

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056365	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Yucaipa Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 13542 2nd St. Yucaipa, CA 92399	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure one of two crash carts (a wheeled cart carrying emergency equipment and medications for use in case of emergency) were checked and documented daily by staff as per facility's policy and procedure (P&P) titled, Emergency Medical supplies and equipment when the crash cart in the upper unit (CCUU) was not checked and documented. This failure had the potential to cause delay in availability and functionality of emergency equipment and medications in case of an emergency which will impact the health and safety of all residents in the facility. Findings: During a concurrent observation and interview on January 7, 2026, at 11:00 AM, with Infection Preventionist nurse (IP), the facility's crash cart in the upper unit (CCUU) was checked and observed to have missing signatures for the following dates: July 1, 2025, through July 31, 2025 (31 days on night shift were missing signatures) August 6, 2025, and August 7, 2025 (2 days on night shift were missing signatures) August 15, 2025 (PM shift was missing signature) August 13, 20, 21, 26, and 27, 2025 (5 days on AM and PM shifts were missing signatures) September 5, 6, 11, 12, 17, 25, 30, 2025 (7 days AM and PM shifts missing signatures) September 18, 2025 (missing signatures on 3 shifts) September 19, 2025 (night shift was missing signatures) October 1, 2, 3, 8, 9, 15, 16, 17, 22, 23, 29, 30, and 31, 2025 (13 days on AM and PM shifts missing signatures) October 13 and 14, 2025 (2 days were missing night shift signatures) November 31, 2025 (AM and PM shift were missing signatures) December 4, 2025 supplies were not checked in the crash cart. The IP stated, the staff are required to check the crash cart each shift and sign the log. The IP acknowledged that there were multiple shifts had missing signatures indicating that the crash cart in the upper unit (CCUU) was not checked or inspected. During an interview on January 7, 2026, at 11:30 AM, with Director of Nursing (DON), the DON stated, The licensed staff are educated to check the crash cart every shift and sign the log. The DON further stated, There is no specific policy for crash cart in the facility. The DON acknowledged that there are missing signatures in multiple shifts. During a concurrent interview and record review on January 8, 2026, at 1:40 PM, with DON, facility's P&P titled, Emergency Medical Supplies and equipment, undated, was reviewed. The P&P indicates, Policy: It is the policy of this facility to maintain an adequate inventory of emergency medical supplies and equipment all times. Procedures: 4. Supplies/equipment are checked daily and as necessary/appropriate. The DON stated, the policy was not followed as we are missing signatures.		

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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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow their policy and procedure (P&P) for Foods brought by family/visitors when one of 6 sampled residents (Resident 47) reviewed for nutrition received food from a visitor of another resident. This failure had the potential to compromise dietary compliance and risk Resident 47's health and nutritional needsFindings:During an observation on January 7, 2026, at 12:45 PM, in activity/dining room, Resident 47 was sitting on table one with other residents . One of the resident's (Resident 19) wife (not a resident in the facility/visitor) brought snacks including potato chips, marshmallows, a packet of hot [NAME] powder (a package of powder which contains chocolate and sugar and can be mixed with water or milk to make hot chocolate) were handed by the visitor to Resident 47. Resident 47 opened the packet and put some powder on his desert, and swallowed the remaining powder directly. It was also observed that the visitor was offering potato chips to resident 47.During a concurrent observation and interview on January 7, 2026, at 1:00 PM, with Director of Nursing (DON), the meal tray for Resident 47 had an open and empty package of [NAME] powder packet. The DON stated, that the [NAME] powder did not come with the meal tray.During an interview on January 7, 2026, at 1:05 PM, with Director of Activities (DA), the DA stated that Resident 19's visitor comes to the facility every day during lunch time.During a review of Resident 47's admission Record (demographic data), the admission Record indicates, Resident 47 was admitted to the facility on [DATE], with the diagnosis of Traumatic brain injury (injury to the brain caused by force), type 2 diabetes mellitus without complications (high blood sugar), hyperlipidemia (high cholesterol in blood), hypertension (high blood pressure).During a review of Resident 47's document titled, order summary report, dated October 8, 2025, the order summary report indicated, Resident 47's diet order was consistent Carbohydrate Diet(CCHO- a diet ordered for a diabetic patient with controlled carbohydrate to regulate blood sugar) with thin consistency. Resident 47 also had orders for Glipizide oral tablet (a medication for the treatment of blood sugar) 10 mg (milli gram- a unit of measurement) 1 tablet (a form of medication) by mouth two times a day for diabetes mellitus and Metformin HCL (hydrochloride- an acid salt form from an organic base for treatment of diabetes mellitus) 1000 mg ,1 tablet by mouth two times a day for diabetes mellitus.During a review of Resident 47's document titled, Care Plan Report, dated October 10, 2025, the care plan report indicated, Resident 47's Diet changes should be made and evaluated by a registered dietician.During a concurrent interview and record review on January 8, 2026, at 1:30 PM, with DON, the facility's Policy and Procedure (P&P) titled, Foods brought by family/Visitors, undated, was reviewed. The P&P indicated, Policy statement Foods brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a home-like environment with nutritional and safety needs of the residents. Policy interpretation and implementation.2. Foods brought by family/visitors for individual residents are not shared with or distributed to other residents. The DON stated, that it is expected not to share outside food with other residents. The DON acknowledged that the policy was not followed.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow policy and procedure (P&P) titled, Oxygen Administration, for one out of one sampled resident (Resident 7) when oxygen was not administered according to the physician's order. This failure had the potential to compromise Resident 7's respiratory status which would risk resident 7's health and well-being. Findings: During a concurrent observation, and interview, on January 6, 2026, at 10:26 AM, with Infection Preventionist Nurse(IP) in Resident 7's room, Resident 7 was lying on bed with eyes closed. Resident 7 had nasal canula (a clear plastic tube through which the oxygen is delivered to the nostrils) which was connected to oxygen on her face but the nose piece (the opening where the oxygen is delivered to the patient) was away from Resident 7's nostrils. The IP stated, the oxygen was not on Resident 7's nose and she might have pulled that out. The IP acknowledged that nurses are responsible for checking the placement and delivery of oxygen to the residents. During a concurrent observation and interview on January 6, 2026, at 10:30 AM, with Licensed Vocational Nurse 2 (LVN 2), the LVN 2 checked the oxygen saturation (amount of oxygen in the blood) for Resident 7 and was noted as 89 (less than normal) percentage (unit of measurement for gases). The LVN 2 stated, Resident 7 was ordered for continuous oxygen therapy as per physician. During a review of Resident 7's document titled, admission Record (demographic data), the admission Record indicates, Resident 7 was re admitted to the facility on [DATE], with the diagnosis of chronic respiratory failure (a condition in which lungs are unable to get enough oxygen from blood and remove carbon dioxide). During a review of Resident 7's document titled, order summary report, dated September 29, 2025, the order summary report indicates, Resident 7 has the order for continuous oxygen of 2 to 5 liters per minute by nasal canula to maintain an oxygen saturation at 92 percentage. During a concurrent interview and record review on January 8, 2026, at 1:35 PM, with the Director of Nursing (DON), the facility's P&P titled, Oxygen Administration, undated, was reviewed. The P&P indicated, Policy: it is the policy of this facility that oxygen therapy is administered, as ordered by the physician or as an emergency measure until the order can be obtained. The DON stated, that it was a miss, and the nurses should have checked her. The DON further stated, that the policy was not followed.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store and prepare food in accordance with professional standards for food safety when there was visible accumulation of grime and debris within an actively used oven and the continued presence of a non-functional refrigerator in the food preparation area. This failure had the potential to result in accumulating pathogenic microorganisms (germs or infectious agents that can cause disease) and to attract insects or rodents, which could place the health and safety of 81 highly vulnerable residents who receive food from the kitchen at risk. Findings: During a concurrent observation on January 5, 2026, at 7:57 AM, with the Dietary Supervisor (DS), an initial tour of the kitchen was conducted. A non-functional refrigerator, labeled out of order was observed in the kitchen food preparation area. The DS stated, the refrigerator had been non-operational for approximately two weeks and was not being used. The refrigerator continued to take up space in the kitchen and had not been relocated to another area. During a concurrent observation on January 5, 2026, at 8:02 AM, with the DS, an oven was observed to have visible accumulation of grease and debris trapped between the glass panels. The DS stated, the oven was actively used for resident meal preparation and the kitchen staff cleaned equipment regularly. However, staff were unable to access the area between the glass panels for cleaning. The DS further stated, maintenance had attempted to remove the glass panels but was unable to do so. During a concurrent interview and record review on January 6, 2026, at 3:20 PM, with the DS, the facility policy and procedure (P&P) titled, Ranges and Ovens, revised in 2023, was reviewed. The policy indicated, .Ovens .Cleaning Procedure: .5. Clean the exterior of the oven according to manufacturer's instructions. The DS confirmed she was responsible for overall kitchen cleanliness, including the oven, and acknowledged the oven should not have visible buildup. The DS stated, the facility did not follow policy for cleaning ovens, and did not refer to manufacturer instructions. During a further interview on January 6, 2026, at 3:28 PM, with the DS, the DS stated, the non-operational refrigerator should not remain in the kitchen. The expectation is that non-functioning equipment should be removed immediately. During an interview on January 6, 2026, at 3:32 PM, with the Maintenance Director (DOM), the DOM confirmed he was aware of the oven condition, and that it had visible grime and debris for an extended period of time. The DOM further stated, manufacturer guidance had not been reviewed. The DOM also stated, the non-functional refrigerator should not remain in the kitchen and the expectation was to have it removed immediately. During a concurrent interview and record review on January 6, 2026, at 3:56 PM, with the Administrator (Admin), the following facility P&Ps were reviewed: Ranges and Ovens, revised in 2023, and Sanitation, revised in 2023. The P&P, Ranges and Ovens, indicated, .Ovens .Cleaning Procedure: .5. Clean the exterior of the oven according to manufacturer's instructions. The P&P, Sanitation, indicated, .11. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corruptions, open seam, cracks, and chipped areas .16. The kitchen staff is responsible for all the cleaning with the exception of ceiling vents, light fixtures, and the hood over stove, which will be cleaned by the maintenance staff . The Admin confirmed facility policy requires kitchen equipment to be maintained in a clean and sanitary condition, and the unused refrigerator should not have remained in the kitchen once it was no longer functional. Admin further stated, the facility did not follow both policies. During a review of the US FDA (United States Food and Drug Administration) Federal Food Code, dated 2022, section 6-601.11, titled, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, indicated, Equipment food-contact surfaces and utensils shall be clean to sight and touch .The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations .Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. The FDA Food Code, Section 4-601.11, further indicated, The objective of cleaning focuses on the need to remove organic matter from (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	food-contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate, and insects and rodents will not be attracted.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 maintain an effective infection control practices for one of 18 sampled residents (Resident 6) when an indwelling urinary catheter (Foley-a tube that stays inside the bladder to drain the urine into a bag) drainage bag was observed resting on the floor. This failure had the potential to promote the transmission of infection by allowing contamination of the urinary catheter drainage system and increasing the risk of urinary tract infection. Findings: A review of Resident 6's face sheet (FS- a document with resident demographics, brief medical history, and emergency contacts), the FS indicated, Resident 6 was admitted on [DATE] with diagnoses which included urinary tract infection (UTI-an infection in the bladder or urinary system that can cause pain, burning, frequent urination, fever or confusion), neuromuscular dysfunction of the bladder (the nerves and muscles that control the bladder do not work properly, making it difficult to urinate or causing leakage), and dementia (a condition that affects the brain, making it difficult to think, remember, and make decisions). A review of Resident 6's Physician's Order dated November 18, 2025, indicated, Indwelling catheter. to closed drainage bag, may change as needed for leaking, dislodged [moved out of place] or clogged. A review of Physician Order dated November 20, 2025, indicated, Foley catheter care every shift for catheter management. During a concurrent observation and interview on January 5, 2026, at 9:30 AM with the Director of Nursing (DON) in Resident 6's room, the foley catheter bag was observed resting on the floor. The DON stated that the nursing staff should have hung the catheter on the bed and it should not be on the floor. During an interview on January 7, 2026, at 11:17 AM, with the Licensed Vocation Nurse 1 (LVN 1), LVN 1 stated both the Certified Nursing Assistants (CNAs) and LVNs are in charge of the foley care. LVN 1 further stated, the foley bag should hanging on the side of the bed and it is never acceptable to find the bag on the floor. During a concurrent interview and record review on January 7, 2026, at 11:30 AM, with the DON, the facility's policy and procedures (P&P) titled, Catheter Care, Indwelling, dated January 2025 indicated, Purpose: to promote hygiene, comfort and decrease risk of infection for catheterized residents. 12. Keep tubing below level of the bladder. The DON stated that the nursing staff did not follow the policy and noted that it is not acceptable for the bag to be on the floor for infection control purposes. During an interview on January 8, 2026, at 9:14 AM with the Infection Preventionist (IP), the IP stated that the foley bag should not touch the floor as it can cause back flow into the bladder and increase the risk of bacteria.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of 46 resident's rooms (rooms [ROOM NUMBERS]) had the required 80 square feet (Sq Ft - unit of measurement) of space for each resident. This failure had the potential to negatively impact resident comfort, dignity, and safety by limiting adequate space for movement, equipment placement and staff assistance of four residents (Resident 1, 27, 35, and 57) who reside in the two rooms. Findings: During an interview on January 5, 2026, at 8:28 AM with the Director of nursing (DON) and the Administrator (Admin) the admin stated, the facility had two rooms (rooms [ROOM NUMBERS]) that were smaller than the required 80 Sq feet. The Admin stated they did not have any type of waiver variance for the room size. During an observation on January 5, 2025, at 9:32 AM, in room [ROOM NUMBER], no residents were currently in the room. The room was free of clutter, no concerns with the beds, bedside table, and the room was wheelchair accessible. During a concurrent observation and interview on January 5, 2025, at 10:19 AM with the residents (Resident 1 and 35) in room [ROOM NUMBER] the following was observed: Bed 11 A was occupied by Resident 35, who was observed resting comfortably in bed. Resident 35 did not verbalize any concerns with the room size. There were no concern with the beds, bedside tables, and wheelchairs which are accessible to the room. Bed 11 B was occupied by Resident 1 who was observed resting comfortably in bed watching television. Resident 1 did not verbalize any concerns with the room size. There were no concerns with the beds, bedside tables and wheelchairs which are accessible to the room. During an observation and interview on January 5, 2025, at 12:01 PM in the dining room, Resident 57 who is staying in room [ROOM NUMBER] A was seen in a wheelchair waiting for lunch. Resident 57 did not verbalize any concerns with the room size. During an observation and interview on January 5, 2025, at 12:07 PM in the dining room, Resident 27 who is staying in room [ROOM NUMBER] B was seen in a wheelchair waiting for lunch. Resident 27 did not verbalize any concerns with the room size. During a concurrent observation and interview on January 5, 2025, with the Maintenance Director (DOM) during an environmental tour of rooms [ROOM NUMBERS], the following measurements were noted as follows: 1. room [ROOM NUMBER] measured 12 feet (Ft. -unit of measurement) 10 inches (In.-unit of measurement) x (by) 11 feet 1 inches = (equals) 142.24 SQ Ft. total (71.12 SQ Ft per resident). The DOM verified that room [ROOM NUMBER] did not have the required 80 Sq Ft of space for each resident. 2. room [ROOM NUMBER] measures 12 Ft. 9 In. x 11 Ft. 1 in. = 142.38 Sq Ft. total (71.19 SQ Ft per resident). The DOM verified that room [ROOM NUMBER] did not have the required 80 SQ Ft of space for each resident. During the course of the survey, room [ROOM NUMBER] and 11 were not crowded and did not impose any safety hazards. There were no complaints of space or room issues from the residents occupying these rooms.		