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	06/11/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to ensure one of two sampled resident's (Resident 4) head of the bed (HOB) was kept between 30 to 45 degrees when Resident 4's gastrostomy tube (GT - a tube inserted into an artificial external opening in the stomach for nutritional support) feeding was running (Resident 4 received nutrition), the facility failed to turn off Resident 4's GT feeding when Resident 4's HOB was lowered to a flat position.This deficient practice had the potential to result in aspiration pneumonia (a serious complication of GT feeding when food, liquid, or other materials enter the lungs causing an infection) and a physical decline to Resident 4.Findings:During a review of Resident 4's admission Record (AR), the AR indicated the facility admitted Resident 4 on 5/12/2025, with diagnoses that included chronic respiratory failure (long lasting condition that requires ventilatory support or supplemental oxygen [colorless odorless gas] due to inadequate gas exchange) and dysphagia (difficulty swallowing).During a review of Resident 4's Minimum Data Set (MDS -a resident assessment tool), target date 5/1/2026, the MDS indicated Resident 4's cognitive (the ability to think and process information) was severely impaired. The MDS indicated Resident 4 was dependent on staff for activities of daily living.During an observation on 6/10/2026 at 1:20 PM, Certified Nursing Assistant (CNA) 1 entered Resident 4's room and lowered Resident 4's HOB to a flat position. CNA 1 prepared items needed for pericare (process of gently washing a person's private parts, performed daily), removed the nasal cannula (NC, lightweight flexible plastic tube with two prongs that sit in the nostrils to deliver supplemental oxygen) prongs from Resident 1's nose, removed Resident 1's gown, and began wiping Resident 1's face. Resident 1's GT feeding remained running during pericare.During a concurrent observation and interview on 6/10/2026 at 1:30 PM, with Licensed Vocational Nurse (LVN) 1, Resident 4's HOB was in a flat position, LVN 1 stated the GT feeding needed to be turned off [due to the lowered HOB]. LVN 1 turned off Resident 4's GT feeding. During an interview on 6/10/2026 at 3:05 PM, CNA 1 stated CNA 1 did not ask the licensed nurse (in general) to turn off Resident 4's GT feeding prior to lowering Resident 4's HOB. CNA 1 stated CNA 1 thought Resident 4's GT feeding was already off. CNA 1 stated GT feedings needed to be turned off when the HOB was lowered to prevent food (GT feeding) from going back up the throat and into the lungs.During an interview on 6/11/2026 at 11:10 AM, with the Director of Staff Development (DSD), the DSD stated GT feedings needed to be turned off when the HOB was lowered during paricare.During a review of Resident 1's Order Summary Report (OSR) that include a physician's order, initiated on 3/9/2026, the order indicated to elevate the HOB 30-45 degrees at all times while feeding was on [running].During a review of the facility's Policy and Procedure (P&P) titled Bolus Feeding, dated 5/1/2026, the P&P indicated to limit the risk for aspiration and reflux (stomach acid comes back up to the back of the throat), raise the HOB 30-45 degrees during [GT] feeding and for 1 hour after feeding.

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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(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 - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to provide a sanitary environment for one of one sampled resident (Resident 1) when Certified Nursing Assistant 1 provided pericare (process of gently washing a person's private parts, performed daily) to Resident 1 and used the sink instead of a wash basin in accordance with the facility's Policy and Procedure (P&P) titled Perineal Care. This deficient practice had the potential to result in the development and spread of infections (the invasion and growth of germs in the body) and the potential to result in a urinary tract infection (UTI - an infection in the bladder/urinary tract) to Resident 1. Findings:During a review of Resident 4's admission Record (AR), the AR indicated the facility admitted Resident 4 on 5/12/2025, with diagnoses that included chronic respiratory failure (long lasting condition that requires ventilatory support or supplemental oxygen [colorless odorless gas] due to inadequate gas exchange) and dysphagia (difficulty swallowing).During a review of Resident 4's Minimum Data Set (MDS -a resident assessment tool), target date 5/1/2026, the MDS indicated Resident 4's cognitive (the ability to think and process information) was severely impaired. The MDS indicated Resident 4 was dependent on staff for activities of daily living.During an observation on 6/10/2026 at 1:20 PM, CNA 1 entered Resident 4's room and lowered Resident 4's head of the bed. CNA 1 prepared items needed for pericare, took a large towel from the bedside table, placed the towel inside the bathroom sink and ran the water. CNA 1 poured liquid body wash onto the towel and the water in the sink became bubbly. CNA 1 removed Resident 4's gown and used the wet towel from the sink to clean Resident 4's face. Next, CNA 1 removed Resident 4's diaper, squeezed the same wet towel and soapy water dripped to Resident 4's perineal (private) area. CNA 1 went back to the bathroom dipped the towel in the sink's soapy water, returned to Resident's bedside, and squeezed the same towel dripping water on Resident 4's perineal area. CNA 1 continued pericare by drying Resident 4's perineal area with a dry towel.During an interview on 6/11/2026 at 11:10 AM with the Director of Staff Development (DSD), the DSD stated the DSD followed the CNAs (in general) during the completion of the orientation's Competency Evaluation Checklist. The DSD stated, through this evaluation, the CNAs demonstrated perineal care that included gathering supplies such as a basin, towels, wash cloths. The DSD stated CNA's should not put pericare towels (used during pericare) directly on the bathroom sinks. The DSD stated the sink became dirty and the sink was shared by other residents (multi resident room).During an interview on 6/11/2026 at 2:54 PM, CNA 1 stated CNA 1 did not use a wash basin and stated Resident 4 did not have a wash basin. CNA 1 stated CNA 1 had never used a basin for Resident 4's pericare and CNA 1's practice was to always use the sink. CNA 1 stated CNA 1 needed to use a basin because the sink was dirty.During a review of the facility's P&P titled Perineal Care dated November 1, 2017, the P&P indicated the purpose of Perineal Care was to maintain cleanliness of the genital area, to reduce odor and to prevent infection or skin breakdown. The P&P indicated to prepare the following equipment for Perineal Care that included a washbasin, soap, washcloths, bath towel, pad, gloves.to put on gloves, wash the pubic area, wash the penis from the urethral opening or tip of the penis, wash the scrotum, rinse and dry.During a review of the facility's P&P titled Infection Prevention and Control Program (IPCP) dated October 24, 2022, the P&P indicated the purpose of the IPCP was to ensure the facility established and maintained an Infection Control Program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection in accordance with federal and state requirements.