescribing Information (PI, detailed description of a drug's uses, dosage range, side effects, drug-drug interactions, and contraindications that is available to clinicians) for Seroquel, revised January 2022, indicated, Warnings and Precautions .antipsychotic drugs have been associated with metabolic changes that include hyperglycemia [high blood sugar]/diabetes mellitus, dyslipidemia [high cholesterol] .Any patient treated with atypical antipsychotics should be monitored for symptoms of hyperglycemia . Dyslipidemia: Undesirable alterations have been observed in patients treated with atypical antipsychotics. Appropriate clinical monitoring .including fasting blood lipid testing at the beginning of, and periodically, during treatment .		

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 48240 Based on observation, interview, and record review, the facility failed to have a full-time director of food and nutrition services. The lack of a full-time, qualified supervision over Food and Nutrition services had the potential to result in residents not being assessed regarding their nutritional needs, as well as lack of oversight of food preparations, services, and storage for 30 residents. Findings: On March 26, 2024, at 9:31 a.m., an interview with Cook (CK) 1 was conducted. CK 1 stated there was no Dietary Supervisor (DSS) for about a month now. On March 26, 2024, at 3:15 p.m., an interview was conducted with the DSS. The DSS stated she worked full time until February 28, 2024, then transitioned to on-call (expected to be available at any time, usually with short notice) until the facility could find a replacement. On March 28, 2024, at 10:04 a.m., an interview with the Administrator (ADM) was conducted. The ADM acknowledged the facility did not have a full-time DSS. On March 28, 2024, at 11:05 a.m., an interview with the Registered Dietitian (RD) was conducted. The RD stated, she visited the facility once a week and worked 24 hours per month. A review of the facility's payroll work hours for the DSS, indicated, the DSS worked on the following dates: - March 4, 2024 - 0.78 hours (hrs); - March 6, 2024 - 0.5 hrs.; - March 7, 2024 - 1 hr.; - March 8, 2024 - 1.79 hrs.; - March 13, 2024 - 0.5 hrs.; - March 15, 2024 - 3.5 hrs.; - March 18, 2024 - 1.47 hrs.; - March 22, 2024 - 1.21 hrs.		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 44504 Based on observations, interviews, and record reviews the facility failed to ensure dietary staff were able to carry out the functions of food and nutrition services safely and effectively when: 1. Food service workers did not recognize that the Quat sanitizer concentration was not at the right concentration; (Cross referred F 812) This failure had the potential to cause foodborne illness for 30 out of 31 sampled residents who received foods from the kitchen. 2. Diet Aide 1 and Cook 2 were unable to properly clean working surface; This failure had the potential to cause foodborne illness for 30 out of 31 sampled residents who received foods from the kitchen. 3. Cook 2 did not follow the menu for serving on 3/27/24 lunch; (Cross referred F 803 and F 804) This failure had the potential for 30 out of 31 residents receiving food prepared in the kitchen do not meet their nutritional needs which may lead to nutritional related health complications. 4. Diet Aide served Jello to residents who require nectar thick consistency (Cross referred F 805); and This failure had the potential risk of aspiration for two of two sampled residents, Residents 6 and 24 who received nectar thick consistency from the kitchen. 5. Cook 2 did not know the right concentration of chlorine (sanitizer) for the dish machine. This failure had the potential to cause foodborne illness for 30 out of 31 sampled residents who received foods from the kitchen. Findings: 1. A review of the Quat sanitizer bottle's guidelines showed appropriate sanitizing levels were 200-400 ppm. On March 26, 2024, at 10:10 a.m., a concurrent observation and interview were conducted with Dietary Aide 1 (DA 1). DA 1 was asked to test the Quat sanitizer solution in the sanitizer bucket. The sanitizer test strip read between 100 -200 ppm (parts per million). DA 1 stated the test strip should read 100 -200 ppm and the sanitizer was at the right concentration. (continued on next page)		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On March 26, 2024, at 11:06 a.m., a concurrent observation and interview were conducted with Cook 2 (CK 2). CK 2 was observed testing the Quat sanitizer solution in the sanitizer bucket. The sanitizer test strip read between 100 -200 ppm. CK 2 stated the test strip should read between 200-400 ppm. CK 2 hesitated for few seconds and stated the sanitizer was at the right concentration even though it was under 200 ppm. CK 2 did not throw away or change the sanitizer and continue let the kitchen used the sanitizer. On March 26, 2024, at 4:00 p.m., a concurrent observation and interview were conducted with the Dietary Supervisor (DSS). The DSS was observed testing the Quat sanitizer solution in the sanitizer bucket. The sanitizer test strip read between 100 -200 ppm. The DSS stated the test strip should read 100 -200 ppm and the sanitizer currently was at the right concentration. On March 27, 2024, at 12:22 p.m., a concurrent observation and interview were conducted with Dietary Aide 2 (DA 2). DA 2 was observed testing the Quat sanitizer solution in the sanitizer bucket. The sanitizer test strip read between 100 -200 ppm. DA 2 stated the test strip should read 200 ppm. DA 2 unsure the sanitizer was in right concentration. DA 2 seek guideline with CK 2. CK 2 stated the sanitizer was in right concentration with under 200 ppm. On March 28, 2024, at 12:06 p.m., a concurrent observation, interview, and Quat sanitizer's bottle instructions review was conducted with the Registered Dietitian (RD). The RD was observed testing the Quat sanitizer solution. The sanitizer test strip read between 100 -200 ppm. The RD stated that is right concentration. A review of the Quat sanitizer bottle's instructions indicated, .To sanitize .apply 200 -400 ppm active quaternary (Quat) solution . During a review of the facility's Policy and Procedure (P&P) titled, Sanitizer bucket for cleaning cloths, dated 1/1/2017, the P&P indicated, 1. Sanitizer buckets are filled with . an appropriate sanitizer at a high concentration to ensure that the solution stays effective Quat ppm at 200 .6 While dispenser pumps set up by the chemical company may be used, it is the responsibility of the staff to ensure that sanitizing is at an effective level . 2. During a general food production observation on March 27, 2024, at 10:27 a.m., Diet Aide 1 (DA 1) was observed cleaning the Prep table after preparing raw chicken. DA 1 only used green bucket detergent to clean the Prep table. When interviewed, DA 1 stated the green bucket contained soap and she used the soap to clean the Prep table. During a general food production observation on March 27, 2024, at 11:08 a.m., Cook 2 (CK 2) was observed cleaning the Prep table after preparing mashed potatoes. CK 2 only used red bucket sanitizer to clean the Prep table. On March 28, 2024, at 11:05 a.m., an interview with the RD was conducted. The RD stated the proper way to clean the Prep table surfaces was to clean with detergent, rinse and sanitize to minimize the soil and microbial contamination. (continued on next page)		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled, Cleaning and Sanitizing - Basics, dated 2018, the P&P indicated, When cleaning and sanitizing any food contact surface, it is extremely important . Clean and sanitize in place method (for .work table surfaces) 1. Clean items with warm water and detergent. 2. Rinse with clear warm water. 3. Sanitizer surfaces with .Quaternary Ammonia (Quat) 200 ppm/ 1 minute . During a review of the facility Job Description, titled Food and Nutrition Services Aide (kitchen Aide), dated 1/1/2017, the job description indicated, Primary function: Under general supervision performs a variety of simple, routine tasks related to the preparation and serving of foods; to clean kitchen area .Worked performed: .2. Cleans work area according to directions . During a review of the facility Job Description, titled Cook, dated 1/1/2017, the job description indicated, Primary function: .maintains area utilizing high standard of sanitation . 3. During a food production observation on March 27, 2024, between 10:00 a.m. until 12:30 a.m., Cook 2 did not follow menu for serving lunch on 3/27/24. a. Pureed chicken was being served to puree diets by using a # 8 scoop; whereas the menu specified a # 10 scoop; b. Three Potatoes wedges were being served to regular diets; whereas the menu specified four potato wedges; and c. Spinach was being served to all diets except pureed spinach using a #10 scoop; whereas the menu specified a # 8 scoop. d. CK 2 did not follow the pureed chicken and spinach recipes by adding water and thickener. e. CK 2 did not serve biscuit per menu for Regular diets, small portion, large portion, Mechanical soft diets, and Carbohydrate control diets (a meal plan for Diabetic resident). f. CK 2 did not serve gravy per menu for puree diets. On March 28, 2024, at 11:05 a.m., an interview was conducted with the RD. The RD stated cooks should follow the menu. During a review of the facility Job Description, titled Cook, dated 1/1/2017, the job description indicated, Primary function: Under general supervision prepared food for residents using menu and standardized recipes.Worked performed: .3. Follows menu and recipes . 4. On March 27, 2024, at 12:35 p.m., during a lunch tray assembly observation in the kitchen with DA 2, DA 2 served Jello to Residents 6 and 24 who required nectar thick liquids. On March 27, 2024, at 12:54 p.m., a concurrent observation and interview with the Activity Director (AD) was conducted in the dining room. The AD verified Resident 24 was on nectar thick consistency and received Jello on her meal tray. (continued on next page)		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On March 27, 2024, at 1:14 p.m., a concurrent observation and interview with Certified Nurse Aide 1 (CNA 1) was conducted at Resident 6's bedside. CNA 1 stated Resident 6 received Jello with her meal and Resident 6 finished the Jello. On March 28, 2024, at 11:05 a.m., an interview was conducted with the RD. The RD stated residents on nectar thick consistency should not receive Jello because Jello melts in the mouth, it turned into a thin liquid. According to the International Dysphagia Diet Standardization Initiative (IDDSI) framework (is an international set of descriptors describing texture modified foods and thickened liquids for people with eating, drinking and swallowing problems (dysphagia) across the lifespan) describes edible gelatin, indicated, .Per testing and due to the challenging and variable nature of gelatin/Jell-O preparations across the USA, it is best practice to have gelatin/Jell-O only on the Regular, . Thin Liquid .https://iddsi.org/IDDSI/media/images/Posters/GELATIN-JELLO-FAQ-USIRG-CHART-FINAL.pdf During a review of the facility Job Description, titled Food and Nutrition Services Aide (kitchen Aide), dated 1/1/2017, the job description indicated, Primary function: Under general supervision performs a variety of simple, routine tasks related to the preparation and serving of foods .Work performed . 2. Sets up trays accurately . 5. On March 27, 2024, at 3 p.m., a concurrent observation, interview and dish machine Operational Requirements review were conducted with CK 2. CK 2 was observed checking the chlorine of the dish machine. The chlorine test strip read between 100 -200 ppm. CK 2 stated the test strip should read between 100-200 ppm and it was at the right concentration. During a review of the dish machine Operational Requirements posted on the dish machine, it was indicated that it required 50 ppm available chlorine. On March 28, 2024, at 11:05 a.m., an interview was conducted with the Registered Dietitian (RD). The RD stated the dish machine chlorine should read bet 50 -100 ppm. During a review of the facility Job Description, titled Cook, dated 1/1/2017, the job description indicated, Primary function .maintains area utilizing high standard of sanitation .		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 44504 Based on observation, interview, and facility document review, the facility failed to ensure the menus were followed and resident nutritional needs were met when: 1. Correct portion sizes were not followed; 2. The Cook did not serve biscuit during lunch on 3/27/2024; and 3. The Cook did not serve gravy for pureed diet during lunch on 3/27/2024. These failures had the potential for 30 out of 31 residents receiving food prepared in the kitchen do not meet their nutritional needs which may lead to nutritional related health complications. Finding: (Cross referred 802) 1. On March 27, 2024, at 12:21 p.m., an interview was conducted with Cook 2 (CK 2) in front of Trayline (a system of food preparation in which trays move along an assembly line). CK 2 stated he was going to use a grey scoop numbered 8 to serve pureed chicken, and an ivory scoop numbered 10 to serve Spinach. On March 27, 2024, at 12:30 p.m., an observation of the lunch meal plating service was conducted with CK 2. The following were observed: Pureed chicken was being served to the pureed diets using a # 8 scoop; Three Potatoes wedges was being served to the regular diet; and Spinach was being served to all diets except pureed spinach using a #10 scoop. A review of the facility document titled Daily Cook's Menu, dated Week 3, Wednesday, Standard Spring 2024, indicated, # 10 scoop pureed chicken was to be served, 4 wedges Potato was to be serve to regular diet and # 8 scoop (1/2 cup) Spinach was to be served to all other diets . On March 27, 2024, at 3:16 p.m., an interview was conducted with the Dietary Supervisor (DSS). The DSS stated it was very important to follow menu's portion sizes when serving the residents because dietary staff did not want to over or underserve portions to the residents. The DSS explained underserved portion sizes could cause residents to not get enough nutrients while overserved portion sizes could lead to residents receiving many nutrient resulting in unplanned weight gain. On March 28, 2024, at 11:05 a.m., an interview was conducted with the Registered Dietitian (RD). The RD stated cooks should follow the menu. A review of the facility document titled, The Facility's Resident Diet List, dated March 26, 2024, indicated seven residents, Residents 1, 6, 8, 9, 10, 14, and 24 were on a pureed diet. (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility document titled, The Facility's Resident Diet List, dated March 26, 2024, indicated eight residents, Residents 5, 13, 18, 22, 28, 30, 36, and 38 were on a regular diet. A review of the facility's Policy and Procedure (P&P) titled, Portion Control, undated, the P&P indicated, Policy: Individual will receive the appropriate portions of food as outlined on the menu. Control at the point of service is necessary to assure that accurate portion sizes are served. Procedure .2. The menu should list the specific portion size for each food item .3. Food should be served with .scoops .of standard sizes .a. Portions that are too small result in the individual not receiving the nutrients needed. b. Portions that are too large increase food costs as well as providing the individual with more food that needed . A review of the facility's Policy and Procedure (P&P) titled, Menu Guidelines, dated 1/1/2017, the P&P indicated, Policy: To prepare foods according to the menu .Procedures .a. Correct portion size will be given per menu pattern; . 2. On March 27, 2024, at 12:30 p.m., an observation of the lunch meal plating service was conducted with CK 2 in front of the trayline. There were no biscuits available in the trayline. A review of the facility document titled Daily Cook's Menu, dated Week 3, Wednesday, Standard Spring 2024, indicated, Biscuit was to be served to Regular diet, small portion, large portion, Mechanical soft diet, and Carbohydrate control diet [(CCHO) a meal plan for diabetic residents]. On March 27, 2024, at 3:16 p.m., an interview was conducted with the DSS. The DSS stated CK 2's usual assignment was preparing evening meal and today he was being asked to cook the noon meal, which was not his usual assignment. The DSS acknowledged that even though preparing the noon meal was not CK 2's usual assignment, CK 2 still needed to prepare and serve all food items on the menu to residents. On March 28, 2024, at 11:05 a.m., an interview was conducted with the RD. The RD stated cooks should follow the menu. A review of the facility document titled, The Facility's Resident Diet List, dated March 26, 2024, indicated Residents 2, 4, 5, 7, 12, 13, 16, 17, 18, 20, 21, 22, 23, 27, 28, 29, 30, 32, 35, 36, 38, and 93 were on a regular diet, small portion, large portion, Mechanical soft diet and CCHO diet. A review of the facility's Policy and Procedure (P&P) titled, Menu Guidelines, dated 1/1/2017, the P&P indicated, Policy: To prepare foods according to the menu . 3. On March 27, 2024, at 12:30 p.m., an observation of the lunch meal plating service was conducted with CK 2 in front of the trayline. There was no gravy available on the trayline. A review of the facility document titled Daily Cook's Menu, dated Week 3, Wednesday, Standard Spring 2024, indicated, Gravy was to be served to Pureed diet. On March 27, 2024, at 3:16 p.m., an interview was conducted with the DSS. The DSS stated CK 2 usual assignment was preparing evening meal and today he was being asked to cook noon meal which was not his usual assignment. The DSS acknowledged even though preparing noon meal was not CK 2's usual assignment, CK 2 still needed to prepare and serve all food items on menu. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48240 Based on observation, interview, and record review, the facility failed to ensure the recipe for preparing puree was followed for seven of seven residents (Residents 1, 6, 8, 9, 10, 14 and 24) receiving pureed (any food item that has been processed into a smooth and uniform texture) foods. This failure had the potential to compromise the nutritional status of Residents 1, 6, 8, 9, 10, 14, and 24 resulting in decreased oral intake and weight loss. Findings: (Cross referred 802) On March 27, 2024, at 11:40 a.m., a concurrent observation of the puree preparation for lunch and interview with Cook (CK) 2 were conducted. CK 2 placed seven pieces of chicken into the blender, added unmeasured hot water, and blended. After the chicken was pureed, CK 2 transferred the chicken into a pan, and the end product of pureed chicken came out with a running/ watery consistency. CK 2 stated he added about a quart (a unit of measurement) of water to the chicken in the blender. CK 2 stated he added 1/2 cup of thickener (a thickening agent that increases the viscosity of a liquid) to the pureed chicken to make a smooth pudding consistency. On March 27, 2024, at 12:01 p.m., a concurrent observation and interview were conducted with CK 2. CK 2 was observed preparing pureed spinach. After the spinach was pureed, CK 2 transferred the spinach into a pan, and the end product of pureed spinach came out with a watery/running consistency. CK 2 stated, he added unmeasured amount of cooked spinach, half a quart [16 (ounce) a unit of measurement] of hot water and half a quart of spinach juice to make pureed spinach. CK 2 further stated, he added 1/2 cup of thickener to the pureed spinach to achieve a pudding consistency. On March 27, 2024, at 3:16 p.m., an interview was conducted with the Dietary Service Supervisor (DSS). The DSS stated plain water should not be added to make pureed food. The DSS stated by adding water, the nutritive value of the foods would decrease and it would also dilute the flavor. On March 28, 2024, at 11:05 a.m., an interview was conducted with the Registered Dietitian (RD). The RD stated by adding plain water to make puree, food will become diluted and thinner. The RD further stated, chicken broth should have been added if it was for chicken. A review of facility document titled, (name of the facility) Diet List, dated March 26, 2024, was reviewed. The document indicated the following: Resident 1 .Diet Order .Regular-Puree . .Resident 6 .Diet Order .Fortified-Puree-Nectar Thick Liquids . .Resident 8 .Diet Order .Fortified-Puree . .Resident 9 .Diet Order .Fortified-Puree . .Resident 10 .Diet Order .Fortified Puree . (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.Resident 14 .Diet Order .Regular-Puree-Large Portions . .Resident 24 .Diet Order .Fortified-Puree-Nectar Thick Liquids . A review of the facility's General Description of Diet titled, Pureed Diet, dated 2017, indicated, The Pureed diet is recommended for residents who have difficulty chewing and /or swallowing, missing teeth or poorly fitting dentures. The texture of the food should be smooth and moist; the consistency, thick and able to hold its shape (mashed potato or pudding like consistency) .Food that is pureed to a runny consistency can be unappetizing . A review of the facility's Recipe titled, Chicken, for the period 3/11/2024 - 6/9/2024, indicated, .PUREE: .Add 1 tablespoon broth, gravy, or sauce cover securely. Blend until smooth .Add additional broth gravy, or sauce as needed. Continue blending until pudding like consistency is reached . A review of the facility's Recipe titled, Spinach, for the period 3/11/2024 - 6/9/2024, indicated, .PUREE: Place number of portions needed of prepared product in blender or food processor. Gradually add 1-1/2 teaspoon thickener for each portion. Blend until smooth .Continue blending until pudding -like consistency is reached .		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 48240 Based on observation, interview and record review, the facility failed to ensure the appropriate liquid texture was provided when two of two (Residents 6 and 24) did not receive nectar thick liquids as prescribed by the physician and the residents were served jello during lunch on March 27, 2024 . This failure had the potential to place the residents at risk for aspiration (when food is breathed into the lungs). Findings: (Cross referred F802) a. A review of Resident 6's physician orders for March 2024, indicated a fortified pureed diet with nectar thick liquids was ordered on November 22, 2022. On March 27, 2024, at 1:14 p.m., a concurrent observation of Resident 6 and an interview with Certified Nurse Assistant (CNA) 1 were conducted. Resident 6 was observed in her room, head of bed elevated and was being fed by CNA 1. CNA 1 stated he fed Resident 6 jello and was offered to drink milk served with her meal tray. On March 27, 2024, at 1:31 p.m., an interview with the Dietary Service Supervisor (DSS) was conducted. The DSS stated Resident 6's milk had chunks of thickener (a thickening agent that increases the viscosity of a liquid) at the bottom of the glass. The DSS explained the provided milk was not in nectar thick consistency due to dietary staff not stirring the thickener well. The DSS stated the potential risk of not providing nectar thick consistency per physician order was aspiration. The DSS also stated residents on nectar thickened liquid should not receive jello. b. A review of Resident 24's physician orders for March 2024, indicated a fortified pureed diet with nectar thickened liquid was ordered on October 9, 2023. On March 27, 2024, at 12:54 p.m., a concurrent observation of Resident 24 and an interview with the Activity Director (AD) were conducted in the dining room. Resident 24 was observed sitting on a geri chair (a specialized chair), with milk and jello (gelatin) on her meal tray. The AD assisting Resident 24 stated jello was provided for Resident 24. On March 27, 2024, at 1:08 p.m., an interview with the Infection Preventionist (IP) was conducted in the dining room. The IP stated Resident 24's milk on the meal tray did not look like nectar thick consistency. On March 28, 2024, at 11:05 a.m., an interview with the Registered Dietitian (RD) was conducted. The RD stated, thickened liquids should be mixed well with no visible chunks of thickener on bottom of glass to make the right consistency of fluid. The RD further stated residents on nectar thickened liquid should not receive jello because when jello melted into the mouth, it turned into a thin liquid. (continued on next page)		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's undated policy and procedure titled, Thickened Liquids, was reviewed. The policy indicated, .it is the policy of this facility to ensure that individuals requiring thick liquids receive the appropriate consistency .thin liquids will be thickend according to MD order in the dietary Department .this applies to all liquids being served to individuals including milk . According to the International Dysphagia Diet Standardization Initiative framework (is an international set of descriptors describing texture modified foods and thickened liquids for people with eating, drinking and swallowing problems across the lifespan) describes edible gelatin, indicated, .Per testing and due to the challenging and variable nature of gelatin/Jell-O preparations across the USA, it is best practice to have gelatin/Jell-O only on the Regular .Thin Liquid .		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 44504 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food preparation and storage practices in the kitchen when: 1. The Prep sink did not have an air gap (is vertical space between the end of a pipe and the top of a nearby sink that prevents the backflow of contaminated water); 2. The Quat sanitizer used to sanitize food preparation surfaces did not meet the right concentration requirements on 3/26/2024, 3/27/2024 and 3/28/2024; (Cross referred 802) 3. Dust was observed on several areas in the kitchen; 4. Reach in refrigerator shelves had chipped paint; 5. Several equipment in the kitchen found to have buildup; 6. Trash were found in multiple areas in the kitchen; 7. Inside the containers used to store clean scoops, utensils and lids had food residuals; 8. Broken tiles found under reach in refrigerator and utility area; 9. During thawing process, ground meat not fully submerged into running water; 10. Cook with facial hair did not wear hair restraint; 11. The dirty trash can touching several clean surfaces; 12. Rust found on several equipment in the kitchen; and 13. There were several food items that were open and exposed to the air in the reach in freezer. Having the food exposed to the air in the freezer could potentially cause freezer burn and affect the quality of the foods. These failures had the potential to cause foodborne illness (stomach illness acquired from ingesting contaminated food) in a medically vulnerable population of 30 out of 31 residents who received food prepared in the kitchen. 1. On March 26, 2024, at 10:31 a.m., during a concurrent observation and interview with Cook 1 (CK 1) in front of the Prep sink (sink used for washed produce), CK 1 stated he used the sink as Prep sink. CK 1 stated, there was no air gap for the Prep sink. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On March 26, 2024, at 3:15 p.m., an interview was conducted with the Dietary Supervisor (DSS) in front of the Prep sink. The DSS confirmed the Prep sink did not have an air gap. The DSS stated she was not aware the Prep sink needs an air gap. During a review of the U.S Food and Drug Administration's (FDA) Food Code 2022, Section 5-203.14 Backflow Prevention Device, the FDA Food Code indicated, A PLUMBING SYSTEM shall be installed to preclude backflow of a solid, liquid, or gas contaminant into the water supply system at each point of use at the FOOD ESTABLISHMENT, .backflow prevention is required by LAW, by: (A) Providing an air gap . 2. A review of the Quat sanitizer bottle's guidelines showed appropriate sanitizing levels were 200-400 ppm. On March 26, 2024, at 10:10 a.m., a concurrent observation and interview were conducted with Dietary Aide 1 (DA 1). DA 1 was asked to test the [NAME] sanitizer solution in the sanitizer bucket. The sanitizer test strip read between 100 -200 ppm (parts per million). DA 1 stated the test strip should read 100 -200 ppm and the sanitizer was in right concentration. On March 26, 2024, at 11:06 a.m., a concurrent observation and interview were conducted with Cook 2 (CK 2). CK 2 was observed testing the Quat sanitizer solution in the sanitizer bucket. The sanitizer test strip read between 100 -200 ppm. CK 2 stated the test strip should read between 200 -400 ppm. CK 2 hesitated for few seconds and stated the sanitizer was at the right concentration even though it was under 200 ppm. CK 2 did not throw away or change the sanitizer and continued to allow the kitchen to use the sanitizer. On March 26, 2024, at 4:00 p.m., a concurrent observation and interview were conducted with the Dietary Supervisor (DSS). The DSS was observed testing the Quat sanitizer solution in the sanitizer bucket. The sanitizer test strip read between 100 -200 ppm. The DSS stated the test strip should read 100 -200 ppm and the sanitizer currently was at the right concentration. On March 27, 2024, at 12:22 p.m., a concurrent observation and interview were conducted with Dietary Aide 2 (DA 2). DA 2 was observed testing the Quat sanitizer solution in the sanitizer bucket. The sanitizer test strip read between 100 -200 ppm. DA 2 stated the test strip should read 200 ppm. DA 2 was unsure if the sanitizer was at the right concentration and sought guideline from CK 2. CK 2 stated the sanitizer was at the right concentration with under 200 ppm. On March 28, 2024, at 11:05 a.m., an interview was with the Registered Dietitian (RD) was conducted. The RD stated if the Quat sanitizer did not meet the right concentration requirements per manufacturer guideline, it would be ineffective to sanitize food preparation surfaces. On March 28, 2024, at 12:06 p.m., a concurrent observation, interview, and Quat sanitizer's bottle instructions review were conducted with the Registered Dietitian (RD). The RD was observed testing the Quat sanitizer solution. The sanitizer test strip read between 100 -200 ppm. The RD stated that is right concentration. A review of the Quat sanitizer bottle's instructions indicated, .To sanitize .apply 200 -400 ppm active quaternary (Quat) solution . During a review of the facility's Policy and Procedure (P&P) titled, Cleaning and Sanitizing - Basics, dated 2018, the P&P indicated, .Always refer to manufacturer's recommendation of dilution strength . (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's Policy and Procedure (P&P) titled, Sanitizer bucket for cleaning cloths, dated 1/1/2017, the P&P indicated, .1. Sanitizer buckets are filled with . an appropriate sanitizer at a high concentration to ensure that the solution stays effective (Quat ppm at 200 .6 .While dispenser pumps set up by the chemical company may be used, it is the responsibility of the staff to ensure that sanitizing is at an effective level . 3. On March 26,2024, at 3:15 p.m., a concurrent observation and interview with the DSS was conducted, in the kitchen. The DSS confirmed brown debris was dust on the wall next to the entrance door. On March 26,2024, at 3:17 p.m., a concurrent observation and interview with the DSS was conducted, at the beverage Prep area. The DSS confirmed brown debris was dust underneath Prep table where clean serving cups stored on the bottom of the Prep table. On March 26,2024, at 3:19 p.m., a concurrent observation and interview with the DSS were conducted, next to oven. The DSS confirmed dust was hanging on silver shelves. On March 26,2024, at 3:20 p.m., a concurrent observation and interview with the DSS were conducted, in front of dish machine. The DSS confirmed black debris was dust hanging on the exhaust fan above dish machine. On March 27,2024, at 3:13 p.m., a concurrent observation and interview with the DSS were conducted, inside the walk-in refrigerator. The DSS confirmed black debris was dust hanging on the wires inside walk-in refrigerator near the entrance door. The DSS stated dust should not be found in the kitchen which could cause cross contamination. On March 28,2024, at 11:05 a.m., an interview with the RD was conducted. The RD stated dust should not be found in the kitchen and needs to be removed. During a review of the U.S Food and Drug Administration's (FDA) Food Code 2022, indicated, Cleanliness of the food establishment is important to minimize attractants for insects and rodents, aid in preventing the contamination of food and equipment, and prevent nuisance conditions. During a review of the U.S Food and Drug Administration's (FDA) Food Code 2022, indicated, Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. Also, The objective of cleaning focuses on the need to remove . soil from non-food contact surfaces so that pathogenic microorganisms will not be allowed to accumulate, and insects and rodents will not be attracted. 4. On March 26,2024, at 3:15 p.m., a concurrent observation and interview with the DSS were conducted, in front of the reach-in refrigerator. The DSS confirmed there were four out of seven grey shelves had chipped paint. The DSS stated grey shelves not supposed to have chipped paint. During a review of the U.S Food and Drug Administration's (FDA) Food Code 2022, indicated, food-contact surfaces and utensils are to be clean to sight and touch and utensils and food contact surfaces of equipment are to have a smooth, easily cleanable surface and resistant to scratching, pitting, and decomposition. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. On March 26,2024, at 3:15 p.m., a concurrent observation and interview with the DSS was conducted. Several equipment in the kitchen found to have buildup of grime. a. Microwave; b. The reach in refrigerator's door; c. The reach in refrigerator's hinge; d. Underneath Pre table next to dry storeroom where on bottom stored clean kitchen ware; e. Oven range; and f. Inside both oven. The DSS confirmed buildup of grime found on those equipments. The DSS stated buildup of grime was not supposed to be on those equipment because it could cause cross contamination. On March 28,2024, at 11:05 a.m., an interview with the RD was conducted. The RD stated buildup grime not supposed be on the equipment, the equipment needed to be clean. During a review of the U.S Food and Drug Administration's (FDA) Food Code 2022, 4-602.13 Nonfood-Contact Surfaces , the Food code indicated, The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. During a review of the U.S Food and Drug Administration's (FDA) Food Code 2022, indicated, Cleanliness of the food establishment is important to minimize attractants for insects and rodents, aid in preventing the contamination of food and equipment, and prevent nuisance conditions. 6. On March 26,2024, at 3:15 p.m., a concurrent observation and interview with the DSS were conducted. There was food debris found on the floor under oven. The DSS confirmed food debris found on the floor under oven. On March 26,2024, at 3:26 p.m., a concurrent observation and interview with the DSS were conducted. A dirty mug, a dirty cup, 4 oz shake, dust, condiments, and trash were found on the floor under the reach-in refrigerator. The DSS confirmed there was a dirty mug, a dirty cup, 4 oz shake, dust, condiments, and trash on the floor under the reach-in refrigerator. The DSS stated food debris and trash on the floor could attract pests to the kitchen. On March 28,2024, at 11:05 a.m., an interview with the RD was conducted. The RD stated food debris, trash, and dust should not be on the floor. The kitchen floor needs to be kept clean. During a review of the U.S Food and Drug Administration's (FDA) Food Code 2022, indicated, Cleanliness of the food establishment is important to minimize attractants for insects and rodents, aid in preventing the contamination of food and equipment, and prevent nuisance conditions. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. On March 26, 2024, at 3:15 p.m., a concurrent observation and interview with the DSS were conducted. There were food residuals found inside the pan used to stored clean lids. Food residuals were also found inside two plastic containers used to store clean scoops and utensils. The DSS confirmed food residuals were found inside the pan and two plastic containers used to store clean lids, scoops and utensils. The DSS stated pan and plastic containers should be clean. The DSS stated the potential risk having food residuals inside the pan and plastic containers was cross contaminate the clean lids, scoops, and utensils. On March 28, 2024, at 11:05 a.m., an interview with the RD was conducted. The RD stated the pans and plastic containers used to store clean lids, scoops and utensils needed to keep clean. On March 28, 2024, at 4:00 p.m., an interview with the DSS was conducted. The DSS stated the facility did not have policy and procedure for sanitation or general cleanness of the kitchen. During a review of the U.S Food and Drug Administration's (FDA) Food Code 2022, 4-602.13 Nonfood-Contact Surfaces , the Food code indicated, The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. 8. On March 27, 2024, at 3:26 p.m., a concurrent observation and interview with the DSS was conducted. There was a broken tile found under the reach in refrigerator floor and utility area. The DSS confirmed the broken tiles under the reach in refrigerator floor and utility area. The DSS stated kitchen could not have broken tiles because the bacteria could get into the broken tiles and grow inside the broken tiles and then spread in the kitchen. On March 28, 2024, at 11:05 a.m., an interview with the RD was conducted. The RD stated the kitchen should try to maintain good working floor condition so dietary staff could clean and sanitizer the floor properly. During a review of the U.S. FDA (Food and Drug Administration) Food Code 2022, Annex Section 6-201.11 Cleanability Floors, walls, and Ceilings the FDA Food Code indicated, .Floors that are of smooth, durable construction and that are nonabsorbent are more easily cleaned. Requirements and restrictions regarding floor coverings, utility lines, and floor/wall junctures are intended to ensure that regular and effective cleaning is possible and that insect and rodent harborage is minimized . 9. On March 27, 2024, at 2:58 p.m., a concurrent observation and interview with CK 2 was conducted at the prep sink. There was a tub of ground meat only submerged 75 percent into running water in a small pan. CK 2 stated he was thawing the ground meat so he could use the ground meat for tonight dinner. On March 28,2024, at 11:05 a.m., an interview with the RD was conducted. The RD stated when thawing of foods, they needed to fully submerged under running water. During a review of the facility's Policy and Procedure (P&P) titled, Thawing of Food, dated 1/1/2017, the P&P indicated, Time/Temperature control (TCS/PHF) foods shall be thawed only: .b. Completely submerged under potable running water ., and with sufficient velocity to agitate and flush off loose food particles into the sink drain. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10. During general food production observation on March 27, 2024, at 10:59 a.m., CK 2 was noted to have facial hair without covering. The DSS was confirmed CK 2 had facial hair without covering. The DSS stated CK 2 need to cover his facial hair while working in the kitchen. During a review of the facility's Policy and Procedure (P&P) titled, Hair Nets and Personnel Permitted in Food & Nutrition Services Department, dated 1/1/2017, the P&P indicated, Dietary (Food and Nutrition Services) staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent their hair from contacting exposed food. 11. On March 26, 2024, at 11:35 a.m., an observation was conducted in kitchen. A big grey dirty trash can lined between a clean can opener and clean coffee cart. And they were touching each other. On March 26, 2024, at 3:15 p.m., an interview with the DSS was conducted. The DSS stated the big grey dirty trash can not supposed lined between a clean can opener and clean coffee cart and touching each other because it could cause cross contamination. On March 27, 2024, at 10:12 a.m., an observation was conducted in utility area. The same big grey dirty trash can touch the clean kitchenware stored in utility area. On March 28,2024, at 11:05 a.m., an interview with the RD was conducted. The RD stated the big grey dirty trash can not supposed to touch any clean surface due to potential cross contamination. During a review of the U.S Food and Drug Administration's (FDA) Food Code 2022, indicated, Cleanliness of the food establishment is important to minimize attractants for insects and rodents, aid in preventing the contamination of food and equipment, and prevent nuisance conditions. 12. On March 26,2024, at 3:15 p.m., a concurrent observation and interview with the DSS were conducted. The white rack used to dry dome (a piece of kitchen equipment used as a cover to keep food hot) had brown grime. The DSS verified brown grime was rust. On March 26,2024, at 3:17 p.m., a concurrent observation and interview with the DSS was conducted in utility area. The silver shelves used to store clean kitchenware had rust. The DSS confirmed rust on silver shelves. The DSS stated rust could get into clean dome and clean kitchen ware which could cause cross contamination. On March 27,2024, at 3:13 p.m., a concurrent observation and interview with the DSS was conducted. There was brown grime inside the ice cream freezer. The DSS confirmed the brown grime was rust. On March 28,2024, at 11:05 a.m., an interview with the RD was conducted. The RD stated rust not supposed found on drying rack, silver shelves and ice cream freezer. On March 28, 2024, at 4:00 p.m., an interview with the DSS was conducted. The DSS stated the facility did not have policy and procedure for rust. During a review of the U.S Food and Drug Administration's (FDA) Food Code 2022, indicated, food-contact surfaces and utensils are to be clean to sight and touch and utensils and food contact surfaces of equipment are to have a smooth, easily cleanable surface and resistant to scratching, pitting, and decomposition. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	13. On March 27, 2024, at 10:21 a.m., a concurrent observation and interview with the DSS was conducted. There was an opened bag of beef [NAME] and an opened bag of dice chicken exposed to the air in the reach-in freezer. The DSS confirmed an opened bag of beef [NAME] and an opened bag of dice chicken not sealed. The DSS stated opened food items in freezer needed to be sealed otherwise could cause freezer burn. On March 28, 2024, at 4:00 p.m., an interview with the DSS was conducted. The DSS stated the facility did not have policy and procedure for food items that were open and exposed to the air in the reach-in freezer.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055598	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024
NAME OF PROVIDER OR SUPPLIER The Bradley Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 980 West Seventh Street San Jacinto, CA 92582	
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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 36038 Based on interview and record review, the facility failed to electronically submit staffing information based on payroll data to the Federal (Center for Medicare & Medicaid Services- CMS) database for the first Fiscal Quarter of the year. This deficient practice prevented the provision of complete and accurate direct care staffing information to the public. Findings: During a review of the CMS PBJ (pay roll based journal) Staffing Data Report CASPER (Certification and Survey Provider Enhanced Report) FY (fiscal year) Quarter 1 (October 1- December 31) indicated, .Failed to submit Data for the Quarter . During an interview on March 28, 2024, at 3:30 p.m., with the Business Office Manager (BOM), the BOM stated, the Payroll Manager (PM) was responsible for submitting the report to CMS. During an interview on March 28, 2024, at 3:35 p.m., the PM stated, she had outsourced the PBJ reporting to a third party. The PM stated, the company contracted to handle the PBJ reporting encountered difficulties in submitting the report on February 9, 2024. The PM stated, she did not take any action and relied on the company. The PM further stated, the deadline for submission for the first Fiscal Quarter was the 14th of February. The PM stated, the PBJ report was not submitted to CMS. According to the manual for PBJ submission, the deadline for each reporting period, indicated: .FISCAL QUARTER .1 .REPORTING PERIOD .October 1- December 31 .DUE DATE .February 14 . FISCAL QUARTER 2 .REPORTING PERIOD .January 1- March 31 .DUE DATE .May 15 . FISCAL QUARTER . 3 .REPORTING PERIOD .April 1- June 30 .DUE DATE .August 14 . FISCAL QUARTER . 4 .REPORTING PERIOD .July 1- September 30 .DUE DATE .November 14 .		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055598	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024
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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. 46393 Based on observation, interview, and record review, the facility failed to ensure the infection prevention program was implemented when a facility staff did not disinfect the automatic blood pressure (BP-pressure of blood in blood vessels) cuff machine before and after residents' use according to the facility policy. This failure had the potential for the vulnerable residents to be exposed to cross-contamination and the development of infections. Findings: On March 27, 2024 at 8:43 a.m., a medication pass observation was conducted with Licensed Vocational Nurse (LVN) 2. LVN 2 was observed carrying an automatic BP cuff machine from on top the medication cart and then proceeded to Resident 21's room. LVN 2 applied the automatic BP cuff on Resident 21's right arm. After obtaining Resident 21's BP reading, LVN 2 removed the automatic BP cuff from Resident 21's arm and placed the automatic BP cuff machine on top of the medication cart. LVN 2 was not observed to have disinfected the automatic BP cuff machine before and after use on Resident 21. On March 27, 2024 at 8:53 a.m., a medication pass observation was conducted with LVN 2. LVN 2 retrieved the same automatic BP cuff machine from on top of the medication cart, and proceeded to Resident 5's room. LVN 2 applied the automatic BP cuff on Resident 5's right arm. After obtaining Resident 5's BP reading, LVN 2 removed the automatic BP cuff from Resident 5's right arm and placed the same automatic BP cuff machine on top of the same medication cart. LVN 2 was not observed to have disinfected the used automatic BP cuff machine before and after use on Resident 5. During an interview March 27, 2024 at 9:10 a.m. with LVN 2, LVN 2 stated she did not disinfect the automatic BP cuff machine before and after use on Residents 21 and Resident 5. LVN 2 further stated she should have used the disinfectant wipes to disinfect the used automatic BP cuff before and after each resident use. She said, I will do it right now. When asked why it is important to disinfect a shared BP cuff machine before and after use on each resident, LVN 2 stated, Important for infection control. During an interview March 27, 2024 at 3:01 p.m. with the Director of Nursing (DON), the DON stated the expectation is for nursing staff to clean and disinfect any equipment before and after use on each resident. (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 review of the facility's policy and procedure (P&P) titled, Cleaning and Disinfecting of Resident-Care Items and Equipment, dated October 2018, the P&P indicated, Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to the current CDC (Centers for Disease Control and Prevention- a nationally recognized disease control and prevention organization) recommendations for disinfection .Non-critical items are those that come in contact with intact skin but not mucous membrane .Non-critical resident-care items include .blood pressure cuffs . According to the CDC article titled, Disinfection and Sterilization Guideline for Disinfection and Sterilization in Healthcare Facilities, updated May 2019, .non-critical patient-care devices are disinfected when visibly soiled and on a regular basis .such as after use on each patient .		

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37536 Based on observation and interview, the facility failed to ensure the two resident bedrooms (rooms [ROOM NUMBERS]) did not accommodate more than four residents per room. This failure had the potential to have an adverse effect on the residents' safety and wellbeing. Findings: During the facility survey on March 26 to March 29, 2024, rooms [ROOM NUMBERS] were observed to have five beds which can accommodate five residents in each room. room [ROOM NUMBER] was observed to have five beds occupied by four residents. room [ROOM NUMBER] was observed to have five beds and currently being occupied by five residents. During the facility survey days on March 26 to March 29, 2024, no adverse effects impacting the quality of life of the residents residing in rooms [ROOM NUMBERS] were observed. On March 26, 2024, at 9:18 a.m., the Director of Nursing (DON) was interviewed. The DON stated, there was no complain from the residents regarding having five residents in the room. The DON stated, there was no quality of life issues.		