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	06/04/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to adequately monitor one of two sampled residents (Resident 1) psychotropic (drug or substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) medication by failing to monitor Resident 1's anxious behavior and side effects of Ativan (brand name psychotropic drug used for anxiety) from 5/9/2025 to 5/23/2025. This deficient practice had the potential for Resident 1 to experience adverse (unwanted) effects from Ativan. Findings: During a review of Resident 1's admission Record, (AR) the AR indicated Resident 1 was admitted to the facility on [DATE] with multiple diagnoses including chronic respiratory failure (lungs can't get enough oxygen into the blood) and quadriplegia (a condition where a person experiences paralysis in both arms and legs.) During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 3/20/2025, the MDS indicated Resident 1 had intact cognition (ability to understand and process information) and was dependent (helper does all the work) on staff for bathing and toileting. During a review of Resident 1's Medication Administration Record (MAR) dated as 5/31/2025, the MAR indicated Resident 1 received thirteen 1 milligram (mg - unit of weight) doses of Ativan for anxiety manifested by screaming and yelling due to being overly concerned about health condition from 5/9/2025 to 5/23/2025. During a concurrent interview and record review on 6/4/2025 at 4:18 PM with Registered Nurse Supervisor (RNS), Resident 1's MAR with active orders as of 5/31/2025 was reviewed. The RNS stated Resident 1's MAR did not indicate Resident 1 was monitored for side effects from Ativan when it was administered from 5/11/2025 to 5/23/2025. The RNS stated the MAR also did not indicate Resident 1's anxious behavior was monitored during the same timeframe. The RNS stated the side effects of Ativan needed to be monitored because any person taking the medication had potential to experience adverse effects from the medication. The RNS further stated Resident 1's anxious behavior needed to be monitored so the doctor could know whether the medication was effective or still needed. (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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/4/2025 at 4:45 PM with the Director of Nursing (DON), the DON stated Resident 1 had a previous order for Ativan from 4/26/2025 to 5/10/2025 and the nursing staff monitored for episodes of overly concern of health condition tallied by hashmark and also monitored for potential side effects of Ativan. The DON stated the orders were only in effect for 14 days and the nursing staff must have forgot to renew the orders for behavior monitoring and side effect monitoring when Resident 1's doctor wrote a new order for Ativan beginning 5/8/2025. The DON stated monitoring for potential side effects of Ativan and monitoring Resident 1's anxious behavior was necessary for the staff and doctor so they would know whether the medication was working as intended and should be continued or if the resident potentially experienced adverse side effects. During a review of the facility's policy and procedure (P&P) titled, Psychotherapeutic Drug Management, dated 5/17/2024, the P&P indicated nursing will monitor psychotropic drug use daily noting any adverse effects and will monitor the presence of target behaviors on a daily basis charting by exception (i.e. charting only when the behaviors are present).

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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 - Few	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 document one of one sampled resident's (Resident 1) diagnosis of mood disorder in Resident 1's admission Record (AR). This failure had the potential to result in Resident 1 to not receive medication and services related to a mood disorder. Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with multiple diagnoses including chronic respiratory failure (lungs can't get enough oxygen into the blood) and quadriplegia (a condition where a person experiences paralysis in both arms and legs). The AR did not indicate a diagnosis of mood disorder. During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 3/20/2025, the MDS indicated Resident 1 had intact cognition (ability to understand and process information) and was dependent (helper does all the work) on staff for bathing and toileting. During a review of Resident 1's Order Summary Report (OSR) with active orders as of 5/24/2025, the OSR indicated Resident 1 had a physician order for Depakote Sprinkles (medication used to treat seizure disorders, and mental/ mood conditions) oral capsule delayed release 125 milligrams (mg - unit of weight), to administer four capsules via jejunostomy tube (J-Tube, feeding tube inserted directly into the small intestine through the abdominal wall) every 12 hours for poor impulse manifested by inconsolable screaming and yelling with a start date of 5/10/2025. During a review of Resident 1's Medical Professional Progress Notes (MPPN), dated 5/8/2025, the MPPN indicated Resident 1's Psychiatrist's planned to begin a medication regimen of Depakote 500mg via J-tube twice a day for mood disorder. During an interview on 6/4/2025 at 4:45 PM with the Director of Nursing (DON), the DON stated Resident 1's Depakote was for a diagnosis of mood disorder manifested by screaming and yelling. The DON stated the physician order for Depakote did not include the diagnosis of mood disorder. The DON further stated Resident 1's AR should have been updated to show the new diagnosis and give justification for Resident 1's Depakote and ensure all staff was aware of Resident 1's current condition. The DON further stated the physician's order should have included the diagnosis along with the indication for the medication. During a review of the facility's policy and procedure (P&P) titled, Psychotherapeutic Drug Management, dated 5/17/2024, the P&P indicated the psychotherapeutic medication (drug that affects how the brain works and used to treat mental health conditions) order will include the following information: drug and dosage, diagnosis for the medication, indications and manifestations of the disorder treated.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow the public health nurse (PHN) guidance intended to reduce the transmission of Covid-19 (infectious disease caused by the SARS-CoV-2 virus) in the facility during a Covid-19 outbreak by failing to: a. Ensure the proper signage was displayed in front of the rooms with residents presumed to be infected with Covid-19 for 4 of 4 sampled residents (Resident's 8,7,5 and 4). b. Test newly admitted and re-admitted residents to the facility for Covid-19 on day 0, 3, and 5 per the PHN guidance for 4 of 4 sampled residents (Residents 8, 7, 9, 5 and 4) c. Ensure one of eleven facility staff (LVN 2) ensured their Covid-19 rapid antigen test (RAT -quick test done to find out if one has Covid-19) was negative prior to entering patient care areas at the beginning of the 3-11PM shift on 6/3/2025. This deficiency had the potential to spread Covid-19 to patients and other staff throughout the facility. Findings: a. During a review of Resident 8's admission Record (AR), the AR indicated Resident 8 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including chronic obstructive pulmonary disease (long-term lung condition caused by damage to the airways and air sacs in the lungs that makes it hard to breathe.) During a review of Resident 8's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 2/19/2025, the MDS indicated Resident 8 had moderately impaired cognition (ability to understand and process information) and required moderate assistance (helper does less than half the effort) for bathing and personal hygiene. During a review of Resident 8's Order Summary Report (OSR) with active orders as of 6/4/2025, the OSR indicated Resident 8 had a physician order for novel precautions due to being a readmit per California Department of Public Health (CDPH) recommendations every shift for 10 days dated 6/2/2025. b. During a review of Resident 7's AR, the AR indicated Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including Alzheimer's disease (condition that occurs late in life and worsens with time in which brain cells degenerate; it is accompanied by memory loss, physical decline, and confusion.) During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7 had intact cognition and was dependent (helper does all of the effort) on staff for bathing and toileting. During a review of Resident 7's OSR with active orders as of 6/4/2025, the OSR indicated Resident 7 had a physician order for novel precautions due to readmit per CDPH recommendations every shift for 10 days dated 6/1/2025. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. During a review of Resident 9's AR, the AR indicated Resident 9 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including hemiplegia (condition characterized by weakness or paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (type of stroke that results in death of brain tissue due to lack of blood flow) affecting the left non-dominant side. During a review of Resident 9's MDS dated [DATE], the MDS indicated Resident 9 had moderately intact cognition and was dependent on staff for bathing and toileting hygiene. During a review of Resident 9's OSR with active orders as of 6/4/2025, the OSR indicated Resident 9 had a physician order for novel precautions due to readmit per CDPH recommendations every shift for 10 days dated 5/30/2025. d. During a review of Resident 5's AR, the AR indicated Resident 5 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including paraplegia (the inability to voluntarily move the lower parts of the body). During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5 had intact cognition and was dependent on staff for bathing and toileting. During a review of Resident 5's OSR with active orders as of 6/4/2025, the OSR indicated Resident 5 had a physician order for novel precautions due to readmit per CDPH recommendations every shift for 10 days dated 5/27/2025. e. During a review of Resident 4's AR, the AR indicated Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including dependence on ventilator status (a person connected to a machine that assists the lungs to breathe) with tracheostomy (surgical procedure that creates an opening in the neck to help a person breathe.) During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4 and severely impaired cognition and was dependent on staff for bathing and personal hygiene. During a review of Resident 4's OSR with active orders as of 6/4/2025, the OSR indicated Resident 4 had a physician order for novel precautions due to readmit per CDPH recommendations every shift for 10 days dated 6/3/2025. During an interview on 6/3/2025 at 10:14 AM with the Assistant Director of Nursing (ADON), the ADON stated the facility did not have any residents who were positive with Covid-19 and the only residents currently under isolation were newly or re-admitted residents. The ADON stated the department of health directed the facility to treat all newly admitted residents and re-admitted residents as though they are potentially infected with Covid-19. The ADON further stated the residents were placed under enhanced barrier precautions (EBP). During a telephone interview on 6/3/2025 at 12:12 PM with the Public Health Nurse (PHN), the PHN stated all residents exposed to Covid-19, newly admitted residents and re-admitted residents should be under novel respiratory precautions. The PHN stated it was necessary to place them under these precautions because the facility must presume, the residents are infected with Covid-19 until it is proven that they're not. (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 concurrent observation and interview on 6/3/2025 at 12:36 PM with the Infection Preventionist Nurse (IPN), the signage posted in front of Residents 8, 7, 9, 5 and 4's room were viewed. The IPN stated Residents 8, 7, 9, 5, and 4 needed to have signage for novel respiratory precautions in front of their room. The IPN stated Resident 9's room was the only room with the correct signage at this time and Residents 8, 7, 5 and 4 had signage for EBP. The IPN stated under novel respiratory precautions, staff must wear all personal protective equipment (PPE) including face mask, face shield or goggles, gown and gloves every time staff entered the room. The IPN stated under EBP, staff was only required to wear gown and gloves if there was direct patient contact. The IPN stated Covid-19 could still be spread under EBP. During an interview on 6/3/2025 at 1:42 PM with Registered Nurse (RN) 1, RN 1 stated the facility's former Infection Preventionist Nurse would place residents exposed to Covid-19 under EBP and novel respiratory precautions were not implemented for Residents 8, 7, 9, 5, and 4 until 6/3/2025. During a review of the facility's policy and procedure (P&P) titled, Covid-19 Mitigation Plan, undated, the P&P indicated the recommended signage for those confirmed or suspected to be infected with a contagious disease was novel respiratory precautions. The P&P further indicated signs should be posted immediately outside of resident rooms indicating appropriate infection control and prevent precautions and required PPE in accordance with CDPH guidelines. f. During a review of the facility's PHN instructions for Covid-19 dated 5/15/2025, the PHN instructions indicated all new or re-admitted residents should be tested on days 0, 3, and 5 and quarantine for 10 days upon arrival to the facility. During an interview on 6/3/2025 at 10:14 AM with the ADON, the ADON stated all residents, including Residents 8, 7, 9 and 5 were tested twice weekly for Covid-19 on Mondays and Thursdays. During a telephone interview on 6/3/2025 at 12:12 PM with the PHN, the PHN stated the PHN had assumed the facility was performing serial testing per the instructions in the email. During a review of the facility's undated policy and procedure (P&P) titled, Covid-19 Mitigation Plan, the P&P indicated new admissions and readmissions who are asymptomatic without a current diagnosis of Covid-19 at the time of admission and without known close contacts, serial test a total of three times on days 0, 3, and 5. g. During an observation on 6/3/2025 at 3:10 PM in the front entrance of the facility, Licensed Vocational Nurse (LVN) 2 was observed entering the facility and self-performed a Covid-19 RAT. LVN 2 then placed the test labeled with name and date on a table near the entrance of the facility. During a concurrent observation and interview on 6/3/2025 at 3:14 PM with the Receptionist (RCP), LVN 2's RAT was reviewed. The RCP stated the results of the RAT were not fully developed. (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 concurrent observation and interview on 6/3/2025 at 3:50 PM with LVN 2, LVN 2's RAT was reviewed. LVN 2 stated when each staff begins their shift, staff will perform a Covid RAT and wait until they see a negative result and show the receptionist their test. LVN 2 stated a RAT is complete when a solid line shows under the C (control line). LVN 2 stated one line indicates a negative result and two lines indicates a positive result. LVN 2 stated LVN 2 believed their test was negative, but the result was not clearly indicated in the picture of their RAT. LVN 2 stated LVN 2's test was not fully developed and did not indicate a clear negative result. LVN 2 stated LVN 2 should have waited for a longer period of time to ensure the test was negative before starting the shift because one never knows if the test will result positive. LVN 2 stated a positive test could expose other residents and staff and potentially get them sick. During a review of the facility's PHN instructions for Covid-19 dated 5/15/2025, the PHN instructions indicated all staff should test before each shift. During a review of the facility's policy and procedure (P&P) titled, Covid-19 Testing & Quarantine, dated 6/5/2023, the P&P indicated all Covid-19 testing will be conducted in a manner that is consistent with current standards of practice. The P&P further indicates facility staff will be restricted from work pending results of Covid-19 testing.