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	05/28/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 6) with tracheostomy tube (a curved tube inserted into a surgically created opening in the neck [stoma] and into the windpipe [trachea] to provide an alternative airway for breathing) received necessary care and services when:1. The cause of Resident 6's accidental decannulation (accidental removal of tracheostomy tube from the stoma) on [DATE] was not investigated.2. A care plan (CP - summary of a person's health condition, care needs, treatments, goals of treatment, and specific interventions for each identified condition or care need) regarding Resident 6's accidental decannulation was not developed and implemented.These failures placed Resident 6 and other residents with tracheostomy tube at risk for accidental decannulation which could negatively affect the residents' health and well-being.During a review of Resident 6's admission Record (AR), the AR indicated Resident 6 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure with hypoxia (when the lungs suddenly cannot get enough oxygen into the blood or remove carbon dioxide [waste gas made in the body's cells] from the blood) and pulmonary embolism (a blood clot that blocks and stops blood flow to the lungs). The AR indicated Resident 6 had a tracheostomy tube.During a review of Resident 6's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated [DATE], 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 [DATE], the MDS indicated Resident 6 had mildly impaired cognitive skills (ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 6 was dependent on staff for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 6's Care Plan Report (CPR), initiated on [DATE], the CPR indicated Resident 6 had a tracheostomy related to impaired breathing mechanics. The CPR interventions included ensuring tracheostomy ties are secured at all times.During a review of Resident 6's SBAR Communication Form (SBAR- situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated [DATE] and timed at 8:04 AM, the SBAR indicated Resident 6 had an accidental decannulation while being red capped (process of placing a plug [red cap] to cover the opening of a tracheostomy tube to test if the individual can breathe on their own without the tracheostomy tube) on [DATE]. The SBAR indicated Resident 6 complained of pain at the tracheostomy site after being red capped and restorative nursing assistant (RNA, certified nursing assistant who had special training in ambulation, range of motion exercises, applying and removing splints, and positioning) (unidentified) and charge nurse (unidentified) immediately observed Resident 6's tracheostomy tube was out of place.During a review of Resident 6's Respiratory Therapy Note (RTN), dated [DATE] and timed at 9:25 AM, the RTN indicated Resident 6 had an episode of decannulation around 8:40 AM on [DATE]. The RTN indicated Resident 6's tracheostomy tube was reinserted, and the tracheostomy tie was secured.During a review of Resident 6's medical record, there was no documentation regarding how Resident 6's tracheostomy tube accidentally came out on [DATE].During a review of Resident 6's current care plans (CPs), there was no care plan regarding (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

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 6's episode of accidental decannulation on [DATE].During an interview on [DATE] at 1:46 PM with Resident 6, Resident 6 stated Resident 6's tracheostomy tube had been accidentally disconnected while being repositioned and cared for by a CNA (unidentified) once before. Resident 6 was unable to remember when the incident happened.During a phone interview on [DATE] at 2:57 PM with RNA 1, RNA 1 stated on the morning of [DATE] Resident 6 told RNA 1 Resident 6's tracheostomy felt uncomfortable. RNA 1 stated RNA 1 did not know Resident 6 had an accidental decannulation on [DATE].During a phone interview on [DATE] at 4:35 PM with Respiratory Therapist (RT) 1, RT 1 stated Resident 6 had an accidental decannulation on [DATE]. RT 1 stated Resident 6 told RT 1 on [DATE] that Resident 6's tracheostomy came out after certified nursing assistants (CNAs) (unidentified) repositioned and changed Resident 6.During a phone interview on [DATE] at 2:14 PM with Licensed Vocational Nurse (LVN) 5, LVN 5 stated licensed nurses should have developed and implemented a care plan after Resident 6 had an accidental decannulation. LVN 5 stated LVN 5 did not know the reason and the details regarding Resident 6's accidental decannulation on [DATE].During a phone interview on [DATE] at 4:25 PM with Registered Nurse (RN) 2, RN 2 stated RN 2 should have developed and implemented a care plan after Resident 6 had an accidental decannulation on [DATE] to provide care, to monitor for respiratory distress and vital signs (measurements of the body's basic functions, such as heart rate, breathing rate, blood pressure, and temperature), and to prevent accidental decannulation again. RN 2 stated RN 2 did not know the reason or details that caused Resident 6's accidental decannulation on [DATE].During a concurrent interview and record review on [DATE] at 3:40 PM with the Assistant Director of Nursing (ADON), Resident 6's SBAR, dated [DATE], and current CPs were reviewed. The ADON stated licensed nurses should have developed and implemented a CP regarding Resident 6's accidental decannulation on [DATE]. The ADON stated it was important to create a care plan regarding Resident 6's accidental decannulation to prevent decannulation again and to maintain the resident's well-being.During an interview on [DATE] at 4:55 PM with the Director of Nursing (DON), the DON stated the facility did not investigate Resident 6's accidental decannulation on [DATE] and did not know the cause of the accidental decannulation. The DON stated it was important to investigate the accidental decannulation to find the cause and create a care plan regarding resident's accidental decannulation to provide care to prevent decannulation again and maintain resident's well-being.During a review of the facility's Policy and Procedure (P&P) titled, Care Planning, revised [DATE], the P&P indicated that the facility should ensure that a comprehensive person-centered care plan is developed for each resident based on their individual assessed needs. The P&P indicated, A Licensed Nurse will initiate the Care Plan, and the plan will be finalized in accordance with OBRA/MDS guidelines and updated as indicated for change in condition, onset of new problems, resolution of current problems, and as deemed appropriate by clinical assessment and judgment on an as needed bases.During a review of the facility's P&P titled, Change of Condition Notification, dated [DATE], the P&P indicated when there is an accident involving a resident a licensed nurse must Update the Care Plan to reflect the resident's current status and A Licensed Nurse will document each shift for at least seventy-tow (72) hours.