

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/31/2025
NAME OF PROVIDER OR SUPPLIER  Gladstone Sub-Acute and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  435 E. Gladstone St Glendora, CA 91740	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>44027</p> <p>Based on interview and record review, the facility failed to notify the physician of one of five sampled residents (Resident 1) regarding Resident 1's missed hemodialysis (HD, a process of filtering the blood of a person whose kidneys are not working normally) on 1/15/2025 and 1/16/2025.</p> <p>This failure had the potential for Resident 1 to not receive HD treatment and to experience a decline in Resident 1's health and well-being.</p> <p>Cross Reference F684 and F776</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident on 1/7/2025 (no diagnoses documented in AR). The AR indicated Resident 1's responsible party (RP) was RP 1.</p> <p>During a review of Resident 1's History and Physical (H&amp;P), the H&amp;P indicated Resident 1 had diagnoses including congestive heart failure (CHF, the heart doesn't pump blood as well as it should), end stage renal disease (ESRD, a condition in which a person's kidneys cease functioning), and required hemodialysis.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 10/24/2025, the MDS indicated Resident 1 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for toileting hygiene. The MDS indicated Resident 1 required partial/moderate (helper does less than half the effort) assistance from staff for dressing and personal and oral hygiene.</p> <p>During a review of Resident 1's Progress Notes (PN), dated 1/15/2025, timed at 3 pm, the PN indicated transportation for Resident 1's HD did not show up to pick up Resident 1. The PN indicated HD for today (1/15/2025) was canceled and rescheduled for 1/16/2025 at 2 pm. The PN indicated RP 1 was notified. The PN indicated no documentation Resident 1's physician was notified of the missed HD.</p> <p>During a review of Resident 1's PN, dated 1/16/2025, timed at 2:08 pm, the PN indicated Resident 1's dialysis was rescheduled for tomorrow (1/17/2025) due to transportation. The PN indicated RP 1 was notified. The PN indicated no documentation Resident 1's physician was notified of the missed HD.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 1/30/2025 with RP 1, RP 1 stated facility staff (unidentified) informed RP 1 Resident 1 had missed her HD (on 1/15/2025) and would reschedule the HD for 1/16/2025. RP 1 stated Resident 1 also missed HD on 1/16/2025.</p> <p>During a concurrent interview and record review on 1/31/2025 at 11:34 a.m. with the Assistant Director of Nursing (ADON), Resident 1's PN, dated 1/15/2025 to 1/17/2025 were reviewed. The PN indicated on 1/15/2025 at 3 p.m., Resident 1's scheduled transportation did not show up to take Resident 1 to HD. The PN indicated the HD appointment was canceled and rescheduled for 1/16/2025. The 'PN did not indicate Resident 1's physician was notified of the missed HD. The ADON confirmed Resident 1 missed her HD on 1/15/2025.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Change of Condition Notification, dated 11/1/2017, the P&amp;P indicated, the purpose of the P&amp;P was, To ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner. The P&amp;P indicated, The Facility will promptly .consult with the resident's Attending Physician when the resident endures a significant change in their condition caused by, but not limited to: . A significant change in treatment . The P&amp;P indicated, Notification to the Attending Physician will include a summary of the condition change and an assessment of the resident's vital signs and system review focusing on the condition and/or signs and symptoms for which the notification is required. The P&amp;P indicated, .A Licensed Nurse will document the following:</p> <p>i. Date, time, and pertinent details of the incident and the subsequent assessment in the Nursing Notes.</p> <p>ii. The time the Attending Physician was contacted, the method by which he was contacted, the response time, and whether or not orders were received .</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>44027</p> <p>Based on interview and record review, the facility failed to monitor one of five sampled resident's (Resident 1) condition following an acute change of condition (ACOC- a sudden, clinically important deviation from a resident's baseline in physical, cognitive [relating to or involving the processes of thinking and reasoning], behavioral, or functional domains) on 1/16/2025.</p> <p>This failure had the potential for Resident 1 to not receive the necessary care and treatment which could result in a decline of Resident 1's health.</p> <p>Cross Reference F580 and F776</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident on 1/7/2025 (no diagnoses documented in AR). The AR indicated Resident 1's responsible party (RP) was RP 1.</p> <p>During a review of Resident 1's History and Physical (H&amp;P), the H&amp;P indicated Resident 1 had diagnoses including congestive heart failure (CHF, the heart doesn't pump blood as well as it should), end stage renal disease (ESRD, a condition in which a person's kidneys cease functioning), and required hemodialysis ( a process of filtering the blood of a person whose kidneys are not working normally).</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 10/24/2025, the MDS indicated Resident 1 was moderately impaired in cognitive skills. The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for toileting hygiene. The MDS indicated Resident 1 required partial/moderate (helper does less than half the effort) assistance from staff for dressing and personal and oral hygiene.</p> <p>During a review of Resident 1's SBAR (Situation-Background-Assessment-Request) Communication Form (SBAR), dated 1/16/2025, timed at 11:06 pm., the SBAR indicated on 1/16/2025, untimed, Resident 1 had episodes of low oxygen, congestion (an abnormal accumulation of fluid), nausea and vomiting. The SBAR indicated Resident 1 was noted with low oxygen (O2) saturation (O2 saturation- refers to the percentage of oxygen carried by red blood cells in the bloodstream) level of 85 percent (%) (normal O2 sat is 95% to 100%) on room air. The SBAR indicated Resident 2 was placed on two (2) liters per minute (LPM) of oxygen via nasal cannula (NC- a thin, flexible tube that delivers oxygen through the nose) and still noted with 89% O2 sat. The SBAR indicated oxygen was increased to four (4) LPM via NC and Resident 1's O2 saturation increased to 96%. The SBAR indicated MD was made aware and ordered chest x-ray (CXR- a quick noninvasive imaging test that uses radiation to create pictures of the body) and Zofran (anti-nausea medication) as needed.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 1/30/2025 with RP 1, RP 1 stated RP 1 visited Resident 1 at the facility on 1/16/2025. RP 1 stated the facility staff called RP 1 in the morning of 1/17/2025 to inform RP 1 the facility sent Resident 1 to the hospital for low oxygen (O2) saturation (O2 saturation- refers to the percentage of oxygen carried by red blood cells in the bloodstream). RP 1 stated while RP 1 was at the facility with Resident 1 on 1/16/2025 at around 5 p.m., Resident 1's O2 saturation had dropped to 85 percent (%) (normal range 95-100%). RP 1 stated RP 1 was able to calm Resident 1 and Resident 1's O2 saturation was then better at 95%. RP 1 stated when RP 1 left the facility at 9 p.m. on 1/16/2025, Resident 1 was fine. RP 1 stated a facility staff (unidentified) called RP 1 at around 11 p.m. on 1/16/2025 to inform RP 1 that Resident 1 was doing better, and that the facility staff would monitor Resident 1 during the night.</p> <p>During a concurrent interview and record review on 1/31/2025 at 6:39 a.m. with Registered Nurse (RN) 1, Resident 1's SBAR, dated 1/16/2025, timed at 11:06 pm, and Resident 1's Progress Notes, dated 1/16/2025 and 1/17/2025 were reviewed. The SBAR indicated Resident 1 had an episode of low O2 saturation and congestion on 1/16/2025. The Progress Notes dated 1/17/2025, timed at 8:15 am, indicated on 1/17/2025 at 8:15 a.m., the facility staff called 911 and Resident 1 was transferred to the hospital for low O2 saturations, low blood pressure, and altered level of consciousness. RN 1 stated RN 1 was working overnight from 1/16/2025 to 1/17/2025. RN 1 stated since Resident 1 had a change of condition (COC) by having low O2 saturations, Resident 1's charge nurse (Licensed Vocational Nurse [LVN] 1) needed to monitor Resident 1's vital signs including Resident 1's O2 saturation every 2 hours. RN 1 stated LVN 1 needed to check Resident 1's O2 saturation every 2 hours and document the results of the monitoring at least once during the shift. The Progress Notes failed to indicate LVN 1 monitored Resident 1's O2 saturation during the shift. RN 1 confirmed LVN 1 did not document any monitoring of Resident 1's O2 saturations and condition in Resident 1's medical records.</p> <p>During a telephone interview on 1/31/2025 at 9:05 a.m. with LVN 1, LVN 1 stated LVN 1 worked overnight from 1/16/2025 to 1/17/2025. LVN 1 stated LVN 1 was assigned to care for Resident 1 during that time. LVN 1 stated LVN 1 did not document the monitoring of Resident 1's O2 saturation during LVN 1's shift. LVN 1 stated LVN 1 did not know if LVN 1 needed to document each shift regarding the monitoring of a residents' change in condition.</p> <p>During a concurrent interview and record review on 1/31/2025 at 12:28 p.m. with the Assistant Director of Nursing (ADON), Resident 1's Progress Notes, dated 1/16/2025 and 1/17/2025 were reviewed. The Progress Notes failed to indicate LVN 1 monitored Resident 1's O2 saturation during the 11 pm to 7 am shift on 1/16/2025. The ADON stated nurses (in general) should have monitored Resident 1's COC each shift following Resident 1's COC for 72 hours. The ADON stated LVN 1 needed to document about Resident 1's breathing on LVN 1's shift. The ADON stated LVN 1 should monitor Resident 1's O2 saturation at least every two hours and document. The ADON stated whenever there is a COC, nurse (in general needed to complete Alert charting for 72 hours following the COC. The ADON stated if the monitoring was not documented then it did not happen. The ADON confirmed LVN 1 did not document anywhere in Resident 1's medical record the monitoring of Resident 1's COC.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Change of Condition Notification, dated 11/1/2017, the P&amp;P indicated, An acute change of condition (ACOC) is a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains. The P&amp;P indicated, .A Licensed Nurse will document each shift for at least seventy-two (72) hours.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's P&amp;P titled, Documentation - Nursing, dated 11/1/2017, the P&amp;P indicated:</p> <p>A. Alert charting is documentation done to track a medical event for a period of 72 hours or longer.</p> <p>B. Alert charting is completed by professional staff rather than non-professional staff.</p> <p>C. Events may include but are not necessarily limited to:</p> <ul style="list-style-type: none"> <li>(a) New physician orders;</li> <li>(b) Suspected or actual change in condition;</li> <li>(c) Initiation of new medical treatment;</li> <li>(d) Fall with or without injury; and/or</li> <li>(e) Resident-to-resident event.</li> </ul> <p>D. Alert charted describes what is going on.</p> <ul style="list-style-type: none"> <li>(a) Describe the resident's condition, include what you see, hear, smell, feel, etc.</li> <li>(b) Use the resident's own words if needed.</li> <li>(c) Describe what you have done in response to what is going on with the resident.</li> <li>(d) Describe how the resident responded to the actions.</li> </ul>

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<p>F 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them.</p> <p>44027</p> <p>Based on interview and record review, the facility failed to ensure a chest X-ray (an imaging test that uses X-rays to create detailed pictures of the organs) was completed for one of five sampled Residents (Resident 1) as ordered by Resident 1's physician on 1/16/2025.</p> <p>This failure had the potential for Resident 1 to not receive the necessary services to meet the medical needs of Resident 1.</p> <p>Cross Reference F580 and F684</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident on 1/7/2025 (no diagnoses documented in AR). The AR indicated Resident 1's responsible party (RP) was RP 1.</p> <p>During a review of Resident 1's History and Physical (H&amp;P), the H&amp;P indicated Resident 1 had diagnoses including congestive heart failure (CHF, the heart doesn't pump blood as well as it should), end stage renal disease (ESRD, a condition in which a person's kidneys cease functioning), and required hemodialysis ( a process of filtering the blood of a person whose kidneys are not working normally).</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 10/24/2025, the MDS indicated Resident 1 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for toileting hygiene. The MDS indicated Resident 1 required partial/moderate (helper does less than half the effort) assistance from staff for dressing and personal and oral hygiene.</p> <p>A review of Resident 1's physicians orders (PO), dated 1/16/2025, timed at 7:19 pm, the PO indicated Resident 1 had an order for a STAT (immediately) chest X-ray due to increased congestion (an abnormal accumulation of fluid) and desaturation (a condition where oxygen levels in the blood drop).</p> <p>During a telephone interview on 1/30/2025 with RP 1, RP 1 stated RP 1 visited Resident 1 at the facility on 1/16/2025. RP 1 stated while RP 1 was at the facility with Resident 1 on 1/16/2025 at around 5 p.m., Resident 1's O2 saturation (O2 saturation refers to the percentage of oxygen carried by red blood cells in the bloodstream) had dropped to 85% (normal range 95-100%). RP 1 stated the facility was going to order a chest X-ray because Resident 1's O2 saturation had dropped.</p> <p>(continued on next page)</p>		

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<p>F 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 1/31/2025 at 6:39 a.m. with Registered Nurse (RN) 1, Resident 1's SBAR (Situation-Background-Assessment-Request) Communication Form (SBAR), dated 1/16/2025 and Resident 1's Progress Notes, dated 1/16/2025 and 1/17/2025 were reviewed. The SBAR indicated Resident 1 had an episode of low O2 saturation and congestion on 1/16/2025. The SBAR indicated Resident 1's doctor ordered a chest X-ray for Resident 1. The Progress Notes indicated a STAT (meaning immediately) chest X-ray was ordered for Resident 1 on 1/16/2025 at 7:22 p.m. for increased congestion and desaturation (low O2 saturation). RN 1 stated RN 1 was working overnight from 1/16 /2025- 1/17/2025 (11 pm to 7 am shift). RN 1 stated a STAT chest X-ray had been ordered for Resident 1 on 1/16/2025. RN 1 stated STAT X-rays needed to be obtained within 4 hours. RN 1 stated RN 1 called the contracted radiology company three times during RN 1's shift but company never arrived to do the X-ray for Resident 1.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Laboratory, Diagnostic and Radiology Services, dated 11/1/2017, the P&amp;P indicated, .Laboratory, diagnostic and radiology services ordered will be documented on the 24-Hour Report or electronic health record, to ensure that services are coordinated and results are received timely Any orders labeled STAT will be followed up on during the same shift.</p>		