STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056024	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Palms Healthcare Center	7534 Palm Ave Highland, CA 92346

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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 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. Based on observation, interview, and record review, the facility failed to maintain a sanitary kitchen when the walk-in refrigerator had a wet box containing cold cut meat sitting on top of a thawing roast beef inside the container.This failure had the potential to cause food borne illness (illnesses contracted from eating contaminated food or beverages) to 91 of 91 medically compromised residents who received food from the kitchen.During a concurrent observation and interview on April 27, 2026, at 9:08 AM, with the Dietary Supervisor (DS), in the kitchen, the walk-in refrigerator was inspected. There was a wet box thawing inside a plastic container. When DS lifted the wet box, a thawed roast beef under was observed. DS opened the contents of the wet box and stated the box contained cold meat. and it was sitting on top of the thawing roast beef.During a follow up interview with DS on April 27, 2026, at 3:20 PM, DS stated, the box contains individually rapid cold cuts. DS stated, the cold cut should have been taken out of the box and placed on a pan.During a concurrent interview and record review on April 27, 2026, at 4:39 PM, with Administrator (Admin), the facility's policy and procedure (P&P) titled Thawing of Meats, dated 2023, was reviewed. The P&P indicated, . a. Use a drip pan under food being thawed so drippings do not contaminate other food. The Admin stated, the cold cut should have been taken out of the box and placed on a drip pan.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain infection control and prevention practices for two of four sampled residents (Resident 36 and 122) when:1.Resident 122's foley catheter bag (a drainage unit attached to an indwelling catheter to collect urine) was on the floor, while Resident 122 was in the dining room. 2.One Registered Nurse 1 (RN 1) carried pre-prepared Intravenous medication (IV- into the vein) in his scrub pocket before administering it through a peripherally inserted central catheter (PICC line - a very long thin flexible tube inserted into the large vein in the upper arm and threaded to a vessel just above the heart) to one vulnerable resident (Resident 36). These failures had the potential for compromising 91 vulnerable residents' health and safety, placing them at risk for infectious disease which may result in illness and adverse health outcomes. During a review of Resident 122's admission Record (contains demographic and medical information), it indicated Resident 122 was admitted to the facility on [DATE], with diagnoses which included urinary tract infection (a common infection caused by germs, usually bacteria, getting into any part of your urinary system and multiplying), bacteremia (the presence of bacteria in the bloodstream, often causing fever, chills, rapid heart rate, and fatigue) and chronic kidney disease (the long-term, progressive loss of kidney function). During a concurrent observation and interview on April 27, 2026, at 12:15 PM, with Treatment Nurse (TN), in the dining room area, Resident 122 was awake, sitting on his wheelchair, and his foley catheter bag was visible and touching the floor. The urine color appeared yellow and cloudy. Treatment Nurse (TN) stated the catheter bag was touching the floor, and that it was not supposed to be dragging on the floor. TN further stated the catheter bag had to be securely hanged on the side of the wheelchair because it was an infection control issue. During a concurrent interview and record review on April 28, 2026, at 2:12 PM, with the Director of Nursing (DON) and Administrator, the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, dated September 2014, was reviewed. The P&P indicated.Infection Control. 2. b. Be sure the catheter tubing and drainage bag are kept off the floor when identified. Both Administrator and DON stated the P&P was not followed. The Administrator further stated catheter bag should have been off from the floor for infection control. 2.During a review of facility's documents for Resident 36's AR, dated April 23, 2026, the AR indicated, Resident 36 was admitted to the facility with diagnoses of necrotizing fasciitis (a condition in which the fascia [a thin fibrous connective tissue surrounding the muscle] is infected). During a review of Resident 36's OS, dated April 23, 2026, the OS indicated, Resident 36 had an order for Daptomycin sodium chloride (drug name – an antibiotic) 660 mg (milligram- a unit of measurement) every day through PICC line for necrotizing fasciitis. During a concurrent observation and interview on April 29, 2026, at 8:07 AM, with RN 1, Resident 36's IV medication administration was observed. RN 1 used proper PPE (as gown, gloves and face mask) before entering the resident's room and removed the pre- prepared 50 ml (milli liter- a unit of measurement) IV medication bag of Daptomycin sodium chloride 660 mg from his scrub pants pocket and started to prime (to run the fluid through the tube) the IV tubing (a line through which the medication is delivered to the patient). then connected it to Resident 36's PICC line. RN 1 stated, he (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	usually brings the pre-prepared medication in his pocket to all residents. RN 1 further stated, he brings the IV cart (a movable table with the IV medication supplies) to the front of the resident's room when he prepares the powdered medication form. During a concurrent interview and record review on April 29, 2026, at 1:30 PM, with the DON, the facility's P&P titled Administration set/tubing changes, dated October 2024, was reviewed. The P&P indicated, .Purpose: The purpose of this procedure is to provide guidelines for aseptic administration set changes in order to prevent infections associated with contaminated IV therapy equipment. Preparation: Assemble equipment and supplies as needed. Assess equipment for sterile condition. Do not use if not sterile. General Guidelines : 1. Adhere to Standard-ANTI when connecting, changing and accessing administration set injection ports. The DON acknowledged that RN 1 did not follow the process correctly. DON stated, it is not acceptable to carry a medication in his scrub pants pocket to be administered for a resident, it is a concern for infection. DON further stated, the policy was not followed. During a concurrent interview and record review on April 30,2026, at 12:45 PM, with Admin, the facility's P&P tilted IPCP, dated October 2018 was reviewed. The P&P indicated, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The Admin stated, RN should have done that, it is a concern for infection control.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a complete and accurate clinical records (documentation used to show that ordered treatments and care were provided) for one of eight sampled residents (Resident 10) reviewed for treatment orders when monitoring and care for indwelling urinary catheter (a tube inserted into the bladder to drain urine that requires routine care and monitoring) and APP mattress (a special air mattress used to prevent skin breakdown that requires routine monitoring to ensure proper function) were not documented for multiple days from March 2026 through April, 2026.This failures had the potential to result in unverified treatment orders, lack of continuity for care, and increase for adverse outcomes, including infection, skin breakdown, and decline in residents conditions.During a review of Resident 10's admission Record (contains demographic and medical information), it indicated, Resident 10, was admitted to the facility on [DATE], with diagnoses which included benign prostatic hyperplasia with lower urinary tract symptoms (a condition where the prostate gland is enlarged, which can block or slow the flow of urine), chronic obstructive pulmonary disease, (COPD - a long-term lung disease that make it hard to breathe) and acute respiratory failure with hypoxia (a serious condition where the lungs are not able to provide enough oxygen to the body)During a concurrent observation and interview on April 27, 2026, at 10:38 AM, inside Resident 10's room, Resident 10 was lying in bed awake, alert, with an indwelling urinary catheter in place. During the interview, Resident 10 reported experiencing leakage from his urinary catheter. Resident 10 stated he had previously informed facility staff of this concern; however, the issue had not been resolved.During a review of Resident 10's Physician Orders dated December 12, 2025, the physician orders, indicated, Indwelling Urinary Catheter Size FR # 16 (16 French - a urinary catheter size used) / 10 ML (ten milliliters, a fluid used to keep the catheter securely in place inside the bladder) [NAME] for Urinary Retention Related to Obstructive Uropathy (a condition where the resident is unable to empty the bladder completely due to blockage or obstruction) Check every shift intact/ Functioning. Start date December 15, 2025 at 3:00 PM.During a concurrent interview and record Review on April 30, 2026 at 11:31 AM, with the Treatment Nurse (TN 1), Resident 10's PACS - Treatment Administration Record TAR dated March 1, 2026 - March 31, 2026, was reviewed. The TAR, indicated there was no documented evidence for the indwelling Urinary Catheter monitoring every evening shift for the following dates: March 3, 2026, evening shift March 4, 2026, evening shift March 5, 2026, evening shift March 10, 2026, evening shift March 11, 2026, evening shift March 12, 2026, evening shiftA total of six (6) occurrences of missing, documentation were was identified and confirmed by TN 1. The TN 1 stated the documentation should have been completed. The TN 1 further stated that failure to document catheter care and monitoring could result in serious complications, including urinary tract infection During a review of Resident 10's Physician Orders dated December 13, 2025, the physician orders indicated, Indwelling Urinary Catheter: Cleanse site with Warm Soap & Water & Rinse Then Pat Dry every shift. Start Date December 13, 2025During further review, the TAR indicated a treatment order Indwelling Urinary Catheter: Cleanse site with Warm & Rinse then Pat Dry, every shift. There was no documented evidence that the treatment was completed during evening shift on the following dates: March 3, 2026, evening shiftMarch 4, 2026, evening shift March 5, 2026, evening shift March 10, 2026, evening shiftMarch 11, 2026, evening shift March 12, 2026, evening shift. A total of six (6) additional occurrences of missing documentation were identified and confirmed by TN 1. The TN 1 stated the treatment should have been documented as completed. The TN 1 further stated the failure to perform and document catheter care could place the resident at risk for complications including urinary tract infection.During a review of Resident 10's Physician Orders dated December 12, 2025, it indicated, APP Mattress. Set to Resident's weight. Check to ensure proper Placement and Function. Every shift for Mattress Check.During a concurrent interview and record review on April 30, 2026, at 11:31 AM, with TN 1, Resident 10's PACS - (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Treatment Administration Record TAR dated March 1, 2026 - March 31, 2026, was reviewed. The TAR, indicated that there was no documented evidence for the APP Mattress. Set to Resident's Weight. was checked for the following dates: March 3, 2026, evening shift March 4, 2026, evening shiftMarch 5, 2026, evening shift March 10, 2026, evening shift March 11, 2026, evening shift March 12, 2026, evening shiftA total of six (6) additional occurrences of missing documentation were identified and confirmed by TN 1. The TN 1 stated the treatment should have been documented as completed. The TN 1 stated the APP mattress was utilized to provide pressure relief and prevent skin breakdown. TN 1 confirmed the APP mattress checks should have been completed and documented every shift.During a concurrent interview and record Review on April 30, 2026, at 11:31 AM, with the Treatment Nurse, TN 1, Resident 10's PACS - Treatment Administration Record TAR dated April 1, 2026 - April 30, 2026 was reviewed. The TAR, indicated that there was no documented evidence the indwelling Urinary Catheter Size FR. was monitored every evening shift, for the following date:i. April 9, 2026, evening shift.A total of one (1) occurrence of missing documentation was identified and confirmed with the TN 1. The TN 1, stated the treatment should have been documented as completed.During further review, the TAR indicated a treatment order Indwelling Urinary Catheter: Cleanse site with Warm & Rinse then Pat Dry, every shift. There was no documented evidence that the treatment was completed during evening shift on the following date: April 9, 2026, evening shift A total of one (1) occurrence of missing documentation was identified and confirmed with the TN 1. The TN 1, stated the treatment should have been documented as completed. During a further review, of the TAR indicated a treatment order for APP Mattress. Set to Resident's weight Check to ensure proper placement and function. Every shift for mattress check. Start date December 13, 2025 at 07:00 AM. There was no documented evidence that the treatment was completed during evening shift on the following date: i. April 9, 2026, evening shiftA total of one (1) occurrence of missing documentation was identified and confirmed with the TN 1. The TN 1, stated the treatment should have been documented as completed. During a concurrent interview and record review on April 30, 2026, at 11:57 AM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled Physician Orders, Accepting, transcribing, and implementing (noting) was reviewed. The P&P indicated, All physician orders are to be complete and clearly defined to ensure accurate implementation. the DON stated the policy was not followed by the staff because care was not recorded as completed in the Treatment Administration Record.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the Electronic Health Records (EHR- medical records kept on a computer system) was kept secure for one of five sampled residents (Resident 132), when a Licensed Vocational Nurse (LVN 1) left Resident 132's health information on the computer screen unattended and visible to the public in the hallway.This failure had the potential to place Resident 132's confidential information at risk of disclosure to unauthorized individuals.During a concurrent observation and interview on April 29, 2026, at 09:25 AM, with the LVN 2, the LVN 2 logged into the computer on top of the medication cart, checked Resident 132's EHR, and prepared the medication. LVN 2 then proceeded to go inside room [ROOM NUMBER] without logging off the computer, and administered the medications. Resident 132's information was left open and accessible on top of a medication cart. When asked, LVN 2 stated she was not supposed to keep the computer unattended. During a concurrent interview and review of the facility policy and procedure (P&P) titled, Confidentiality Information and Personal Property , dated October 2017, with the Administrator, on April 30, 2026, at 9:57 AM, the P&P indicated .1.The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records and prevent any breaches of their records. The administrator agreed that the policy was not followed.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure its policy and procedure (P&P) for Pre-admission Screening and Resident Review (PASARR- a screening assessment to ensure individuals who are identified to have a significant mental illness [SMI] or intellectual/developmental [I/DD] disability are appropriately placed in nursing homes for long term care) was followed for one out of six residents (Resident 51) when Registered Nurse 1 (RN 1) assessed and documented the level 1 PASARR incorrectly.This failure had the potential to result in Resident 51's condition not being identified prior to admission and the needs for treatment and services not being accurately assessed, placing Resident 51 at risk for unmet mental health needs.During a record review on April 28, 2026, at 8 :44 AM, facility's electronic documents titled PASARR, dated December 20, 2025, was reviewed. The PASARR indicated, Resident 51 level 1 screening for serious mental illness (SMI- major mental disorder) and Intellectual disability (a person's cognitive function and adaptive skills are affected), developmental disability, or related conditions (ID/DD/RC) was negative and Resident 51 does not require a level 2 screening for mental health evaluation.During a review of Resident 51's admission Record(AR), the AR indicated, Resident 51 was admitted on [DATE] with diagnoses which included, schizophrenia (a serious mental disorder where individuals interpret reality abnormally which leads to symptoms as disorganized thinking) and bipolar disorder (a mental health condition where intense, alternating mood swings between extreme highs and low).During an interview on April 28, 2026, at 11:30 AM, with RN1, the RN1 stated he was the person responsible in the facility who completes the PASARR for all the admitting residents. RN1 verified and acknowledged that level 1 screening was incorrect as he wrote no for question regarding resident's diagnosis of serious mental illness. RN 1 further stated, incorrect level I screening delays the residents' care and need for level II screening.During a concurrent interview and record review on April 29,2026, at 3:30 PM, with Director of Nursing (DON), the facility's policies and procedures (P&P) titled, admission Criteria PASARR, dated March 2019, was reviewed. The P&P indicated, .9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process. a. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for an MD, ID or RD. b. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. (I) The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID or RD. The DON verified and acknowledged that PASARR was documented incorrectly. The DON stated that the policy was not followed as RN did not complete the level 1 screening.

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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. Based on observation, interview, and record review, the facility failed to ensure medications were secured to prevent unauthorized access when one of four medication carts (Medication cart 1), was unattended and unlocked in a common area accessible to residents, staff, and visitors.This failure had the potential to result in medications being accessible, diverted, or used inappropriately by unauthorized individuals.During an observation on April 29, 2026 at 5:59 AM, medication cart 1, was observed unattended and unlocked. The cart was parked directly in front of the Nurses' Station I near the main entrance of the building, an area accessible to residents, staff, and visitors. The medication cart contained eight drawers. On the top of the cart, there was a binder labeled Station I Narcotic & Antibiotic Record. The License Vocational Nurse (LVN 1) was observed down the hallway administering medications, leaving the cart unsecured, and unattended.During a concurrent observation and interview on April 29, 2026, at 6:02 AM, with the facility Consultant 1, (C1), C1 walked by Medication cart 1 and noted the lock was found dislodged from its secured position, resulting in the cart being left unsecured and accessible. The C1 manually pushed the lock back to secure the cart. The C1, confirmed the Medication cart 1, had been left unlocked and unattended. C1 stated the Medication cart should not be left unlocked because it can be accessible to anyone, including residents and visitors.During an interview on April 29, 2026, at 6:22 AM, with LVN 1, LVN 1 acknowledged that leaving the Medication cart 1 unattended and unlocked is not a safe practice. LVN 1 further stated the cart may have been left open after medication administration, approximately at 5:25 AM.During a concurrent interview and record review on April 30, 2026, at 10:01 AM, with the Director of Nursing (DON), in his office, the facility's policy and procedure (P&P) titled, Storage of Medications dated Revised April 2007 was reviewed. The P&P indicated, . 7. Compartments containing drugs and biological shall be locked when not in use, and trays or carts sued to transport such items shall not be left unattended if open or otherwise potentially available to others. The DON stated that medication carts are required to remain locked at all times when not in used to avoid unauthorized access.