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	05/22/2025

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

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement Care Plan (CP, a form where one can summarize a person's health conditions, specific care need, and current treatments) interventions for two of 12 sampled residents (Residents 1 and 5), in accordance with the facility's policy and procedure (P&P) titled, Care Planning, by failing to: 1. Obtain an order for Resident 1's left heel splint (medical device used to support and protect an injured part of the body) and failing to assess pedal pulses every shift as indicated in the CP. 2. Ensure the Restorative Nursing Aides (RNA) provided restorative nursing services (RNS- specialized nursing interventions provided by a RNA focused on helping to maintain or regain functional abilities to achieve the highest level of well-being, often after rehabilitation or to prevent decline) to Resident 5 for the month of 4/2025. This deficient practice had the potential to inflict further injury to Resident 1. As a result of these failures, Resident 5 did not receive any Restorative Nursing Services for the month of 4/2025. These failures have the potential to result in Resident 5 developing further physical decline, loss of function and mobility, and the inability to walk. Cross Reference: F825 and F842 Findings: a. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including osteoporosis, (condition where bones become weak and fragile, making them more susceptible to fractures) osteoarthritis, (degenerative joint disease where the protective layer that cushions the ends of bones, breaks down over time) and dementia (a gradual decline in mental ability usually caused by a brain disease.) During a review of Resident 1's History and Physical (H&P), dated 5/29/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 3/19/2025, the MDS indicated Resident 1 used a manual wheelchair with supervision or touching assistance (helper provides verbal cues and/or touching/ steadying and/or contact guard assistance as resident completes the activity) and required maximal assistance (helper does more than half the effort) for toileting and bathing. The MDS further indicated Resident 1 required maximal assistance to walk 10 feet. During a review of Resident 1's SBAR Communication Form and progress note - V2 (SBAR), dated 5/6/2025 at 7:30 AM, the SBAR indicated Resident 1 was noted with swelling and discoloration to the left ankle on 5/3/2025 and X-ray (type of electromagnetic radiation used to create images of internal structures) was done to rule out a fracture. The SBAR further indicated that on 5/6/2025 Resident 1 experienced increased discoloration and Resident 1's Medical Doctor (MD) was informed and gave order to transfer Resident 1 to a general acute care hospital (GACH). During a review of Resident 1's Progress Notes (PN) dated 5/6/2025 at 8:38 PM, the PN indicated Resident 1 returned from the (GACH) with an X-ray and computed tomography (CT - medical imaging technique that uses X-rays to create detailed cross - sectional images of the body) result of left calcaneus fracture (break in the heel of the foot.) The PN indicated Resident 1 was noted with a splint on the left leg and the Medical Doctor (MD) was made aware of Resident 1's return. During a review of Resident 1's CP titled, She has injury of unknown cause; Xray result fracture to left heel, dated 5/6/2025, the interventions indicated to, Apply splint as ordered, and Monitor limb for swelling and skin changes. Take pedal pulses every shift. During a review of Resident 1's Order Summary Report (OSR) with active orders dated as of 5/20/2025, the OSR did not indicate an order for a splint to the left leg. During an interview on 5/20/2025 at 11:10 AM with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 wears a splint all the time since the fracture, but Resident 1 is sometimes confused and attempts to remove the splint. CNA 1 stated CNA 1 did not know who was responsible for removing and placing the splint. During an interview on 5/20/2025 at 11:35 AM with CNA 2, CNA 2 stated Resident 1 wore a splint on the left foot, but CNA 2 did not know if it was worn all the time. CNA 2 further stated Resident 1 was not currently wearing the splint and did not wear it all the time. CNA 2 stated Resident 1 usually wore the splint when Resident 1 was up in a wheelchair. During an interview on 5/20/2025 at 12:30 PM with the Treatment Nurse (TN), the TN stated Resident 1 was not currently wearing a splint, but Resident 1 had worn it before. The TN further stated the TN would most likely be responsible for placing and removing the splint, but Resident 1 did not have a current order for the splint. The TN stated the TN was primarily responsible for monitoring Resident 1's skin and swelling. During an interview on 5/20/2025 at 3:58 PM with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 1 was supposed to wear the splint until Resident 1's doctor instructed it could be removed. LVN 2 further stated pedal pulses needed to be checked any time a resident's circulation could be affected such as with Resident 1. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/20/2025 at 4:05 PM with the Assistant Director of Nursing (ADON), the ADON stated the ADON may have returned to the facility with a splint from the hospital. The ADON further stated when Resident 1 returned, an order for Resident 1's splint should have been clarified with Resident 1's doctor to ensure staff was aware of when and how long the splint should be used and to prevent any further injury to Resident 1. The ADON also stated there was no documentation to indicate if Resident 1's pedal pulses were being checked every shift as indicated in the CP. The ADON stated the purpose of the CP is to ensure Resident 1 receives the appropriate care needed. b. During a review of Resident 5's admission Record (AR), the AR indicated the facility admitted Resident 5 on 9/10/2022 with diagnoses that included other abnormalities of gait and mobility (inability to walk normally due to injuries or underlying conditions) and unspecified dementia (progressive states of decline in mental abilities). During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool) dated 3/18/2025, the MDS indicated Resident 5 had intact cognition. The MDS indicated Resident 5 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity and may be provided throughout the activity or intermittently) with walking 50 feet (ft- unit of measurement). During a review of Resident 5's Order Summary Report (OSR), the OSR indicated Resident 5 had an order for (the) RNA to assist with ambulation (the act of walking) using a front wheel walker (FWW- mobility aid designed to assist with walking) three times per week, up to 100 feet (ft- unit of measurement) or up to patient's limits to maintain functional mobility skills, active as of 3/31/2025. During a review of Resident 5's untitled Care Plan (CP) initiated 3/31/2025, the CP indicated Resident 5 was receiving ambulation using FWW three times per week, up to 100 ft or up to [Resident 5's] limit to maintain functional mobility skills. The CP goals indicated Resident 5 would maintain functional abilities through the RNA [program as ordered through the next review period]. The CP goals indicated to monitor and observe Resident 5 for tolerance, pain, and skin integrity, and to notify licensed nurses (LN), rehabilitation (services) and physician if Resident 5 showed a decline in function. During an interview on 5/21/2025, at 12:21 PM, with RNA 3, RNA 3 stated on 4/30/2025 in the afternoon, MR printed out the RNR for residents receiving RNS for the month of 5/2025 (for RNAs to sign/initial as treatment is given for 5/2025). RNA 3 stated in the morning on 5/1/2025, RNA 3 realized Resident 5 had RNS orders for the month of 4/2025, but did not receive any RNS for 4/2025. RNA 3 stated RNA 3 realized Resident 5's RNS orders were placed on 3/31/2025. RNA 3 stated RNA 3 informed the Assistant Director of Nursing (ADON), who informed the DON. RNA 3 stated the DON informed RNA 3 to start Resident 5's RNS orders on 5/2/2025. RNA 3 stated Resident 5 was first ambulated on 5/2/2025 since the RNS orders were placed on 3/31/2025. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/21/2025 at 1:33 PM, with the ADON, the ADON stated the ADON did know what dates in April when Resident 5 did not receive RNS. The ADON stated the ADON did not remember when the missed RNS was brought to the DON's attention, and did not remember what the DON instructed the ADON to do about Resident 5's missed RNS dates. The ADON stated Resident 5 could develop a decline in activities of daily living (ADL- the tasks of everyday life fundamental to caring for oneself), loss of muscle mass (amount of muscle in the body) and the ability to walk from not receiving RNS. The ADON stated Resident 5 could become weaker and put Resident 5 at risk for complications from not receiving the ordered RNS. During a concurrent interview and record review on 5/21/2025 at 1:46 PM, with the DON, Resident 5's RNR for 4/2025 was reviewed. The DON stated, in regard to Resident 5's RNS, there was a miscommunication between nursing, RNA, and rehabilitation staff. The DON stated on 5/1/2025 or 5/2/2025 (exact date unknown), the ADON informed the DON that Resident 5's RNR for 4/2025 was missing. The DON stated the DON informed the RNAs (unidentified) to continue Resident 5's RNS orders. The DON stated the first week of 5/2025 (exact date unknown) RNA 3 informed the DON that Resident 5 had not been ambulated (as ordered) for 4/2025. The DON stated the DON did not know how many dates Resident 5 was not ambulated. During an interview on 5/21/2025 at 4:05 PM with Resident 5, Resident 5 stated they (exact staff unknown) had been walking Resident 5 for about a month, but did not remember when facility staff began walking Resident 5. During an interview on 5/22/2025 at 3:19 PM, with the DON, the DON stated Resident 5 was supposed to receive 14 RNS treatments for 4/2025. The DON stated if a resident had a CP for RNS, then it needed to be followed it because it was how [staff] were supposed to guide the resident's care. The DON stated if the CP is not followed, then the resident would not get the care they're supposed to be getting. The DON stated by not receiving RNS as ordered, Resident 5 could have a decline in health and ability to ambulate, and a decline in function and suffer muscle wasting that could lead to a negative effect on Resident 5's quality of life. During a review of the facility's policy and P&P titled, Care Planning, revised 10/24/2022, the P&P indicated the resident has the right to receive the services and/or items included in the plan of care.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to provide care and services for one of 12 sampled residents (Resident 12), to prevent the develop of new pressure injury (PI- localized injury to the skin and/or underlying tissue usually over bone prominence as result of pressure or pressure in combination with shear [mechanical force that cause the skin to break off] and/or friction [movement of one surface of the skin against others]) by failing to: 1. Ensure licensed nurses (LN) and certified nursing assistants (CNA) changed Resident 12's position in bed every two hours as indicated in the facility's policy and procedure (P&P) titled, Positioning and Body Alignment. 2. Ensure Resident 12 was not double briefed (the layering of two briefs [disposable, tab-style under garments designed to provide protection against urinary and fecal incontinence [lack of control over urination or defecation]) when changing Resident 12. These failures had the potential to place Resident 12 at risk for skin breakdown and moisture associated skin damage (MASD- inflammation or skin erosion caused by prolonged exposure to moisture such as urine, stool, or sweat) and had the potential for Resident 12 to develop a PI. Findings: During a review of Resident 12's admission Record (AR), the AR indicated the facility admitted Resident 12 on 3/14/2025 with diagnoses that included morbid chronic disease characterized by excessive accumulation of body fat, defined as a Body Mass Index [BMI- calculation used to estimate body fat percentage based on a resident's height and weight] of 40 or higher), quadriplegia (form of paralysis that affects all four limbs and torso), and chronic respiratory failure (serious condition that makes it breathe on one's own). During a review of Resident 12's untitled Care Plan (CP) initiated 3/14/2025, the CP indicated Resident 12 was at risk for impaired skin integrity such as easy skin bruising/skin discoloration, skin tear/abrasions (cut in the skin) including PI due to thin/fragile skin, friction and shearing, and requiring assistance with activities of daily living (ADL- the tasks of everyday life fundamental to caring for oneself) and functional mobilities. The CP goals indicated Resident 12 would not have unusual skin injury, daily. The CP interventions indicated to keep Resident 12 dry and clean and reposition Resident 12 at least every two hours as needed. During a review of Resident 12's Minimum Data Set (MDS- a resident assessment tool) dated 3/20/2025, the MDS indicated Resident 12 had intact cognition. The MDS indicated Resident 12 was dependent (helper does ALL the effort. Resident does none of the effort to completely the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity) toileting and personal hygiene and rolling left and right (in bed). The MDS indicated Resident 12 was always incontinent with bowel and bladder. During an observation on 5/22/2025 at 1:23 pm, in Resident 12's room, Resident 12 was observed. Resident 12 was in bed, lying in high fowlers position (positioning technique where the head of the bed is elevated to an angle between 60 and 90 degrees, while knees may be straight or bent). Resident 12 was lying on Resident 12's back. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/22/2025 at 1:35 PM, with CNA 3, while in Resident 12's room CNA 3 changed Resident 12's briefs. CNA 3 stated Resident 12 was lying on Resident 12's back. CNA 3 stated Resident 12 was double briefed and the brief touching Resident 12's skin was full or urine. CNA 3 stated Resident 12 was not supposed to be double briefed because Resident 12's brief was supposed to be changed every two hours as needed. During a concurrent observation and interview on 5/22/2025 at 1:52 PM, with CNA 3 and licensed vocational nurse (LVN) 3, while in Resident 12's room, CNA 3 and LVN 3 pulled Resident 12 up so Resident 12 was closer to the head of the bed. CNA 3 and LVN 3 did not reposition Resident 12 to either the left or right side. Resident 12 continued to lay on Resident 12's back. CNA 3 stated Resident 12 was supposed to be repositioned to one of Resident 12's sides to relieve pressure. During an interview on 5/22/2025 at 2:06 PM, with LVN 4, LVN 4 stated LVN 4 and another CNA (unable to identify) changed Resident 12's briefs between 12 PM and 12:30 PM the day of the interview. LVN 4 stated LVN 4 positioned Resident 12 on Resident 12's back. LVN 4 stated if Resident 12 just repositioned, Resident 12 should have been positioned to one of Resident 12's side to avoid too much prolonged pressure to one side. LVN 4 stated Resident 12 was at risk for PI and repositioning Resident 12 helped prevent PI. LVN 4 stated Resident 12 was not supposed to be double briefed because it could cause skin issues. LVN 4 stated double briefing Resident 12 made Resident 12's [skin] hotter, creating more moisture that could lead to skin breakdown. During an interview on 5/22/2025 at 3:19 PM, with the Director of Nursing (DON), the DON stated (in general) staff were not supposed to double brief residents because it made residents hot. The DON stated it was highly discouraged because it could cause rashes, skin breakdown, and was a safety concern. The DON stated total care (dependent) residents had to be repositioned every two hours to prevent PI, otherwise residents could develop skin breakdown. The DON stated residents could develop infections if skin breakdown occurred from being double briefed and not being repositioned every two hours. During a review of the facility's P&P titled, Positioning and Body Alignment, revised 11/1/2017, the P&P indicated the purpose was to improve or maintain the resident's self-performance in moving and from a laying position, turning side to side, and positioning while in bed. The P&P indicated to change the resident's position every two hours, or as otherwise indicated or ordered by the physician. During a review of the facility's P&P titled, Perineal Care, revised 11/1/2017, the P&P indicated the purpose was to maintain cleanliness to the genital area, reduce odor, and to prevent infection or skin breakdown. The P&P did not indicate to double brief residents when cleaning and changing briefs. The facility did not provide a P&P on changing briefs.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, interview, and record review, the facility failed to ensure certified nursing assistant (CNA) 3 worked within their scope of practice (the legal and ethical boundaries within which a health care professional is permitted to practice) by not handing one of 12 sampled residents (Resident 12) gastrostomy tube (G-tube- tube inserted through the belly that brings nutrition directly to the stomach) (medical device used to deliver liquid nutrition, medications, or special formulas to residents who cannot eat by mouth). This failure had the potential to place Resident 12 at risk for G-tube dislodgement (accidental removal, a serious issue that can lead to several complications) and pump malfunction. Findings: During a review of Resident 12's admission Record (AR), the AR indicated the facility admitted Resident 12 on 3/14/2025 with diagnoses that included quadriplegia (form of paralysis that affects all four limbs and torso), and encounter for attention to G-tube. During a review of Resident 12's Minimum Data Set (MDS- a resident assessment tool) dated 3/20/2025, the MDS indicated Resident 12 had intact cognition (ability to think, remember, and reason). The MDS indicated Resident 12 had a feeding tube (g-tube). During a review of Resident 12's Order Summary Report (OSR), the OSR indicated on 3/25/2025 Resident 12 had an enteral [formula] (liquid food products that are specially formulated and designed to increase the amount of various food elements and nutrients that will maintain proper physiological function of the body) feed order in the afternoon, use an enteral pump and infuse at 74 milliliters (mL- unit of liquid measurement) per hour over 20 hours. The order indicated to run the pump from 12 pm until the dose limit is met. During an observation on 5/22/2025 at 1:23 PM, while in Resident 12's room Resident 12 was observed in bed. Resident 12's g-tube feed pump was on and was running at 74 mL per hour. During a concurrent observation and interview on 5/22/2025 at 1:35 PM, while in Resident 12's room, with CNA 3, CNA 3 turned off Resident 12's G-tube feed pump. CNA 3 stated, I turned off the G-tube feed pump, the nurse is supposed to do it, but I did it anyway. During an interview on 5/22/2025 at 2 PM, with licensed vocational nurse (LVN) 3, LVN 3 stated CNAs were not supposed to turn off G-tube feeds because it was not within their scope of practice. LVN 3 stated if CNAs were not trained on the pumps, and the machine could malfunction, or the G-tube itself could get dislodged. During an interview on 5/22/2025 at 2:06 PM, with LVN 4, LVN 4 stated CNAs were not supposed to stop G-tube feeds or touch the pumps because they were not licensed. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/2025 at 3:19 PM with the Director of Nursing (DON), the DON stated CNAs were not supposed to stop G-tube feeds or touch the pump before changing or repositioning a resident because it was not within their scope of practice. The DON stated CNAs could put residents at risk for G-tube pump malfunctioning or the G-tube itself becoming dislodged which would cause them to need a replacement and radiograph (XRAY- type of medical imaging that creates pictures of bones and soft tissue).

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately document restorative nursing services (RNS- specialized nursing interventions provided by a restorative nursing aide [RNA] focused on helping to maintain or regain functional abilities to achieve the highest level of well-being, often after rehabilitation or to prevent decline) on the Restorative Nursing Record (RNR) for four out of 12 sampled residents (Residents 5, 7, 8, and 10), in accordance with to the facility's policy and procedure (P&P) titled, Documentation- Nursing Manual- Restorative Nursing Program, by failing to: 1. Ensure Restorative Nursing Assistant 3 (RNA- a specialized Certified Nursing Assistant [CNA] 3 with additional training in rehabilitation techniques) did not willfully falsify in Resident 5's RNR that RNA 3 had provided ambulation (the act of walking) RNS as ordered by the physician for the month of 4/2025. 2. Ensure RNA 3 did sign/initial Residents 7 and 10's RNR on 4/4/2025, indicating RNA 3 had performed Residents 7 and 10's RNS when RNA 3 was not clocked in for work on 4/4/2025. 3. Ensure RNA 3, RNA 6, and RNA 7 did not sign and initial Resident 8's RNR to indicate RNS was provided to Resident 8 on 4/19/2025, 4/25/2025, and 4/26/2025 when RNA 3, RNA 6, and RNA 7 were not clocked in for work on those dates. These failures resulted in Resident 5 not receiving any RNS for the month of 4/2025 and for Resident 5, 8, and 10's medical records to contain inaccurate information that could affect Residents 5, 8, and 10's care and result in a decline in range of motion (ROM- exercises and/or movements designed to improve the flexibility and mobility of joints) and lead to an inability to ambulate. Cross Reference: F842 Findings: a. During a review of Resident 5's admission Record (AR), the AR indicated the facility admitted Resident 5 on 9/10/2022 with diagnoses that included other abnormalities of gait and mobility (inability to walk normally due to injuries or underlying conditions) and unspecified dementia (progressive states of decline in mental abilities). During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool) dated 3/18/2025, the MDS indicated Resident 5 had intact cognition (ability to think, remember, and reason). The MDS indicated Resident 5 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity and may be provided throughout the activity or intermittently) with walking 50 feet (ft- unit of measurement). During a review of Resident 5's Order Summary Report (OSR), the OSR indicated Resident 5 had an order for the RNA to assist with ambulation (the act of walking) using a front wheel walker (FWW- mobility aid designed to assist with walking) three times per week, up to 100 feet (ft- unit of measurement) or up to the resident's limits to maintain functional mobility skills, active as of 3/31/2025. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 5's untitled Care Plan (CP) initiated 3/31/2025, the CP indicated Resident 5 was receiving ambulation using FWW three times per week, up to 100 ft or up to Resident 5's limit to maintain functional mobility skills. The CP goals indicated Resident 5 would maintain functional abilities through the RNA program as ordered through the next review period. The CP goals indicated to monitor and observe Resident 5 for tolerance, pain, and skin integrity, and to notify the licensed nurses (LN), rehabilitation (services) and physician, if Resident 5 showed a decline in function. During a review of Resident 5's Restorative Nursing Record (RNR- record kept indicating when RNS is provided) for 4/2025, the RNR indicated Resident 5 received RNS on 4/1/2025, 4/3/2025, 4/5/2025, 4/7/2025, 4/9/2025, 4/11/2025, 4/14/2025, 4/16/2025, 4/18/2025, 4/21/2025, 4/23/2025, 4/25/2025, 4/28/2025, and 4/29/2025. During an interview on 5/21/2025, at 12:21 pm, with RNA 3, RNA 3 stated on 4/30/2025 in the afternoon, MR printed out the RNR for residents receiving RNS for the month of 5/2025 (for RNAs to sign/initial as treatment is given for 5/2025). RNA 3 stated in the morning on 5/1/2025, RNA 3 realized Resident 5 had RNS orders for the month of 4/2025, but did not receive any RNS for 4/2025. RNA 3 stated RNA 3 realized Resident 5's RNS orders were placed on 3/31/2025. RNA 3 stated RNA 3 informed the Assistant Director of Nursing (ADON), who informed the DON. RNA 3 stated the DON informed RNA 3 to start Resident 5's RNS orders on 5/2/2025. RNA 3 stated Resident 5 was first ambulated on 5/2/2025 since the RNS orders were placed on 3/31/2025. RNA 3 stated on 5/5/2025, while California Department of Public Health (CDPH) was onsite investigating Resident 5's RNS, CDPH asked for Resident 5's RNR for 4/2025 and [the facility] needed to provide it. RNA 3 stated the DON asked RNA 3 to sign Resident 5's treatment record for 4/2025 because the facility had to, Correct and do something about Resident 5's RNR. RNA 3 stated the DON asked RNA 3 to sign Resident 5's RNR for 4/2025, So I did. RNA 3 stated, The DON didn't tell me I was falsifying [Resident 5's] record, the DON just told me I needed to fix the mistake for Resident 5. RNA 3 stated, Because the DON is my boss, I felt like I had to listen to the DON. During an interview on 5/21/2025 at 1:33 PM, with the ADON, the ADON stated the ADON did know what dates in April Resident 5 did not receive RNS. The ADON stated the ADON did not know why Resident 5's RNR for 4/2025 was signed and initialed, indicating RNS was provided to Resident 5. The ADON stated the ADON did not remember when the missed RNS was brought to the DON's attention, and did not remember what the DON instructed the ADON to do about Resident 5's missed RNS dates. The ADON stated Resident 5 could develop a decline in activities of daily living (ADL- the tasks of everyday life fundamental to caring for oneself), loss of muscle mass (amount of muscle in the body) and the ability to walk from not receiving RNS. The ADON stated Resident 5 could become weaker and put Resident 5 at risk for complications from not receiving the ordered RNS. (continued on next page)

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	05/22/2025

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/21/2025 at 1:46 PM, with the DON, Resident 5's RNR for 4/2025 was reviewed. The DON stated (in general) the physical therapist (PT) put in the RNS orders for residents, and it was the rehabilitation staffs' responsibility to communicate with the RNAs when a RNS order was placed for residents. The DON stated MR will print out the RNR for each resident for the month ahead so RNAs can fill out the RNR as RNS is provided. The DON stated, regarding Resident 5's RNS, there was a miscommunication between nursing, RNA, and rehabilitation staff. The DON stated on 5/1/2025 or 5/2/2025 (exact date unknown), the ADON informed the DON that Resident 5's RNR for 4/2025 was missing. The DON stated the DON informed the RNAs (unidentified) to continue Resident 5's RNS orders. The DON stated the first week of 5/2025 (exact date unknown) RNA 3 informed the DON that Resident 5 had not been ambulated (as ordered) for 4/2025. The DON stated the DON did not know how many dates Resident 5 was not ambulated. The DON stated on 5/5/2025, while CDPH was onsite, the DON asked RNA 3 to find Resident 5's RNR for 4/2025 but RNA 3 could not find it. The DON stated the DON did not know why Resident 5's RNR for 4/2025 was provided to CDPH because the RNR was never printed. During an interview on 5/21/2025 at 3:33 PM, with the Rehabilitation Program Manager (RPM), the RPM stated on 5/1/2025, the DON informed the RPM there was a Discrepancy, with Resident 5's RNS order but did not go into detail because the RPM was not working on 5/1/2025. The RPM stated the RPM returned to work on 5/9/2025 and was not updated on Resident 5's RNS order from the ADON, DON, or rehabilitation staff, So I assumed everything was fine. The RPM stated the RPM was not informed Resident 5 did not receive any RNS for 4/2025. During an interview on 5/21/2025 at 4:05 PM with Resident 5, Resident 5 stated they (exact staff unknown) had been walking Resident 5 for about a month, but did not remember when facility staff began walking Resident 5. During an interview on 5/22/2025 at 3:19 PM, with the DON, the DON stated on 5/1/2025 the DON informed the RPM there was a Discrepancy, with Resident 5's RNS orders for 4/2025. The DON stated the DON Looked into it, and discovered that Resident 5's RNS orders were not communicated to the RNAs. The DON stated the DON asked an unidentified rehabilitation staff what happened with Resident 5's RNS orders for 4/2025, but Did not get an answer so I let it go. The DON stated when CDPH was onsite on 5/5/2025 and provided Resident 5's RNR for 4/2025 the DON did not check the RNR. The DON stated Resident 5's RNR for 4/2025 was missing and should not have been provided to CDPH. The DON stated Resident 5 was supposed to receive 14 RNS treatments for 4/2025. The DON stated by not receiving RNS as ordered, Resident 5 could have a decline in health and ability to ambulate, and a decline in function and suffer muscle wasting that could lead to a negative effect on Resident 5's quality of life. b. During a review of Resident 7's AR, the AR indicated the facility admitted Resident 7 on 1/16/2023 and was readmitted on [DATE] with diagnoses that included a history of falling and chronic kidney disease (damage to the kidneys so they cannot filter blood the way they should) stage three. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 10's AR, the AR indicated the facility admitted Resident 10 on 3/6/2024 and was readmitted on [DATE] with diagnoses that included essential (primary) hypertension (condition where the force of blood against artery walls is consistently too high and blood pressure [BP- the pressure circulating blood against the walls of blood vessels; abnormal BP was less than 120/80 millimeters of mercury [mmHg- unit of measurement] and above 140/90 mmHg considered high blood pressure] is consistently high) and epilepsy (disorder in which nerves in the brain are disrupted, causing seizures [burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone and stiffness, twitching, or limpness movements]). During a review of Resident 10's MDS dated [DATE], the MDS indicated Resident 10 had severely impaired cognition. The MDS indicated Resident 10 was dependent (helper does ALL the effort. Resident does none of the effort to completely the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity) with eating, oral, toileting, and personal hygiene, showering/bathing self, upper and lower body dressing, rolling left and right (in bed), and chair/bed-to-chair transfers. The MDS indicated lying to sitting on side of the bed, sitting to standing, and walking 10 ft were not attempted and the resident did not perform this activity prior to the current illness, exacerbation or injury. During a review of Resident 7's RNR for 4/2025, the RN indicated Resident 7 had a Physicians order to provide RNA ambulation using FWW three times per week, up to 300 ft or up to Resident 7's limits to maintain functional mobility skills. The RNR indicated the order date was dated 2/28/2025 at 7:33 PM. The RNR indicated on 4/4/2025, RNA 3 completed Resident 7's RNS. During a review of Resident 10's RNR for 4/2025, the RNR indicated Resident 10 had a Physicians order for RNS for the RNA to apply a right hand roll (device or technique used to assist with hand and finger positioning, particularly in patients with limited ROM) after splint (medical device that supports and/or immobilizes the hand and fingers to help prevent or correct contractures [abnormal tightening or shortening of muscles and tissues, leading to reduced joint movement]), and may remove during nursing care. The RNR indicated the order date was 4/1/2025 at 9:21 AM. The RNR indicated RNA 3 completed Resident 10's RNS on 4/4/2025. During a review of RNA 3's Timecard Report (TCR) for 4/2025, the TCR did not indicate RNA 3 clocked in for work on 4/4/2025. During a review of Resident 7's MDS, the MDS indicated Resident 7 had intact cognition. The MDS indicated Resident 7 required supervision or touching assistance with sitting to standing, chair/bed-to-chair transfers, toilet transfers, and walking 150 ft. During a concurrent interview and record review on 5/21/2025 at 12:21 PM, with RNA 3, Residents 7 and Resident 10's RNR for 4/2025 was reviewed. RNA 3 stated the RNA did not work on 4/4/2025 but accidently signed and initialed that RNA 3 completed Residents 7 and Resident 10's RNS. c. During a review of Resident 8's AR, the AR indicated the facility admitted Resident 8 on 9/16/2024 and was readmitted on [DATE] with diagnoses that included pain in the right and left lower legs. (continued on next page)

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	056118	A. Building B. Wing	05/22/2025

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 8's MDS dated [DATE], the MDS indicated Resident 8 had intact cognition. The MDS indicated Resident 8 required partial to moderate assistance (helper does less than half the effort and lifts or holds trunk or limbs, but provides less than half the effort) with oral and personal hygiene, upper body dressing, rolling left and right, sitting to lying, lying to sitting on side of bed, sitting to standing, chair/bed-to-chair transfers, toilet transfers and walking 50 ft. During a review of RNA 6's TCR for 4/2025, the TCR indicated RNA 6 was not clocked in for work on 4/19/2025. During a review of RNA 7's TCR for 4/2025, the TCR indicated RNA 7 was not clocked in for work on 4/25/2025. During a review of RNA 3's TCR for 4/2025, the TCR indicated RNA 3 was not clocked in for work on 4/26/2025. During a review of Resident 8's RNR dated 4/2025, the RNR indicated on 4/19/2025 RNA 6 completed Resident 8's RNS. The RNR indicated on 4/25/2025, RNA 7 completed Resident 8's RNS. The RNR indicated on 4/26/2025, RNA 3 completed Resident 8's RNS. During a concurrent interview and record review on 5/21/2025 with RNA 3, Resident 8's RNR for 4/2025 was reviewed. RNA 3 stated RNA 3 did not work on 4/26/2025 but accidentally signed and initialed Resident 8's RNR indicating RNA 3 completed the RNS. During a concurrent interview and record review on 5/21/2025 at 3:16 PM with RNA 7, Resident 8's RNR for 4/2025 was reviewed. RNA 7 stated it was a mistake to document that RNA 7 completed Resident 8's RNR on 4/25/2025 because, I didn't work. RNA 7 stated RNA 7 was unsure if Resident 8 received RNS on 4/25/2025. During a telephone interview on 5/21/2025 at 3:28 PM, with RNA 6, RNA 6 stated RNA 6 did not work on 4/19/2025. RNA 6 stated it was possible RNA 6 made a mistake by signing and initialing Resident 8's RNR on 4/19/2025. During an interview on 5/22/2025 at 3:19 PM, with the DON, the DON stated by signing and initialing a resident's RNR, RNAs were indicating the RNS was completed. The DON stated if the RNAs were unable to complete the RNS, staff were supposed to initial the record, circle the initial and write a note on the back of the RNR indicating why the RNS was not completed. The DON stated if RNS was not provided to residents who had orders for it, then those residents could develop a decline in function, suffer muscle wasting and affect their quality of life. During a review of the facility's P&P titled, Documentation- Nursing Manual- Restorative Nursing Program (RNP), revised 11/1/2017, the P&P indicated the purpose was to ensure that resident progress in the RNP was documented accurately and timely. The P&P indicated that each resident would be given the appropriate treatment and services to maintain or improve his or her abilities, as indicated by the resident's comprehensive assessment, to achieve and maintain the highest practicable outcome. The P&P indicated the RNA will document and communicate any significant resident problems or changes to the charge nurse promptly.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately document restorative nursing services (RNS- specialized nursing interventions provided by a restorative nursing aide [RNA] focused on helping to maintain or regain functional abilities to achieve the highest level of well-being, often after rehabilitation or to prevent decline) on the Restorative Nursing Record (RNR) for four out of 12 sampled residents (Residents 5, 7, 8, and 10), in accordance with the facility's policy and procedure (P&P) titled, Documentation- Nursing Manual- Restorative Nursing Program, by failing to: 1. Ensure Restorative Nursing Assistant 3 (RNA- a specialized Certified Nursing Assistant [CNA] 3 with additional training in rehabilitation techniques) did not willfully falsify in Resident 5's RNR that RNA 3 had provided ambulation (the act of walking) RNS as ordered by the physician for the month of 4/2025. 2. Ensure RNA 3 did not sign and initial Residents 7 and 10's RNR on 4/4/2025, indicating RNA 3 had performed Residents 7 and 10's RNS when RNA 3 was not clocked in for work on 4/4/2025. 3. Ensure RNA 6 and RNA 7 did not sign and initial Resident 8's RNR to indicate RNS was provided to Resident 8 on 4/19/2025, 4/25/2025, and 4/26/2025 when RNA 6 and RNA 7 were not clocked in for work on those dates. These failures resulted in Resident 5 not receiving any RNS for the month of 4/2025 and Resident 5, 8, and 10's medical records to contain inaccurate information that could affect Residents 5, 8, and 10's care and result in a decline in range of motion (ROM- exercises and/or movements designed to improve the flexibility and mobility of joints) decline and lead to an inability to ambulate. Cross Reference F825 Findings: 1. During a review of Resident 5's admission Record (AR), the AR indicated the facility admitted Resident 5 on 9/10/2022 with diagnoses that included other abnormalities of gait and mobility (inability to walk normally due to injuries or underlying conditions) and unspecified dementia (progressive states of decline in mental abilities). During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool) dated 3/18/2025, the MDS indicated Resident 5 had intact cognition (ability to think, remember, and reason). The MDS indicated Resident 5 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity and may be provided throughout the activity or intermittently) with walking 50 feet (ft- unit of measurement). During a review of Resident 5's Order Summary Report (OSR), the OSR indicated Resident 5 had an order for the RNA to assist with ambulation (the act of walking) using a front wheel walker (FWW- mobility aid designed to assist with walking) three times per week, up to 100 feet (ft- unit of measurement) or up to the resident's limits to maintain functional mobility skills, active as of 3/31/2025. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 5's untitled Care Plan (CP) initiated 3/31/2025, the CP indicated Resident 5 was receiving ambulation using FWW three times per week, up to 100 ft or up to [Resident 5's] limit to maintain functional mobility skills. The CP goals indicated Resident 5 would maintain functional abilities through the RNA [program as ordered through the next review period]. The CP goals indicated to monitor and observe Resident 5 for tolerance, pain, and skin integrity, and to notify the licensed nurses (LN), rehabilitation (services) and physician if Resident 5 showed a decline in function. During a review of Resident 5's Restorative Nursing Record (RNR- record kept indicating when RNS is provided) for 4/2025, the RNR indicated Resident 5 received RNS on 4/1/2025, 4/3/2025, 4/5/2025, 4/7/2025, 4/9/2025, 4/11/2025, 4/14/2025, 4/16/2025, 4/18/2025, 4/21/2025, 4/23/2025, 4/25/2025, 4/28/2025, and 4/29/2025. During an interview on 5/21/2025, at 12:21 PM with RNA 3, RNA 3 stated on 4/30/2025 in the afternoon, MR printed out the RNR for residents receiving RNS for the month of 5/2025 (for RNAs to sign/initial as treatment is given for 5/2025). RNA 3 stated in the morning on 5/1/2025, RNA 3 realized Resident 5 had RNS orders for the month of 4/2025, but did not receive any RNS for 4/2025. RNA 3 stated RNA 3 realized Resident 5's RNS orders were placed on 3/31/2025. RNA 3 stated RNA 3 informed the Assistant Director of Nursing (ADON), who informed the DON. RNA 3 stated the DON informed RNA 3 to start Resident 5's RNS orders on 5/2/2025. RNA 3 stated Resident 5 was first ambulated on 5/2/2025 since the RNS orders were placed on 3/31/2025. RNA 3 stated on 5/5/2025, while California Department of Public Health (CDPH) was onsite investigating Resident 5's RNS, CDPH asked for Resident 5's RNR for 4/2025 and [the facility] needed to provide it. RNA 3 stated the DON asked RNA 3 to sign Resident 5's treatment record for 4/2025 because the facility had to, Correct and do something about Resident 5's RNR. RNA 3 stated the DON asked RNA 3 to sign Resident 5's RNR for 4/2025, So I did. RNA 3 stated, The DON didn't tell me I was falsifying [Resident 5's] record, the DON just told me I needed to fix the mistake for Resident 5. RNA 3 stated, Because the DON is my boss, I felt like I had to listen to the DON. During an interview on 5/21/2025 at 1:33 PM, with the ADON, the ADON stated the ADON did know what dates in April Resident 5 did not receive RNS. The ADON stated the ADON did not know why Resident 5's RNR for 4/2025 was signed and initialed, indicating RNS was provided to Resident 5. The ADON stated the ADON did not remember when the missed RNS was brought to the DON's attention, and did not remember what the DON instructed the ADON to do about Resident 5's missed RNS dates. The ADON stated Resident 5 could develop a decline in activities of daily living (ADL- the tasks of everyday life fundamental to caring for oneself), loss of muscle mass (amount of muscle in the body) and the ability to walk from not receiving RNS. The ADON stated Resident 5 could become weaker and put Resident 5 at risk for complications from not receiving the ordered RNS. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/21/2025 at 1:46 PM, with the DON, Resident 5's RNR for 4/2025 was reviewed. The DON stated (in general) the physical therapist (PT) put in the RNS orders for residents and was the rehabilitation staffs' responsibility to communicate with RNAs when a RNS order was placed for residents. The DON stated MR will print out the RNR for each resident for the month ahead so RNAs can fill out the RNR as RNS is provided. The DON stated, regarding Resident 5's RNS, there was a miscommunication between nursing, RNA, and rehabilitation staff. The DON stated on 5/1/2025 or 5/2/2025 (exact date unknown), the ADON informed the DON that Resident 5's RNR for 4/2025 was missing. The DON stated the DON informed the RNAs (unidentified) to continue Resident 5's RNS orders. The DON stated the first week of 5/2025 (exact date unknown) RNA 3 informed the DON that Resident 5 had not been ambulated (as ordered) for 4/2025. The DON stated the DON did not know how many dates Resident 5 was not ambulated. The DON stated on 5/5/2025, while CDPH was onsite, the DON asked RNA 3 to find Resident 5's RNR for 4/2025 but RNA 3 could not find it. The DON stated the DON did not know why Resident 5's RNR for 4/2025 was provided to CDPH because the RNR was never printed. During an interview on 5/21/2025 at 3:33 PM, with the Rehabilitation Program Manager (RPM), the RPM stated on 5/1/2025, the DON informed the RPM there was a Discrepancy, with Resident 5's RNS order but did not go into detail because the RPM was not working on 5/1/2025. The RPM stated the RPM returned to work on 5/9/2025 and was not updated on Resident 5's RNS order from the ADON, DON, or rehabilitation staff, So I assumed everything was fine. The RPM stated the RPM was not informed Resident 5 did not receive any RNS for 4/2025. During an interview on 5/21/2025 at 4:05 PM with Resident 5, Resident 5 stated they (exact staff unknown) had been walking Resident 5 for about a month, but did not remember when facility staff began walking Resident 5. During an interview on 5/22/2025 at 3:19 PM with the DON, the DON stated on 5/1/2025 the DON informed the RPM there was a Discrepancy, with Resident 5's RNS orders for 4/2025. The DON stated the DON Looked into it, and discovered that Resident 5's RNS orders were not communicated to the RNAs. The DON stated the DON asked an unidentified rehabilitation staff what happened with Resident 5's RNS orders for 4/2025, but Did not get an answer so I let it go. The DON stated when CDPH was onsite on 5/5/2025 and provided Resident 5's RNR for 4/2025 the DON did not check the RNR. The DON stated Resident 5's RNR for 4/2025 was missing and should not have been provided to CDPH. The DON stated Resident 5 was supposed to receive 14 RNS treatments for 4/2025. The DON stated by not receiving RNS as ordered, Resident 5 could have a decline in health and ability to ambulate, and a decline in function and suffer muscle wasting that could lead to a negative effect on Resident 5's quality of life. 2a. During a review of Resident 7's AR, the AR indicated the facility admitted Resident 7 on 1/16/2023 and was readmitted on [DATE] with diagnoses that included a history of falling and chronic kidney disease (damage to the kidneys so they cannot filter blood the way they should) stage three. During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7 had intact cognition. The MDS indicated Resident 7 required supervision or touching assistance with sitting to standing, chair/bed-to-chair transfers, toilet transfers, and walking 150 ft. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 7's RNR for 4/2025, the RN indicated Resident 7 had a Physicians order to provide RNA ambulation using FWW three times per week, up to 300 ft or up to Resident 7's limits to maintain functional mobility skills. The RNR indicated the order date was dated 2/28/2025 at 7:33 PM. The RNR indicated on RNR indicated on 4/4/2025, RNA 3 completed Resident 7's RNS. 2b. During a review of Resident 10's AR, the AR indicated the facility admitted Resident 10 on 3/6/2024 and was readmitted on [DATE] with diagnoses that included essential (primary) hypertension (condition where the force of blood against artery walls is consistently too high and blood pressure [BP- the pressure circulating blood against the walls of blood vessels; abnormal BP was [HD1] [DLZ2] less than 120/80 millimeters of mercury [mmHg- unit of measurement] and above 140/90 mmHg considered high blood pressure] is consistently high) and epilepsy (disorder in which nerves in the brain are disrupted, causing seizures [burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone and stiffness, twitching, or limpness movements]). During a review of Resident 10's MDS dated [DATE], the MDS indicated Resident 10 had severely impaired cognition. The MDS indicated Resident 10 was dependent (helper does ALL the effort. Resident does none of the effort to completely the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity) with eating, oral, toileting, and personal hygiene, showering/bathing self, upper and lower body dressing, rolling left and right (in bed), and chair/bed-to-chair transfers. The MDS indicated lying to sitting on side of the bed, sitting to standing, and walking 10 ft were not attempted and the resident did not perform this activity prior to the current illness, exacerbation or injury. During a review of Resident 10's RNR for 4/2025, the RNR indicated Resident 10 had a Physicians order for RNS for the RNA to apply a right hand roll (device or technique used to assist with hand and finger positioning, particularly in patients with limited ROM) after splint (medical device that supports and/or immobilizes the hand and fingers to help prevent or correct contractures [abnormal tightening or shortening of muscles and tissues, leading to reduced joint movement]), and may remove during nursing care. The RNR indicated the order date was 4/1/2025 at 9:21 AM. The RNR indicated RNA 3 completed Resident 10's RNS on 4/4/2025. During a review of RNA 3's Timecard Report (TCR) for 4/2025, the TCR did not indicate RNA 3 clocked in for work on 4/4/2025. During a concurrent interview and record review on 5/21/2025 at 12:21 pm, with RNA 3, Residents 7 and Resident 10's RNR for 4/2025 was reviewed. RNA 3 stated the RNA did not work on 4/4/2025 but accidently signed/initialed that RNA 3 completed Residents 7 and Resident 10's RNS. 3. During a review of Resident 8's AR, the AR indicated the facility admitted Resident 8 on 9/16/2024 and was readmitted on [DATE] with diagnoses that included pain in the right and left lower legs. During a review of Resident 8's MDS dated [DATE], the MDS indicated Resident 8 had intact cognition. The MDS indicated Resident 8 required partial to moderate assistance (helper does less than half the effort and lifts or holds trunk or limbs, but provides less than half the effort) with oral and personal hygiene, upper body dressing, rolling left and right, sitting to lying, lying to sitting on side of bed, sitting to standing, chair/bed-to-chair transfers, toilet transfers and walking 50 ft. (continued on next page)

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	05/22/2025

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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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of RNA 6's TCR for 4/2025, the TCR indicated RNA 6 was not clocked in for work on 4/19/2025. During a review of RNA 7's TCR for 4/2025, the TCR indicated RNA 7 was not clocked in for work on 4/25/2025 and 4/26/2025. During a review of Resident 8's RNR for 4/2025, Resident 8's RNR indicated RNA 6 completed Resident 8's RNS on 4/19/2025. Resident 8's RNR indicated RNA 7 completed Resident 8's RNS on 4/25/2025 and 4/26/2025. During a review of the facility's P&P titled, Documentation- Nursing Manual- Restorative Nursing Program (RNP), revised 11/1/2017, the P&P indicated the purpose was to ensure that resident progress in the RNP was documented accurately and timely. The P&P indicated that each resident would be given the appropriate treatment and services to maintain or improve his or her abilities, as indicated by the resident's comprehensive assessment, to achieve and maintain the highest practicable outcome. The P&P indicated the RNA will document and communicate any significant resident problems or changes to the charge nurse promptly.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, the facility failed to ensure all staff had updated N95 respirator (N95 mask- filtering face mask designed to protect the wearer from breathing in airborne [transmitted by air] particles such as viruses) fit test (verifies that a respirator creates a tight seal with the wearer's face, ensuring proper protection from airborne particles), according to the Centers for Disease Control (CDC) and the National Institute of Occupational Safety and Health (NIOSH). As a result of this failure, 101 staff had expired fit tests, 37 of which were working at the facility on [DATE] between 7 am and 3 pm. This failure had the potential to result in staff spreading infectious agents throughout the facility. Findings: During a review of the facility's titled Fit Test Log (FTL), the FTL indicated 101 staff had expired N95 fit tests. During a concurrent interview and record review on [DATE] at 11:20 am, with the Director of Nursing (DON), the facility's FTL was reviewed. the DON stated the DON was not fit tested for a N95 mask this year (2025). The DON stated according to the FTL the last time the DON was fit tested for a N95 mask was [DATE]. The DON stated the log was last updated on [DATE] and was provided to the Public Health Nurse (PHN- focuses on the health of populations within a community, rather than individual patients, and works to promote health and prevent disease) because of the COVID-19 (infectious disease caused by SARS-CoV-2 virus) outbreak (sudden increase in the occurrence of a disease or other health-related event in a specific geographic area or population over a short period). During a concurrent interview and record review on [DATE] at 11:28 am, with the Assistant Director of Nursing (ADON), the facility's FTL and staffing assignment (SA) dated [DATE] for the 7 am to 3 pm shift was reviewed. The ADON stated there were 37 staff currently working at the facility at the time of the interview who were wearing N95 masks with expired fit tests. During an interview on [DATE] at 2:36 pm, with the (covering) Infection Prevention Nurse (IPN), the IPN stated N95 mask fit testing had to be completed yearly to ensure the appropriate mask was being worn and fitted for the staff. The IPN stated there could be changes to the face such as losing or gaining weight and the mask needed to fit properly to ensure the staff were not inhaling infectious agents or particles. The IPN stated if staff were working with expired fit tests, they could be inhaling infectious particles such as COVID-19 because the facility was currently experiencing an outbreak. The IPN stated staff could get infected with COVID-19 and pass the infections to residents who could become sick with COVID-19. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the CDC website for National Institute (NIOSH) for personal protective equipment (PPE-equipment worn to minimize exposure to a variety of hazards), Fit Testing guidelines, dated [DATE], the guidelines indicated before using a tight-fitting respirator in the workplace, the Occupational Safety and Health Administration (OSHA) required users to pass a fit test to confirm proper fit and tight seal against the user's face. The guidelines indicated OSHA requires an annual (yearly) fit test to confirm the fit of any respirator that forms a tight seal to the face before being used in the workplace. The guidelines indicated because each brand, model, and sizes of respirators will fit slightly different, and if there are any changes to [the employee's] weight or dental alterations, a fit test should be done again to ensure the respirator remains effective. https://www.cdc.gov/niosh/ppe/respirators/fit-testing.html The facility did not provide a policy and procedure on annual N95 mask fit testing.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility failed to designate an individual as the infection preventionist nurse (IPN- oversees the facility Infection Prevention and Control program) on 5/21/2025 and while the facility was having a COVID-19 (an infectious disease caused by the SARS-CoV-2 virus) outbreak (at least three COVID-19 positive cases in the facility within a seven-day period among residents and/or staff). This failure had the potential for the facility ' s Infection Prevention and Control program to not be implemented which could result in residents (in general), staff, and visitors contracting and spreading COVID-19. Findings: During a review of the IPN ' s Time Card Report (TCR) for 5/2025, the TCR indicated the last date the (former) IPN worked was 5/20/2025. During an interview on 5/22/2025 at 9:58 AM with the Director of Nursing (DON), the DON stated on 5/21/2025, the DON was covering as the IPN in the facility because, There was no one here. The DON stated the DON did not have IPN certification. The DON stated the last date the (former) IPN worked was 5/20/2025. The DON stated the COVID-19 outbreak was declared at the facility on 5/12/2025. During an interview on 5/22/2025 at 3:19 PM with the DON, the DON stated the facility needed to have a certified IPN to help monitor and prevent infections. The DON stated the facility had a COVID-19 outbreak and not having a certified IPN put the residents and staff at risk for COVID-19 to spread. During a review of the facility ' s undated job description titled, Infection Control Coordinator (ICC- also known as IPN), the job description indicated the ICC promoted and maintained infection control guidelines and standards. The job description indicated the ICC ensured all infection control documentation is maintained according to federal (Center for Disease Control [CDC] and state requirements and company infection control standards.