STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056118	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gladstone Sub-Acute and Rehab Center	435 E. Gladstone St Glendora, CA 91740

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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 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 interview and record review, the facility failed to ensure physician's orders were timed and carried out or noted timely for three of nine sampled residents (Resident 6, Resident 8, and Resident 9) when: 1. An Optometrist (eye care specialist who diagnose and treat injuries and health conditions that affect the eyes and vision) ordered to administer antibiotic (medication used to prevent and treat infections) eye ointment to Resident 6 on 3/31/25, the order was carried out on 4/3/25, but the antibiotic eye ointment was not administered to Resident 6 until 4/4/25. This failure resulted in delay in providing medication to Resident 6 and had the potential to delay Resident 6's relief from eye discomfort due to blepharitis (inflammation of the eyelids). 2. A physician's order to administer ropinirole (medication used to treat restless leg syndrome which is a condition characterized by an irresistible urge to move the legs due to uncomfortable sensations) to Resident 8, dated 3/28/25 and untimed, was carried out on 3/29/25, one day after the original physician's order was written. This failure resulted in delay in providing medication to Resident 8 and had the potential to delay Resident 8's relief from pain in both legs. 3. A physician's order to check Resident 8's magnesium, Vitamin D, and iron blood levels, dated 3/28/25 and untimed, was carried out on 3/29/25, but Resident 8's blood was not drawn until 3/31/25, 3 days after the original physician's order was written. The physician was not informed of the delay in performing laboratory services. This failure resulted in delay in diagnostic blood draw and had the potential for Resident 8 to not receive appropriate care and services. 4. A physician's order to administer methocarbamol (medication used to treat muscle spasms and pain) to Resident 9, dated 3/28/25 and untimed, was carried out on 3/29/25, one day after the original physician's order was written. This failure resulted in delay in availability of medication for Resident 9 and had the potential to delay relief from pain for Resident 9. Findings: (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During a review of Resident 6's Face Sheet (FS - front page of the chart that contains a summary of basic information about the resident), the FS indicated Resident 6 was admitted to the facility on [DATE] with diagnoses which included Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 6's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 3/29/25, the H&P indicated Resident 6 had fluctuating capacity to understand and make decisions. During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool), dated 3/25/25, the MDS indicated Resident 6 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral hygiene, toileting hygiene, upper and lower body dressing, personal hygiene, and putting on/taking off footwear. Resident 6 required substantial/maximal assistance (helper does more than half the effort) to shower/bathe. During a review of a Progress Note (PN) created by Licensed Vocational Nurse 10 (LVN 10), dated 3/31/25 and timed 2 pm, the PN indicated Resident 6 left the facility to go to an Optometry appointment. During a review of Resident 6's After-Visit Summary (AVS - a document given to patients after a medical visit, summarizing information discussed and actions needed), dated 3/31/25 and timed 2:55 pm, the AVS indicated the Optometrist (eye care specialist who diagnose and treat injuries and health conditions that affect the eyes and vision) ordered bacitracin 500 units per gram eye ointment to be applied to Resident 6's eyes two times a day for blepharitis of both upper and lower eyelids. During a review of a PN, created by LVN 11, dated 3/31/25 and timed 4:45 pm, the PN indicated Resident 6 came back to the facility from an appointment. During a review of a Telephone Order (TO) from Resident 6's primary physician (Medical Doctor 1 [MD 1]), dated 4/1/25 and timed 1:58 am, the TO indicated to instill 0.5 inch of bacitracin 500 units per gram eye ointment in both eyes of Resident 6 two times a day for 7 days for blepharitis. The TO indicated it was confirmed by Registered Nurse 5 (RN 5). During a review of a document titled, Need Clarification, dated 4/1/25, the document indicated Pharmacy 1 faxed the document to the facility's Skilled Nursing Unit on 4/1/25 and was received by the facility on 4/1/25 at 12:19 pm. The document indicated bacitracin 500 units per gram eye ointment ordered by MD 1 for Resident 6 was not available in the market. The pharmacist recommended to change bacitracin 500 units per gram to erythromycin 0.5% eye ointment or to neo-polycin eye ointment. The document also indicated a Pharmacy 1 representative spoke to LVN 1 over the phone and relayed the information to LVN 1. During a review of a TO from MD 1, dated 4/3/25 and timed 4:23 pm, the TO indicated to instill 0.5 inch of erythromycin eye ointment in both eyes of Resident 6 two times a day for 7 days for blepharitis. The TO indicated it was confirmed by LVN 4. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 6's Medication Administration Record (MAR), dated 4/1/25 - 4/30/25, the MAR indicated the first dose of erythromycin 5 mg/gm (equivalent to 0.5%) was administered to Resident 6 on 4/4/25 at 9 am. During an interview on 4/17/25 at 2:10 pm with RN 2, RN 2 reviewed TOs from Resident 6's physician and the Need Clarification document faxed by Pharmacy 1 to the facility. RN 2 stated Resident 6's primary physician ordered antibiotic eye ointment for Resident 6 on 4/1/25 and on 4/1/25, Pharmacy 1 faxed a communication to the facility regarding antibiotic eye ointment recommendations because the antibiotic eye ointment ordered by MD 1 was not available in the market. On 4/3/25, RN 2 came to work and found the faxed Need Clarification document, dated 4/1/25, which indicated to change the antibiotic eye ointment ordered by MD 1 to another antibiotic eye ointment that was available in the market. RN 2 asked LVN 4 to call MD 1 to get an order for a different antibiotic eye ointment which was available in the market. RN 2 stated RN 2 informed the Infection Prevention Nurse (IPN) Resident 6's antibiotic eye ointment was not carried out until after 3 days. During an interview on 4/18/25 at 7:43 am with LVN 1, LVN 1 stated LVN 1 was sitting in the Nurses' Station and picked up the phone on 4/1/25 when a pharmacy representative called about Resident 6's medication (antibiotic eye ointment). The pharmacy representative informed LVN 1 the medication was not available in the market and gave the names of two other medications which could replace the original antibiotic eye ointment ordered by the physician. The pharmacy representative told LVN 1 the facility will receive a clarification document from the pharmacy via fax. LVN 1 reported to LVN 4, who was Resident 6's nurse on that shift, what the pharmacy representative told LVN 1 over the phone. LVN 1 stated LVN 1 expected LVN 4 to call Resident 6's physician and get a new order as soon as LVN 4 received the faxed clarification from the pharmacy. LVN 1 stated it was important to note and carry out physician's orders right away so the resident's medication could be started right away. 2. During a review of Resident 8's Face Sheet (FS), the FS indicated Resident 8 was admitted to the facility on [DATE] with diagnoses which included DM with diabetic neuropathy (a type of nerve damage that can occur with diabetes and most often affects the legs and feet). During a review of Resident 8's H&P, dated 7/16/24, the H&P indicated Resident 8 did not have the capacity to understand and make decisions. During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, lower body dressing, putting on/taking off footwear, and to shower/bathe. Resident 8 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral hygiene, upper body dressing, and personal hygiene. During a review of a physician's order (PO) written by MD 2, dated 3/28/25 and untimed, the PO indicated to administer ropinirole 0.25 mg to Resident 8 at bedtime for restless leg syndrome and to check Resident 8's magnesium, Vitamin D, and iron blood levels. The PO was initialed by RN 3 as noted (carried out). During a review of a TO from MD 3, dated 3/29/25 and timed 8:29 am, the TO indicated to administer ropinirole 0.25 mg to Resident 8 at bedtime for restless leg syndrome. The TO did not include an order for any blood test. The TO indicated it was confirmed by RN 3. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 8's MAR, dated 3/1/25 - 3/31/25, the MAR indicated the first dose of ropinirole 0. 25 mg was administered to Resident 8 on 3/29/25 at 9 pm. During a review of a laboratory service requisition form (LSR - a document used by healthcare professionals to request specific medical tests or procedures from a laboratory), undated and untimed, the LSR indicated RN 3 documented for Resident 8's blood to be drawn on 3/31/25 to test for magnesium, Vitamin D, and iron levels. The LSR indicated Resident 8's blood was drawn on 3/31/25 at 5:07 am. During a review of Resident 8's medical records, there was no documented evidence that the physician was informed Resident 8's blood test for magnesium, Vitamin D, and iron was drawn 3 days after the original physician's order. During an interview on 4/17/25 at 2:44 pm with RN 3, RN 3 reviewed the records for Resident 2. RN 3 stated when RN 3 came to work on 3/29/25, RN 3 checked the PO written by MD 2, dated 3/28/25, and found out the order was not carried out. RN 3 obtained a TO from MD 2 on 3/29/25 at 8:29 am for ropinirole and for blood tests and carried out the TO. During an interview on 4/18/25 at 5:36 am with RN 4, RN 4 stated when a Physician's Order form was flagged from a resident's paper chart, it meant there were new orders to be carried out, and LVNs would usually carry those orders out. RN 4 reviewed the (PO) written by MD 2, dated 3/28/25 and untimed, which indicated to administer ropinirole 0.25 mg to Resident 8 at bedtime for restless leg syndrome and to check Resident 8's magnesium, Vitamin D, and iron blood levels. RN 4 stated RN 4 worked on 3/28/25 from 7 pm - 7 am and RN 3 worked on 3/28/25 from 7 am - 7 pm. RN 3 told RN 4 there were flagged POs which needed to be carried out and if RN 4 was busy, to have the new LVNs carry out the orders so they can practice doing that. RN 4 stated RN 4 did not remember which LVN worked on 3/28/25, but the LVN stayed until 2 am of 3/29/25. RN 4 stated the Director of Nursing asked RN 4 the morning of 3/29/25 why the POs were not carried out. RN 4 told the DON the LVN stayed until 2 am of 3/29/25 and RN 4 assumed the LVN carried out all the POs. RN 4 asked the LVN if the LVN needed help and the LVN repeatedly said no. RN 4 stated RN 4 should have checked to make sure all the orders were carried out and was also RN 4's responsibility. RN 4 stated it was important to carry out orders on time so that the residents can get what they need and get better on time, and for laboratory tests to be done timely so that healthcare providers would know right away if something was going on with the residents. 3. During a review of Resident 9's FS, the FS indicated Resident 9 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9's Brief Interview for Mental Status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) was 15 out of 15. The MDS indicated Resident 9 required setup or clean-up assistance (helper sets up or cleans up and resident completes activity) with eating and oral hygiene, partial/moderate assistance with personal hygiene, substantial/maximal assistance with upper body dressing, and dependent (helper does all of the effort) on others for toileting hygiene, lower body dressing, putting on/taking off footwear, and to shower/bathe. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of a PO written by MD 2, dated 3/28/25 and untimed, the PO indicated to administer the following medications to Resident 9: alprazolam (medication used to treat anxiety) 0.5 mg every 8 hours as needed for anxiety, quetiapine (antipsychotic medication - used to treat symptoms of psychosis, such as hallucinations, delusions, and disorganized thinking) 25 mg every bedtime, acetaminophen (medication used to treat pain) 325 mg 2 tablets every 6 hours as needed for pain, and methocarbamol 500 mg three times a day as needed for muscle spasms. The PO was initialed by RN 3 as noted (carried out). During a review of Resident 9's PN, dated 3/28/25 and timed 5:12 pm, the PN indicated LVN 4 was the one who carried out the PO for alprazolam 0.5 mg every 8 hours as needed for anxiety. During a review of Resident 9's PN, dated 3/28/25 and timed 5:18 pm, the PN indicated LVN 4 was the one who carried out the PO for quetiapine 25 mg every bedtime and the acetaminophen 325 mg 2 tablets every 6 hours as needed for pain. During a review of a TO from MD 2, dated 3/29/25 and timed 8:54 am, the TO indicated to give Resident 9 methocarbamol 500 mg three times a day as needed for muscle spasms. The TO indicated RN 3 confirmed the TO. During a review of Resident 9's MAR, dated 3/1/25 - 3/31/25, the MAR indicated methocarbamol 500 mg was not available for Resident 9 to take until 3/29/25. The MAR indicated the first dose of methocarbamol 500 mg was administered to Resident 9 on 3/29/25 at 4:30 pm. During an interview on 4/17/25 at 2:44 pm with RN 3, RN 3 reviewed Resident 9's records and stated when RN 3 came to work on 3/29/25, RN 3 checked Resident 9's MAR and PO, dated 3/28/25, and found out the order for alprazolam, quetiapine, and acetaminophen were carried out, but the order for methocarbamol was not carried out. RN 3 obtained a TO from MD 2 on 3/29/25 at 8:54 am for methocarbamol 500 mg and carried out the TO. During an interview on 4/18/25 at 6:56 am with RN 4, RN 4 reviewed Resident 9's records and stated, the missed order for Resident 9's methocarbamol happened on the same day Resident 8's ropinirole and blood test order was missed. RN 4 stated it was the same LVN who was supposed to carry out the order. RN 4 stated the LVN carried out the order for Resident 9's alprazolam, quetiapine, and acetaminophen but the order for methocarbamol was not carried out. RN 4 stated RN should have checked that all the orders were carried out. During an interview on 4/18/25 at 7:26 am with the Assistant Director of Nursing (ADON), the ADON reviewed the records for Resident 6, Resident 8, and Resident 9. The ADON stated all licensed nurses were responsible for ensuring all physician's orders were carried out and LVNs and RNs should communicate with each other. The ADON stated after the nurse received the pharmacy communication regarding Resident 6's antibiotic eye ointment, the nurse should have reached out to Resident 6's physician to change the order. The ADON stated laboratory orders should be drawn right away. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/18/25 at 9:56 am with the Director of Nursing (DON), the DON stated blood test orders should be drawn the day after the physician wrote the order. The DON expected licensed nurses to carry out all the physician's orders written on their shift and expected licensed nurses to carry out the whole order instead of only carrying out part of the order. The DON stated antibiotics should be started within 4 hours and the physician should be informed when laboratory orders were not drawn on time and/or when medications were delayed, especially antibiotics. The DON also stated LVNs and RNs were responsible for carrying out physician's orders. A review of the facility's policy and procedure (P&P) titled, Physician Orders, dated 5/1/2019, indicated, the order is transcribed onto the Physician's Order Form at the time the order is taken .physician orders will include the name of the prescriber, the name of the resident, the date and time the order was received, and the signature of the licensed nurse receiving and documenting the order .Whenever possible, the licensed nurse receiving the order will be responsible for documenting and implementing the order . A review of the facility's P&P titled, Laboratory, Diagnostic and Radiology Services, dated 11/1/2017, indicated the facility is responsible for the quality and timeliness of services provided by the laboratory, diagnostic, or radiology provider .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to prevent the spread of infections for 4 of 6 sampled residents (Resident 1, Resident 2, Resident 3, and Resident 4) when failing to ensure hand hygiene was performed appropriately. This failure had the potential to increase the risk of healthcare-associated infections, including the transmission of multidrug-resistant organisms for Resident 1, Resident 2, Resident 3, and Resident 4. Findings: 1. During observation on 04/16/2025 at 12:08 PM in the dining room, Certified Nursing Assistant (CNA) 1 prepared Resident 1's lunch tray and Resident 2's liquid drinks and lunch tray without handwashing or hand hygiene using alcohol-based hand rub (ABHR). CNA 1 assisted in feeding Resident 1 without handwashing or hand hygiene. During an interview on 04/16/2025 at 12:36 PM with CNA 1, CNA 1 stated that staff must use ABHR before and after patient care. CNA 1 stated it is important to sanitize hands before and after contact with a resident to prevent the spread of infection. 2. During observation on 04/16/2025 at 12:14 PM, Licensed Vocational Nurse (LVN) 1 patted the back of Resident 3 and then Resident 4 while saying hello and walked away. LVN 1 did not perform handwashing before and after facility Residents' interactions. During an interview on 04/16/2025 at 12:28 PM with LVN 1, LVN 1 stated that staff supposed to sanitize hands between contact with residents for infection prevention and did not realize that the ABHR was nearby. 3. During an observation on 04/16/2025 at 12:22 PM, LVN 2 held the handle of Resident 3's wheelchair while saying hello then wheeled Resident 4 out of the dining area without handwashing or using ABHR before and after assisting Resident 4. During an interview on 04/16/2025 at 12:44 PM, LVN 2 stated it is important for the facility staff to disinfect hands before and after touching residents for infection control. During an interview with the Director of Nursing (DON), the DON stated the expectation is for staff to sanitize their hands between contact with residents, and ABHR is placed throughout the facility. The DON stated it is important to have good hand hygiene to keep the residents and staff safe and for infection control. A review of the facility's Policy and Procedure (P&P) titled, Hand Hygiene, dated 11/1/2017 indicated Facility Staff, visitors, and volunteers must perform hand hygiene procedure in the following circumstances: Hand wash with soap and water . Before and after assisting residents with dining if direct contact with food is anticipated or occurs. Alcohol-based hand hygiene products can and should be used to decontaminate hands: Before moving from one resident to another in a multiple-bed room or procedure area regardless of glove use.