STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056466	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra View Care Center	14318 Ohio Street Baldwin Park, CA 91706

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of five sampled residents (Resident 4) had a safe and clutter-free room environment when:1. Resident 4's room was full of clutter on top of and alongside Resident 4's bed.2. Multiple packs of cigarettes were inside Resident 4's bedside drawer.3. Resident 4 had medications at the bedside without a physician's order and without locked storage for medications at the bedside.This failure placed Resident 4 at risk for danger of falls and injuries, and risk of fire with a cluttered area of flammable materials (ability to ignite easily and burn rapidly) on top of and alongside Resident 4's bed. This failure also had the potential for Resident 4 and other residents to have an unmonitored adverse reaction to medications.During a review of Resident 4's admission Record (AR), the AR indicated Resident 4 was initially admitted to the facility on [DATE] and then readmitted on [DATE] with diagnoses which included bilateral spinal stenosis (when the space inside the backbone is too small), Post-Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), repeated falls, lower back pain, tobacco use, and chronic pain syndrome (a condition where pain lasts for more than 3-6 months, often continuing long after an injury has healed).During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 3/2/26, the MDS indicated Resident 4 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 4 required supervision with eating, oral hygiene, upper body dressing, and personal hygiene. Resident 4 also required partial/moderate assistance with toileting hygiene, showering/bathing self, lower body dressing, and putting on/taking off footwear.During a review of Resident 4's History and Physical (H&P), dated 2/28/26, the H&P indicated Resident 4 had the capacity to understand and make medical decisions.During a review of Resident 4's Care Plan Report (CPR), initiated on 1/27/23, the CPR indicated Resident 4 has personal belongings on the floor, around the bed, on top of the bed, and refuses to have staff clean and declutter room. The CPR also indicated Resident 4 was at risk for falls due to clutter around room. The CPR interventions included assisting Resident 4 with keeping area clean and clutter free, creating a regular schedule for cleaning Resident 4's room, encouraging Resident 4 to participate in sorting/discarding items, and offering alternative measures to keep personal items in safe and clutter free areas as needed.During a review of Resident 4's CPR, initiated on 6/19/23, the CPR indicated Resident 4 was at high risk for further falls and injuries due to history of falls, poor safety and judgement, and desires to be independent. The CPR interventions included keeping environment free from clutter and hazards and providing Resident 4 safety education as needed.During a review of Resident 4's Social Services Note (SSN), dated 2/12/26, the SSN indicated Resident 4 was educated on his behavior of hoarding (accumulating excessive personal items such as clothing, snacks, candies, food and other personal items) and how Resident 4's behaviors posed a health, safety and tripping hazard to Resident 4, Resident 4's roommates and facility staff.During a review of Resident 4's SSN, dated 2/13/26, the note indicated the Social Services Director (SSD) visited Resident 4 who had a preference of storing food condiments, mail, food snacks on bed side (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
	056466	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra View Care Center	14318 Ohio Street Baldwin Park, CA 91706

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dresser and bed side table longer than a day. The note also indicated the SSD would follow up on Resident 4's cleaning status often.During a review of Resident 4's Social Services Assessment Note, dated 3/2/26, the note indicated, Other mood/behavior concerns (not treated with medication): Resident is noncompliant with room cleanliness.During a review of Resident 4's SSN from 3/3/26 to 3/31/26, there were no other notes regarding Social Services following up on Resident 4's room environment.During a concurrent observation and interview on 4/9/26 at 2:15 pm in Resident 4's room, the room was full of clutter on top of and alongside Resident 4's bed. On the right side of Resident 4's bed there were bags of clothes and other items cluttered against the wall/bed and together they blocked access on the right side of Resident 4's bed. On the left side of the bed and on top of the bed were various clothes, and other items (hats, paper napkins, surgical mask, a comb, an apple, cookies in a small bag, a green plastic clothes hangar, socks, gloves, a stuffed animal). Resident 4's food tray is sitting on top of and near the clothes. On the left side of Resident 4's bed is a 3-drawer dresser with multiple items cluttered on top and in the first drawer which is pulled out enough to see a couple packs of cigarettes, and clothes on the floor in front of the 3-drawer dresser. Resident 4 stated Resident 4 threw Resident 4's dirty clothes on that spot on the floor for laundry to come and pick up. Resident 4 stated Resident 4 had sinus issues inside the nose and pointed to both sides of Resident 4's nose. Resident 4 stated Resident 4 had a bottle of Benadryl (treats symptoms of hay fever, upper respiratory allergies, and common cold) capsules in Resident 4's 3-drawer dresser that Resident 4 used for sinus problem, but Resident 4 thought someone at night came into Resident 4's room and stole the bottle out of the 3-drawer dresser. Resident 4 stated Resident 4 had some Benadryl capsules in Resident 4's jacket pocket. Resident 4 was observed taking out 2 capsules from Resident 4's jacket pocket and placing the capsules on the bed. The capsules were small and half pink and half white in color.During an interview with the SSD on 4/9/26 at 3:19 pm, SSD stated Resident 4 was non-compliant and refused to clean Resident 4's room. SSD stated SSD advised Resident 4 to clean Resident 4's room, but Resident 4 stated Resident 4 liked Resident 4's room and bed that way.During an interview with Certified Nursing Assistant 2 (CNA 2) on 4/9/26 at 4:15 pm., CNA 2 stated, Resident 4 is usually calm and only gets mad if you touch any of (Resident 4's) stuff. CNA 2 stated, If Resident 4 needs something, (Resident 4) will ask for it. CNA 2 stated, I don't touch Resident 4's stuff. CNA 2 stated, All staff know not to touch (Resident 4's) stuff. CNA 2 stated, Resident 4's room has been full of clutter for five years.During an interview with the Administrator (ADM) and Director of Nursing (DON) on 4/9/26 at 4:50 pm, ADM and DON stated that Resident 4's room had been cleaned before, but the current room status happened recently. ADM and DON stated Resident 4's room environment was cluttered due to Resident 4's ongoing hoarding of various items. ADM and DON stated that the surrounding items around Resident 4's bed created a safety and health hazard as well as a tripping hazard for staff caring for Resident 4. When asked if Resident 4 had medications at the bedside, the ADM denied the ADM knew Resident 4 had Benadryl in Resident 4's room and self-medicating. The DON confirmed the DON visited Resident 4's room on 4/9/26 and saw 2 pink and white Benadryl capsules on Resident 4's bed. Both the ADM and the DON stated Resident 4 did not have an Interdisciplinary Team assessment for self-medicating.During a review of the facility's P&P titled, Resident Personal Belongings, revised 12/19/22, the P&P indicated, Policy: It is the policy of this facility to protect the resident's right to possess personal belongings such as clothing and furnishings for their use while in the facility and assure the personal belongings and/or possessions are rightfully returned to the resident, or to the resident's representative in the event of the resident's death or discharge from the facility. Policy Explanation and Compliance Guidelines: The facility may refuse to allow a resident to retain his or her personal possession(s) due to the following reasons: a) Insufficient space in resident's room; b) As protection of health and safety; c) To maintain and prevent the infringement of other resident's rights. The P&P further indicated, The facility will ensure resident belongings are kept in a neat and orderly fashion and maintained in each resident's room.During a review of the facility's P&P titled, Safe and Homelike Environment, revised 12/19/22, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056466	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra View Care Center	14318 Ohio Street Baldwin Park, CA 91706

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the P&P indicated, Policy: In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. The P&P further indicated, Policy Explanation and Compliance Guidelines: The facility will allow residents to use their personal belongings, including furnishings and clothing (as space permits) to assist in creating and maintaining a homelike environment. This use must not infringe upon the rights or health and safety of other residents.During a review of the facility's P&P titled, Resident Rights, revised 12/19/22, the P&P indicated, Resident rights. The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The P&P further indicated, Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.During a review of the facility's P&P titled, Resident Rights, revised 12/19/22, the P&P indicated, Resident rights. Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: The right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate.