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	04/24/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure call lights were within reach for two of two sampled residents (Residents 5 and 12) in accordance with the facility's policy and procedure (P&P) titled Call lights: Accessibility and Timely Response. These failures had the potential for Residents 5 and 12 not to receive necessary care and services in a timely manner and placed the residents at risk for falls/injury Findings: a. During a review of Resident 5's admission Record (AR), the AR indicated the facility admitted Resident 5 on 10/30/2025 and readmitted on [DATE] with diagnoses including unspecified glaucoma (condition that causes damage to the eye's optic nerve [carries electrical impulses from the eye to the brain, which converts the impulses into the things seen]) and myopathy (disorder that directly affects skeletal muscle tissue, causing primary muscle weakness, cramping, or stiffness). During a review of Resident 5's Fall Risk Assessment (FRA- method of assessing a patient's likelihood of falling) dated 3/23/2026, the FRA indicated Resident 5 was assessed as high risk for falls because Resident 5 was disoriented, chairbound, had poor vision and required the use of assistive devices. During a review of Resident 5's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 3/23/2026, the MDS indicated Resident 5 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 5 was dependent (helper does all the effort) on staff for toileting, shower, upper/lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 5 needed maximum assistance (helper does more than half the effort) from staff for oral hygiene and personal hygiene. During a review of Resident 5's untitled Care Plan (CP) revised 4/18/2026, the CP indicated Resident 5 was at risk for falls related to impaired mobility, impaired vision and required assistance with activities of daily living (ADL). The CP intervention indicated for nursing staff to place the call light within Resident 5's reach and encourage Resident 5 to use it for assistance as needed. The CP also indicated Resident 5 needed prompt response to all requested assistance. During an observation on 4/21/2026 at 9:18 am inside Resident 5's room, Resident 5 was awake, lying in bed and unable to find the call light. Resident 5 stated Resident 5 could not find Resident 5's call light. During a concurrent observation in Resident 5's room and interview on 4/21/2026 at 9:35 am with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated CNA 1 could not find Resident 5's call light. CNA 1 stated Resident 5 could not ask for help if the call light was not within reach and not accessible to Resident 5. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation in Resident 5's room and interview on 4/21/2026 at 9:36 am with Registered Nurse 1 (RN 1), RN 1 was looking for Resident 5's call light. RN 1 stated, a call pad was below the pillow of Resident 5. RN 1 stated, the call pad should be within reach and next to Resident 5 for Resident 5 to call for assistance if Resident 5 needed help. RN 1 stated, Resident 5 would not be able to receive care if the call light or call pad was not accessible to the resident. During a review of the facility's P&P titled, Call lights: Accessibility and Timely Response, dated 12/19/2022, the P&P indicated Staff will ensure the call light was within reach of resident and secured, as needed. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room. b. During a review of Resident 12's AR, the AR indicated the facility initially admitted Resident 12 on 4/5/2024 and readmitted on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (weakness on one side of the body) and dementia (a progressive state of decline in mental abilities). During a review of Resident 12's untitled CP dated 4/7/2024, the CP indicated Resident 12 had activities of daily living (ADL) self-care performance deficit related to hemiplegia, hemiparesis and dementia. The CP interventions included encouraging Resident 12 to use the bell to call for assistance. During a review of Resident 12's MDS dated [DATE], the MDS indicated Resident 12 had severely impaired cognition. The MDS indicated Resident 12 required substantial/maximal assistance (helper did more than half the effort) with oral hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 12 was dependent with toileting, shower, and lower body dressing. During a concurrent observation inside Resident 12's room and interview on 4/21/2026 at 8:35 am with Certified Nurse Assistant 3 (CNA 3), Resident 12 was in bed with a splint (a rigid or flexible medical device to immobilize, support or protect and injured part) applied on Resident 12's left hand. The call light was located up on the left side of the bed next to the pillow. CNA 3 stated Resident 12 could not move Resident 12's left hand. CNA 3 stated the call light should be placed next to Resident 12's right hand where the resident could reach and call when help or assistance was needed. During an interview on 4/23/2026 at 3:53 pm with the Director of Nursing (DON), the DON stated the resident's call light should be placed next and close to the resident's strong arm and hand to be able to call for help and staff could timely address the resident's needs. During a review of the facility's P&P titled, Call Lights: Accessibility and Timely Response, revised on 12/19/2022, the P&P indicated, Staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light. Each resident shall, as much as possible, be evaluated for unique needs and preferences to determine any special accommodation that may be needed for the resident to utilize the call system. Staff will ensure the call light is within reach of resident and secured, as needed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement specific, comprehensive, and individualized person-centered care plans to meet the residents' needs for three of three sampled residents (Residents 13, 100 and 42) by failing to: a. Accurately identify specific activity intervention for Resident 13.b.1 and b.2. Identify and implement specific CP interventions that reflect Resident 100's actual and specific needs.c. Develop an individualized care plan to address scaling and stiffness of Resident 42's bilateral lower extremities (BLE) after application of A&D ointment on 3/18/2026. These failures resulted in the residents not receiving individualized care to maintain the residents' highest practicable physical, mental, and psychosocial well-being. Findings: a. During a review of Resident 13's admission Record (AR), the AR indicated the facility admitted Resident 13 on 1/23/2016 and readmitted on [DATE] with diagnoses including blindness, bipolar disorder (mood swings that ranged from the lows of depression to elevated periods of emotional highs), and generalized muscle weakness. During a review of Resident 13's Minimum Data Set (MDS, a resident assessment tool) dated 2/11/2026, the MDS indicated Resident 13 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 13 required supervision from staff with eating. The MDS indicated Resident 13 required maximal assistance (helper did more than half the effort) from staff with oral hygiene and personal hygiene. The MDS indicated Resident 13 was dependent (helper did all the effort) on staff with toileting hygiene, showering/bathing, upper/lower body dressing and mobility. During a review of Resident 13's Social Service Assessment (SSA) dated 2/11/2026, the SSA indicated Resident 13 did not have a family. The SSA indicated the facility's interdisciplinary team (IDT- a group of staff who worked together to plan and review a resident's care) assisted Resident 13 in medical decision making. During a review of Resident 13's History and Physical (H&P) dated 2/28/2026, the H&P indicated Resident 13 did not have the capacity to understand and make decisions. During a concurrent record review and interview with Licensed Vocational Nurse 5 (LVN 5) on 4/23/2026 at 11:26 AM, Resident 13's AR dated 4/23/2026 was reviewed. LVN 5 stated the AR indicated Resident 13 did not have family or friend contacts. LVN 5 stated the AR indicated the facility's IDT was the substitute decision maker (someone who made care choices for the resident when the resident could not speak for themself) for Resident 13. During a concurrent record review and interview with LVN 5 on 4/23/2026 at 11:26 AM, Resident 13's activity care plan (CP) revised 8/22/2025 was reviewed. LVN 5 stated the CP interventions included inviting/ encouraging Resident 13's family members to attend activities with Resident 13 to support participation. LVN 5 stated the CP intervention was not applicable to Resident 13 since Resident 13 did not have a family. LVN 5 stated the facility IDT should have removed the intervention regarding family members to attend activities with Resident 13. LVN 5 stated the facility could not achieve the established goal for Resident 13 without the specific resident-centered CP and could delay necessary care. LVN 5 stated it was important to have specific, individualized, and resident-centered CP. LVN 5 stated the facility's IDT developed CP for residents upon admission, quarterly, and as needed (PRN) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for changes. During an interview with the Activity Director (AD) on 4/23/2026 at 12:03 PM, the AD stated Resident 13 did not have a family. The AD stated Resident 13's CP should be specific and resident centered. b.1. During a review of Resident 100's AR, the AR indicated the facility admitted Resident 100 on 4/18/2026 with diagnoses including osteomyelitis (inflammation of the bone or bone marrow) and bacteremia (germs got into the blood). During a review of Resident 100's H&P dated 4/20/2026, the H&P indicated Resident 100 had the capacity to make medical decisions. During a review of Resident 100's MDS dated [DATE], the MDS indicated Resident 100 had moderately impaired cognition. The MDS indicated Resident 100 required supervision from staff with eating. The MDS indicated Resident 100 required moderate assistance (helper did less than half the effort) from staff with oral hygiene and personal hygiene. The MDS indicated Resident 100 was dependent on staff with toileting hygiene, showering/bathing, and mobility. During a concurrent record review and interview with LVN 5 on 4/23/2026 at 11:36 AM, Resident 100's Order Summary Report (OSR) dated 4/23/2026 was reviewed. LVN 5 stated the OSR indicated Resident 100 was not on intravenous (IV- medicine or fluid that went straight into a vein) hydration. During a concurrent record review and interview with LVN 5 on 4/23/2026 at 11:36 AM, Resident 100's IV therapy CP dated 4/20/2026 was reviewed. The CP indicated an intervention for licensed nursing staff to observe signs and symptoms of fluid under or overload when on IV hydration. LVN 5 stated the CP intervention was not specific for Resident 100. b.2. During a review of Resident 100's OSR dated 4/23/2026, the OSR indicated Resident 100 had an active order of ampicillin (medication to kill germ) two grams IV every six hours for bacteremia. The order was dated 4/18/2026. During a review of Resident 100's IV Administration Report (IVAR) dated from 4/18/2026 to 4/23/2026, the IVAR indicated Resident 100 received 20 out of 20 doses of ampicillin. During a concurrent record review and interview with LVN 5 on 4/23/2026 at 11:36 AM, Resident 100's IV therapy CP dated 4/20/2026 was reviewed. The CP indicated an intervention for licensed nursing staff to check for signs of nephrotoxicity (harm to the kidneys caused by a drug) and observe for hearing changes including ringing in the ears. LVN 5 stated the licensed nursing staff should follow and implement the CP interventions. During a concurrent record review and interview with LVN 5 on 4/23/2026 at 11:36 AM, Resident 100's Nursing Progress Notes (NPN) from 4/18/2026 to 4/23/2026 were reviewed. The NPN did not indicate documentation/ monitoring for signs of nephrotoxicity or hearing changes on Resident 100. LVN 5 stated the licensed nurses should document for signs of nephrotoxicity and/or any hearing changes in the NPN as indicated in Resident 100's CP. During a concurrent record review and interview with LVN 5 on 4/23/2026 at 11:36 AM, Resident 100's Medication Administration Report (MAR) dated 4/18/2026 to 4/23/2026 were reviewed. LVN 5 stated Resident 100's MAR did not indicate documentation for signs of nephrotoxicity or hearing (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	changes. LVN 5 stated the licensed nurses could document the signs of nephrotoxicity and/or any hearing changes to Resident 100 in the MAR. During an interview on 4/23/2026 at 12:14 PM with the Infection Preventionist Nurse (IPN), the IPN stated all nursing staff and the care team should monitor Resident 100 for any hearing changes while Resident 100 was taking ampicillin. The IPN stated a physician's order was not needed to monitor Resident 100's hearing changes because it was the standard of practice. The IPN stated the licensed nurse should document Resident 100's hearing assessment in the NPN, MAR, and/or in other forms of medical record. The IPN stated it was important to monitor and document Resident 100's hearing assessment while on ampicillin. The IPN stated that without proper monitoring and documentation would increase the risk of Resident 100 to experience hearing loss. During an interview on 4/23/2026 at 3:43 PM with the Director of Nursing (DON), the DON stated the CP indicated interventions to address and meet the residents' current and specific needs. The DON stated the CP intervention should be specific and resident centered. The DON stated it was important to implement interventions on the CP. During a review of the facility's P&P titled, Comprehensive Care Plans, revised 12/19/2022, the P&P indicated the facility should develop and implement a comprehensive resident-centered CP for each resident to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the resident's comprehensive assessment. The P&P indicated the comprehensive CP should be developed within seven days after the completion of the comprehensive MDS assessment. The P&P indicated the CP should address the factors identified by the interdisciplinary team. The P&P further indicated the CP should have specific interventions that reflected the resident's needs. c. During a review of Resident 42's AR, the AR indicated Resident 42 was admitted to the facility on [DATE] with diagnoses including peripheral vascular disease (slow, progressive circulatory disorder), osteoarthritis (degenerative joint disease), and mental disorders (disturbances in cognition, emotional regulation, or behavior). During a review of Resident 42's H&P dated 10/31/2025, the H&P indicated Resident 42 was awake and alert. The H&P did not indicate Resident 42's ability to make and understand medical decisions. During a review of Resident 42's MDS dated [DATE], the MDS indicated Resident 42 had intact cognition. During a concurrent observation and interview on 4/21/2026, at 11:35 AM, with Resident 42, Resident 42 stated A&D ointment was applied on Resident 42's BLE on 3/18/2026. Resident 42 stated Resident 42 had scaling and stiffness of Resident 42's BLE and toes after the A&D ointment was applied. During an interview on 4/23/2026, at 9:40 AM with the IPN, the IPN stated the Treatment Nurse (TN) changed the type of A&D ointment applied to Resident 42 from the packet to the tube. During an interview on 4/23/2026, at 3:23 PM with the TN, the TN stated the TN applied the A&D ointment to Resident 42's BLE. The TN stated when the TN was later notified about Resident 42's skin condition, the TN stated the TN observed flakiness and scaling on Resident 42's BLE. The TN stated Resident 42 complained of tightness on Resident 42's BLE. The TN stated the TN did not report the skin condition to the physician. The TN stated it was important to report to the physician so that the physician and Resident 42 would know the cause of the tightness on Resident 42's BLE. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview on 4/24/2026, at 11:11 AM with Licensed Vocational Nurse 7 (LVN 7) and record review of Resident 42's entire care plans, there was no CP developed to address Resident 42's complaint of tightness on Resident 42's BLE. There was also no Situation, Background, Assessment, Recommendation (SBAR- structured, standardized communication framework) in Resident 42's clinical record indicating Resident 42 complained of stiffness and tightness on Resident 42's BLE after A&D ointment use on 3/18/2026. During an interview on 4/24/2026 at 11:32 AM with Minimum Data Set Coordinator (MDS C), the MDS C stated it was important to develop a care plan with specific target interventions to solve the problem. The MDS C stated there should have been an SBAR/Change of Condition (COC- documentation of significant, acute, or unexpected deviation from a patient's baseline) of Resident 42's scaling and stiffness of BLE following the application of the A&D ointment to Resident 42 on 3/18/2026. During an interview on 4/24/2026, at 11:50 AM with Registered Nurse 4 (RN 4), RN 4 stated it was important to develop a care plan to address the resident's specific needs and to guide staff on what needed to be done. RN 4 stated there was no SBAR/COC created on 3/18/2026 related to Resident 42's complaint of scaling of skin and stiffness of BLE. During a review of the facility's P&P titled, Comprehensive Care Plans, revised 12/19/2022, the P&P indicated the facility should develop and implement a comprehensive resident-centered CP for each resident to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the resident's comprehensive assessment. The P&P indicated the comprehensive CP should be developed within seven days after the completion of the comprehensive MDS assessment. The P&P indicated the CP should address the factors identified by the interdisciplinary team. The P&P further indicated the CP should have specific interventions that reflected the resident's needs.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary care and services for residents with indwelling catheter (including suprapubic catheter [a thin, flexible tube inserted through a small abdominal incision into the bladder to drain urine], nephrostomy tube [a thin, flexible catheter inserted through the skin on the lower back into the kidney to drain urine], or a Foley catheter [a soft, flexible tube inserted through the urethra or abdominal wall into the bladder to continuously drain urine into an external bag]) for two of three sampled residents (Residents 6 and 55) by failing to: a. Ensure Resident 6's suprapubic catheter tubing was secured on Resident 6's thigh.b. Ensure Resident 55's Foley catheter tubing was secured on Resident 55's thigh. These failures placed Residents 6 and 55 at risk for infection and injury related to the use of indwelling catheter.Findings: a. During a review of Resident 6's admission Record (AR), the AR indicated the facility initially admitted Resident 6 on 6/9/2023 and readmitted on [DATE] with diagnoses including obstructive and reflux uropathy (disorder of the urinary tract that occurs due to obstructed urinary flow) and benign prostatic hyperplasia (a noncancerous enlargement of the prostate gland). During a review of Resident 6's Order Summary Report (OSR) dated 2/9/2026, the OSR indicated Resident 6 had an order for staff to apply catheter stabilization device to secure foley catheter in place and to check placement every shift. During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool) dated 3/25/2026, the MDS indicated Resident 6 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 6 was dependent (helper does all of the effort) from staff with oral hygiene, toileting, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 6's undated Care Plan (P), the CP indicated Resident 6 had an indwelling catheter (suprapubic) for obstructive and reflux uropathy. The CP intervention indicated for nursing staff to apply catheter stabilization device to secure the catheter in place and to check placement. During a concurrent observation inside Resident 6's room and interview on 4/21/2026 at 8:47 am with Registered Nurse 1 (RN 1), Resident 6 was asleep in bed with FC hanging on the left side of the bed. RN 1 stated Resident 6's suprapubic catheter tubing did not have a catheter securement device and was not secured on Resident 6's thigh. RN 1 stated the suprapubic catheter tubing should be secured properly on Resident 6's thigh to prevent pulling out of the tubing and to prevent injury during Resident 6's movement. During a concurrent observation inside Resident 6's room and interview on 4/21/2026 at 12:30 pm with Treatment Nurse 1 (TN 1), TN 1 stated the securement lock was on Resident 6's right thigh while the catheter tubing was hanging on the left side of the bed. TN 1 stated, the catheter tubing should have been secured on Resident 6's thigh to prevent Resident 6 from pulling the tube that could cause pain and injury. During a review of the facility's Policy and Procedure (P&P) titled, Catheter Care revised 12/23/2023, (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the P&P indicated, It is the policy of the facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. b. During a review of Resident 55's AR, the AR indicated the facility initially admitted Resident 55 on 2/20/2020 and readmitted on [DATE] with diagnoses including chronic kidney disease (CKD, progressive loss of kidney function), heart failure (HF, a heart disorder which causes the heart to not pump the blood efficiently), and dementia (a progressive state of decline in mental abilities). During a review of Resident 55's untitled CP dated 9/16/2021, the CP indicated Resident 55 had an indwelling catheter and was at high risk for catheter related infection or trauma. The CP goals indicated Resident 55 would not show signs and symptoms of urinary infection and remain free from catheter-related trauma. During a review of Resident 55's OSR dated 2/12/2026, the OSR indicated Resident 55 had an order for staff to apply catheter stabilization device to secure Resident 55's foley catheter was in place. During a review of Resident 55's MDS dated [DATE], the MDS indicated Resident 55 had intact cognition. The MDS indicated Resident 55 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completed activity) with eating and oral hygiene, required partial/moderate assistance (helper did less than half the effort) with upper body dressing and personal hygiene and dependent (helper did all the effort) with toileting. The MDS indicated Resident 55 had an indwelling catheter. During a concurrent observation inside Resident 55's room and interview on 4/21/2026 at 9:01 am with Licensed Vocational Nurse 1 (LVN 1), Resident 55 was lying in bed with a foley catheter. LVN 1 stated Resident 55's Foley catheter was not connected to the catheter securement device. LVN 1 stated the foley catheter tubing should be secured to prevent getting pulled out during movement and cause trauma or injury to Resident 55. During an interview on 4/23/2026 at 3:50 pm with the Director of Nursing (DON), the DON stated the foley catheter tubing should be secured on the resident's thigh to prevent from pulling and getting dislodged during bed mobility. During a review of the facility's P&P titled, Catheter Care, revised on 12/23/2023, the P&P indicated, To ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. Ensure straps were snug but not tight.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: a. Provide necessary care and services for gastrostomy tube (GT, a tube inserted through the abdomen that delivers nutrition/medication directly to the stomach) site as ordered by the physician and as indicated in the plan of care for one of two sampled residents (Resident 3).b. Elevate the resident's head of the bed (HOB) while receiving feeding formula through the GT in accordance with the resident's plan of care and physician's order for one of two sampled residents (Resident 65). These failures had the potential to result in complications related to tube feedings for Residents 53 and 65. Findings: a. During a review of Resident 3's admission Record (AR), the AR indicated the facility initially admitted Resident 3 on 6/4/2024 and readmitted on [DATE] with diagnoses including encounter for attention to GT and dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning). During a review of Resident 3's Order Summary Report (OSR) dated 2/20/2026, the OSR indicated for licensed staff to clean the GT site with Normal Saline (NS, a saltwater solution), pat dry and cover with dry dressing, every day shift. During a review of Resident 3's Care Plan (CP) for wound management on the GT site, revised 2/23/2026, the CP intervention indicated for the nursing staff to cleanse the GT site with NS, pat dry and cover with dry dressing. During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 2/24/2026, the MDS indicated Resident 3 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 3 was dependent (helper does all of the effort) from staff with hygiene toileting, shower, upper and lower body dressing and putting on/taking off footwear. During a review of Resident 3's CP for tube feeding related to dysphagia (difficulty swallowing) revised 2/25/2026, the CP intervention indicated for nursing staff to provide local care to GT site as ordered and monitor for signs and symptoms of infection. During an observation 4/21/2026 at 9:14 am, together with Registered Nurse 1 (RN 1), Resident 3 was awake, lying in bed. Resident 3's GT site had a dressing dated 4/19/2026 with light brown colored drainage from the GT site. During an interview on 4/21/2026 at 10:40 am with RN 1, RN 1 stated Resident 3's GT site dressing was not changed yesterday, 4/20/2026. RN 1 stated Resident 3's GT dressing should have been changed daily to prevent infection and to assess the site if there were signs and symptoms of infection. During an interview on 4/21/2026 at 1:11 pm with the Treatment Nurse (TN), the TN stated the TN forgot to change Resident 3's GT site dressing on 4/20/2026. The TN stated Resident 3's GT site dressing needed to be cleaned and changed daily as ordered by the physician to prevent infection. During an interview on 4/24/2026, at 9:11 am, with the Director of Nursing (DON), the DON stated Resident 3's GT site dressing should be changed daily as ordered by the doctor and as needed. The DON stated Licensed Nurses were responsible to change the GT site dressing to prevent infection and skin complications on the GT site. b. During a review of Resident 6's AR, the AR indicated the facility initially admitted Resident 6 on 6/9/2023 and readmitted on [DATE] with diagnoses including encounter for attention to GT, obstructive and reflux uropathy (disorder of the urinary tract that occurs due to obstructed urinary flow) and benign prostatic hyperplasia (a noncancerous enlargement of the prostate gland). During a review of Resident 6's undated CP, the CP indicated Resident 6 required tube feeding related to dysphagia. The CP intervention indicated for nursing staff to keep Resident 6's head of bed elevated at least 30-45 degrees during and 30 minutes after tube feeding. During a review of Resident 6's OSR dated 3/23/2026, the OSR indicated for staff to elevate Resident 6's HOB at a minimum 30 degrees at all times during administration of feedings or medications every shift. During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6 had severely impaired cognition. The MDS indicated Resident 6 was dependent on staff with oral hygiene toileting, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During a (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	concurrent observation and interview on 4/21/2026 at 10 am, together with RN 1, Resident 6 was asleep lying flat in bed, in supine position and connected to an ongoing GT feeding at 50 ml/hr. RN 1 stated, Resident was on supine position and Resident 6's HOB should have been elevated from 30 to 45 degrees while feeding was ongoing to prevent aspiration (food/liquid accidentally goes into the airway or lungs). During an interview on 4/24/2026, at 9:14 am, with the DON, the DON stated Resident 6's HOB should have been elevated at least 30 degrees while on GT feeding to prevent aspiration. During a review of the facility's undated Policy and Procedure (P&P) titled, Gastrostomy Site Care, dated 12/19/2022 the P&P indicated It is the policy of the facility to perform gastrostomy site care as ordered and per current standards of practice. Using normal saline, gently clean the area around the tube and continue in an outward circular fashion, ensuring that under the bolster is cleaned.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure safe food storage practices in one of one facility kitchen, by failing to: a. Discard an open loaf of wheat bread beyond its use-by-date (the last date the food was considered safe to eat) of 4/20/2026 in the kitchen bread storage area. b. Discard an open plastic container of baking soda beyond its use-by-date of 4/15/2026 in the kitchen dry storage area. c. Discard an open pack of tortilla beyond its use-by-date of 4/19/2026 in the kitchen walk-in refrigerator. d. Discard a tray of grilled cheese sandwiches and pizzas beyond its use-by-date of 4/20/2026 in the kitchen walk-in refrigerator. These deficient practices had the potential to result in food-borne illnesses (illness caused by ingesting contaminated food or beverages) for the residents.Findings: a. During a concurrent observation and interview with the Dietary Supervisor (DS) on 4/21/2026 at 8:26 AM, in the kitchen bread storage area, there was one open loaf of wheat bread beyond its use-by-date of 4/20/2026. The DS stated the kitchen staff should discard the bread because it was beyond the use-by-date of 4/20/2026. b. During a concurrent observation and interview with the DS on 4/21/2026 at 8:40 AM, in the kitchen dry storage area, there was one open plastic container of baking soda beyond its use-by-date of 4/15/2026. The DS stated the kitchen staff should discard the baking soda because it was beyond the use-by-date of 4/15/2026. c. During a concurrent observation and interview with the DS on 4/21/2026 at 8:47 AM, in the kitchen walk-in refrigerator, there was one open pack of tortilla beyond its use-by-date of 4/19/2026. The DS stated the kitchen staff should discard the pack of tortilla because it was beyond the use-by-date of 4/19/2026. d. During a concurrent observation and interview with the DS on 4/21/2026 at 8:52 AM, in the kitchen walk-in refrigerator, there was one tray of grilled cheese sandwiches and pizzas beyond its use-by-date of 4/20/2026. The DS stated the kitchen staff should discard the tray of grilled cheese sandwiches and pizzas because it was beyond the use-by-date of 4/20/2026. During an interview with the Infection Preventionist Nurse (IPN) on 4/23/2026 at 9:38 AM, the IPN stated staff should throw away the food beyond the use-by-date because it could cause food-borne illnesses. The IPN stated it was not acceptable to have food for the residents beyond the used-by-date. The IPN stated it was part of infection control to discard food beyond the use-by-date. During an interview with the DS on 4/23/2026 at 10:39 AM, the DS stated it would affect the quality of the food when food was beyond the used-by-date. The DS stated the bread would lose moisture after the use-by date. The DS stated it was not acceptable to provide food beyond the used-by-date because it could cause nausea and vomiting. The DS stated it was part of infection control and quality of care to provide the best quality of food to the residents. During a review of the facility's Policy and Procedure (P&P) titled, Date Marking for Food Safety, revised 12/19/2022, the P&P indicated staff should clearly marked the food to indicate the date or day by which the food shall be consumed or discarded. During a review of the facility's P&P titled, Food storage, revised 8/29/2023, the P&P indicated staff should discard any outdated food products.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, for two of two sampled residents (Residents 11 and 100), the licensed nurse failed to timely document on the residents' medical record: a. Resident 11's respiratory assessment on 4/21/2026. b. Resident 100's ampicillin (medication to kill bacteria) administration on 4/22/2026. These deficient practices had the potential to result in lack of communication between staff and delay and interrupt the provision of care needed to maintain the residents' highest practicable, physical, mental, and psychosocial well-being. Findings: a. During a review of Resident 11's admission Record (AR), the AR indicated the facility admitted Resident 11 on 4/24/2025 and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), asthma (a condition where the airways got swollen and made it hard for the resident to breathe) and dementia (a progressive state of decline in mental abilities). During a review of Resident 11's History and Physical (H&P) dated 4/26/2025, the H&P indicated Resident 11 had the capacity to understand and make decisions. During a review of Resident 11's Minimum Data Set (MDS, a resident assessment tool) dated 1/28/2026, the MDS indicated Resident 11 had moderately impaired cognition (ability to understand). The MDS indicated Resident 11 required supervision from staff with eating and oral hygiene. The MDS indicated Resident 11 required maximal assistance (helper did more than half the effort) from staff with showering/ bathing, and personal hygiene. The MDS indicated Resident 11 was dependent (helper did all effort) on staff with toileting hygiene and bed-to-chair transferring. During a concurrent observation and interview with Registered Nurse 1 (RN 1) on 4/21/2026 at 3:30 PM, at Resident 11's bedside, RN 1 assessed Resident 11's lung sounds and breathing. RN 1 stated RN 1 assessed Resident 11 for chest congestion (a buildup of mucus that made the chest feel tight and breathing harder). During a concurrent record review and interview with RN 1 on 4/23/2026 at 2:02 PM, Resident 11's Nurses Progress Note (NPN) dated from 4/20/2026 to 4/21/2026 were reviewed. The NPN did not indicate Resident 11's respiratory assessment by RN 1 on 4/21/2026. RN 1 stated RN 1 should have documented Resident 11's respiratory assessment on 4/21/2026 in the NPN. RN 1 stated RN 1 did not document because RN 1 was just helping the 3 PM-11 PM shift. During an interview with the Director of Nursing (DON) on 4/23/2026 at 3:43 PM, the DON stated the licensed nurse (in general) should document in the residents' progress note after assessment was done. The DON stated it was important to document the residents' assessment in case of the need to notify the physician for any change in condition. The DON stated the license nurse should document the interventions that were done to the residents for continuity of care. b. During a review of Resident 100's AR, the AR indicated the facility admitted Resident 100 on 4/18/2026 with diagnoses including osteomyelitis (inflammation of the bone or bone marrow) and bacteremia (germs in the blood). During a review of Resident 100's H&P dated 4/20/2026, the H&P indicated Resident 100 had the capacity to make medical decisions. During a review of Resident 100's MDS dated [DATE], the MDS indicated Resident 100 had moderately impaired cognition. The MDS indicated Resident 100 required supervision from staff with eating. The MDS indicated Resident 100 required moderate assistance (helper did less than half the effort) from staff with oral hygiene and personal hygiene. The MDS indicated Resident 100 was dependent on staff with toileting hygiene, showering/bathing, and mobility. During a review of Resident 100's Order Summary Report (OSR) with active orders as of 4/23/2026, the OSR indicated Resident 100 had an active order of intravenous (IV- medicine or fluid that went straight into a vein) ampicillin (medication to kill germ) two grams (gm-unit of measurement) every six hours for bacteremia. The order was dated 4/18/2026. During a concurrent record review and interview with Licensed Vocational Nurse 5 (LVN 5) on 4/23/2026 at 11:36 AM, Resident 100's IV Administration Report (IVAR) from 4/1/2026 to 4/23/2026 was reviewed. The IVAR indicated RN 1 administered (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ampicillin for the 12 PM dose to Resident 100 on 4/21/2026 at 6:58 PM. LVN 5 stated the IVAR indicated RN 1 did not document the ampicillin 12 PM dose timely. LVN 5 stated it was important to document timely to confirm the medication was administered timely. LVN 5 stated the licensed nurse should sign the IVAR when the medication was administered, at the time of service, within the ordered time frame. LVN 5 stated, not documenting timely affected the continuity of residents' care. During an interview with RN 1 on 4/23/2026 at 2:44 PM, RN 1 stated RN 1 did not document the ampicillin 12 PM dose timely for Resident 100 on 4/21/2026 because RN 1 was busy. During an interview with the Director of Nursing (DON) on 4/23/2026 at 3:43 PM, the DON stated it was not acceptable to document the ampicillin 12 PM dose at 6:58 PM on 4/21/2026. The DON stated it was the standard of practice to document medication administration timely at the time of service. During a review of the facility's Policy and Procedure (P&P) titled Documentation in Medical Record, dated 12/19/2022, the P&P indicated the licensed staff should document all assessments, observations, and services provided in the resident's medical record at the time of service, but no later than the shift. The P&P indicated documentation should be timely. During a review of the facility's P&P titled Medication Administration, dated 12/19/2022, the P&P indicated the licensed nurse should administer medication within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. The P&P further indicated the licensed nurse should sign the medication administration record after administrating the medication.

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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 implement and follow infection prevention procedures to prevent the transmission of infectious organisms for two of three sampled residents (Residents 100 and 101) by failing to: a. Ensure the licensed nurse accurately label Resident 100's midline dressing (a clean cover that protected the midline [small tube in a vein that gave fluids or medicine] site) on 4/21/2026. b. Ensure Resident 101's Care Giver 1 (CG1) wore the required personal protective equipment (PPE - clothing and equipment to provide protection against hazardous substances and/or environments) while providing care to Resident 101 who was on Enhanced Barrier Precaution (EBP- extra safety steps using gown and gloves to stop germs from spreading during close care of the resident). These deficient practices had the potential to transmit infectious microorganisms and increase the risk of infection for Residents 100 and 101. Findings: a. During a review of Resident 100's admission Record (AR), the AR indicated the facility admitted Resident 100 on 4/18/2026 with diagnoses including osteomyelitis (inflammation of the bone or bone marrow) and bacteremia (germs in the blood). During a review of Resident 100's History and Physical (H&P) dated 4/20/2026, the H&P indicated Resident 100 had the capacity to make medical decisions. During a review of Resident 100's Minimum Data Set (MDS- a resident assessment tool) dated 4/22/2026, the MDS indicated Resident 100 had moderately impaired cognition (ability to understand and process information). The MDS indicated Resident 100 required supervision from staff with eating. The MDS indicated Resident 100 required moderate assistance (helper did less than half the effort) from staff with oral hygiene and personal hygiene. The MDS indicated Resident 100 was dependent (helper did all the effort) on staff with toileting hygiene, showering/bathing, and mobility. During a review of Resident 100's Order Summary Report (OSR) with active orders as of 4/23/2026, the OSR indicated Resident 100 had an order for licensed staff to change the midline dressing upon admission and as needed for site maintenance. The order was dated 4/18/2026. During a review of Resident 100's Intravenous (medicine or fluid that went straight into a vein) Administration Report (IVAR) dated 4/23/2026, the IVAR indicated Registered Nurse 3 (RN 3) changed Resident 100's midline dressing on 4/20/2026 at 9 PM. During an observation on 4/21/2026 at 10:37 AM, at Resident 100's bedside, Resident 100's midline dressing did not have a date. During an observation on 4/21/2026 at 12:35 PM, at the facility's dining room, Resident 100's midline dressing did not have a date. During an interview on 4/23/2026 at 11:36 AM with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated it was important to date the midline dressing to ensure it was monitored daily, for staff to know when it was changed, and when the next dressing change would be. LVN 5 stated it was not acceptable for the midline dressing to be undated. LVN 5 stated licensed nurses should check the midline dressing to ensure it was intact and dated. LVN 5 stated when the licensed nurse noted the midline dressing did not have a date, the licensed nurse should have informed the RN. LVN 5 stated dating the midline dressing was part of infection control precaution and professional standards of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	practice. LVN 5 stated the undated midline dressing increased the risk for infection at the midline site. During a concurrent interview and pictures review on 4/23/2026 at 12:14 PM with the Infection Preventionist Nurse (IPN), the pictures dated 4/21/2026 at 10:37 AM and 12:35 PM were reviewed. The IPN stated the pictures indicated the midline dressing did not have a date. The IPN stated the RN should have dated the midline site dressing during change of dressing. The IPN stated it was important to keep the midline site clean. During an interview on 4/23/2026 at 1:48 PM with RN 1, RN 1 stated the RN should have changed and dated the midline dressing to prevent infection at the midline site. During a review of the facility's Policy and Procedure (P&P) titled Peripheral Intravenous Catheter Insertion, Maintenance, and Removal, revised 3/17/2025, the P&P indicated the facility should ensure the peripheral intravenous catheters were maintained consistent with current standards of practice. The P&P indicated the nurse should label the dressing with the date the dressing change was performed. b. During a review of Resident 101's AR, the AR indicated the facility admitted Resident 101 on 4/13/2026 with diagnoses including sepsis (life-threatening condition that arises when the body's response to infection injures its own tissues and organs) and encounter for attention to gastrostomy (GT-creation of an artificial external opening into the stomach for nutritional support). During a review of Resident 101's OSR dated 4/14/2026, the OSR indicated to place Resident 101 on EBP related to GT and history of Extended Spectrum Beta-Lactamase (ESBL - bacteria that is not easily killed by antibiotics) in urine. The order further indicated to apply EBP to prevent the spread of infections for specific care activities such as morning and evening care, toileting and changing incontinence briefs, caring for devices and giving medical treatments, wound care, mobility assistance and preparing to leave the room and cleaning and disinfecting the environment. During a review of Resident 101's untitled Care Plan (CP) dated 4/14/2026, the CP indicated Resident 101 was at risk for infection related to septicemia (a serious, life-threatening infection)/urinary tract infection (UTI, infection that affects part of the urinary tract) and presence of GT. The CP indicated for nursing staff to educate the resident/representative on techniques to prevent infection, such as handwashing, adequate rest, nutrition and avoidance of crowds. The CP intervention also included to place Resident 101 on EBP. During a review of Resident 101's MDS dated [DATE], the MDS indicated Resident 101 had severely impaired cognition. The MDS indicated Resident 101 was dependent (helper does all the effort) to staff for oral hygiene, toileting, shower, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. During an observation on 4/23/2026 at 8:19 am, Resident 101 was awake lying in bed in Resident 101's room. Resident 101's Care Giver 1 (CG1) was cleaning Resident 101's arms, face and neck with wet towel without wearing gown and gloves. During an interview on 4/23/2026 at 8:49 am, together with Licensed Vocational Nurse 6 (LVN 6), LVN 6 stated Resident 101 was placed on EBP for the presence of GT. LVN 6 stated visitors and CG 1 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	needed to wear the required PPE while providing care to Resident 101. LVN 6 stated CG 1 did not wear a gown and gloves while providing care to Resident 101. LVN 6 stated CG 1 needed to wear the required PPE to prevent the spread of infection. During an interview on 4/23/2026 at 9:26 am with CG 1, CG 1 stated CG 1 did not wear a gown and gloves while providing care to Resident 101. CG 1 stated CG 1 knew the purpose of wearing the required PPE while providing care to Resident 101 to prevent the spread of infection. During an interview on 4/24/2026 at 9:07 am with the facility's Director of Nursing (DON), the DON stated caregivers, visitors and staff needed to wear gown, gloves and masks before providing direct care to residents on EBP. During a review of the facility's P&P titled, EBP, revised on 3/10/2025, the P&P indicated, It is the policy of the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. EBP are indicated for residents with any of the following: etc. indwelling medical devices (e.g., feeding tube) even if the resident is not known to be infected. Implementation of Enhanced Barrier Precautions: Make gowns and gloves available prior to performing task. Provide education to residents and visitors. High-contact resident care activities include dressing, bathing/showering etc.providing hygiene. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to protect the identifiable health information (any information that could be used to identify the individual, such as the full name, date of birth , etc.) on the ampicillin (medication to kill germ) intravenous (IV- medicine or fluid that went straight into a vein) bag to be exposed for one of one sampled resident (Resident 100). This deficient practice had the potential to result in unauthorized disclosure of Resident 100's personal information to unauthorized users resulting in breach of privacy.Findings: During a review of Resident 100's admission Record (AR), the AR indicated the facility admitted Resident 100 on 4/18/2026 with diagnoses including osteomyelitis (inflammation of bone or bone marrow) and bacteremia (germs got into the blood). During a review of Resident 100's History and Physical (H&P) dated 4/20/2026, the H&P indicated Resident 100 had the capacity to make medical decisions. During a review of Resident 100's Minimum Data Set (MDS- a resident assessment tool) dated 4/22/2026, the MDS indicated Resident 100 had moderately impaired cognition (ability to understand and process information). The MDS indicated Resident 100 required supervision from staff with eating. The MDS indicated Resident 100 required moderate assistance (helper did less than half the effort) from staff with oral hygiene and personal hygiene. The MDS indicated Resident 100 was dependent (helper did all the effort) on staff with toileting hygiene, showering/bathing, and mobility. During a review of Resident 100's Order Summary Report (OSR) with active orders as of 4/23/2026, the OSR indicated Resident 100 had an order of ampicillin IV for bacteremia. The order was dated 4/18/2026. During an observation on 4/21/2026 at 10:37 AM, at Resident 100's bedside, Resident 100's ampicillin IV bag was hanging on the IV pole (a tall stand that held the resident's IV fluids or medications) with Resident 100's health information (first and last name and room number) uncovered. Resident 100's ampicillin IV bag was unattended by facility staff and not connected to Resident 100. During an observation on 4/23/2026 at 2:52 PM, at Resident 100's bedside, Resident 100's ampicillin IV bag was hanging on the IV pole with Resident 100's health information uncovered. During an interview with Registered Nurse 1 (RN 1) on 4/23/2026 at 2:44 PM, RN 1 stated RN 1 did not cover Resident 100's health information on the ampicillin IV bag while hanging on the IV pole at Resident 100's bedside. RN 1 stated it risked exposing Resident 100's health information to unauthorized people. RN 1 stated visitors, housekeeping and maintenance personnel did not need to know Resident 100's health information nor the prescribed medication. RN 1 stated it was Resident 100's right to privacy by protecting Resident 100's health information. RN 1 stated it was important for everyone in the facility to protect the residents' rights to privacy. During an interview with the Director of Nursing (DON) on 4/23/2026 at 3:43 PM, the DON stated the housekeeper and maintenance personnel had access to residents' rooms and did not need to know the residents' health information. The DON stated everyone in the facility should protect the residents' health information as much as possible in accordance with Health Insurance Portability and Accountability Act (HIPPA- federal law that protected a resident's health information) laws. During a review of the facility's Policy and Procedure (P&P) titled Confidentiality of Personal and Medical Records, revised on 12/19/2022, the P&P indicated the facility should honor the resident's right to secure and confidential personal and medical records. The P&P indicated it included the right to confidentiality of all information contained in a resident's records, regardless of the form of storage or location of the record. The P&P indicated the facility should safeguard the content of information including written documentation from unauthorized disclosure without the consent of the individual and/or the individual's surrogate or representative. The P&P further indicated resident's personal or medical information should not be left unattended or viewable by unauthorized persons.

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	04/24/2026

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 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 interview and record review, the facility failed to ensure Dietary recommendation by the facility's Registered Dietician was acted upon for one of one sampled resident (Resident 3) in accordance with the facility's policy and procedure (P&P) titled Nutritional and Dietary Supplements This deficient practice had the potential to result in adverse consequences for Resident 3. Findings: During a review of Resident 3's admission Record (AR), the AR indicated the facility initially admitted Resident 3 on 6/4/2024 and readmitted on [DATE] with diagnoses including hyperlipidemia (high level of fats in the blood), anemia (decrease in the total amount of red blood cells in the blood) and dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning). During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool) dated 2/24/2026, the MDS indicated Resident 3 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 3 was dependent (helper does all of the effort) from staff with eating, toileting, shower, upper and lower body dressing and putting on/taking off footwear. During a review of Resident 3's triglyceride level laboratory result dated 2/25/2026, the laboratory result indicated Resident 3's triglyceride level was 226 milligrams per deciliter (mg/dl - unit of measurement). The normal triglyceride level was below 150 mg/dl. During a review of Resident 3's Nutritional Assessment (NA) dated 2/25/2026, the NA indicated the facility's Registered Dietitian (RD) recommended omega three oral capsule 1,200 milligrams (mg, unit of measurement) once daily for elevated triglycerides. During a review of Resident 3's untitled Care Plan (CP) revised 4/8/2026, the CP indicated Resident 3 had actual/potential nutritional problems related to hyperlipidemia, anemia and dementia. The CP intervention indicated for the RD to evaluate and make diet change recommendations as needed. During an interview and record review on 4/22/2026 at 9:24 am with Registered Nurse 1 (RN 1), Resident 3's medical records (PointClickCare - PCC, a cloud-based software) were reviewed. RN 1 stated Resident 3 received RD recommendation of omega three oral capsule 1,200 mg for elevated triglycerides. RN 1 stated, it was RN 1's responsibility to carry out the RD recommendation. RN 1 stated RN 1 did not follow up with Resident 3's primary physician. RN 1 stated the purpose of RD recommendation was to check the nutritional needs of the residents. RN 1 stated Resident 3's triglyceride level was elevated at 226 mg/dl. During a concurrent interview and record review of the Medical Nutritional Therapy Assessment Recommendations Form (MNTARF) on 4/22/2026 at 9:26 am, RN 1 stated, RN 1 received the RD recommendation for Resident 3 on 2/25/2026. RN 1 stated Resident 3 had a recommendation to start omega three oral capsule 1,200 mg once daily for elevated triglycerides. During an interview on 4/22/2026 at 9:28 am, with the Director of Nursing (DON), the DON stated there was no specific timeframe to carry out or to act upon the RD recommendations. The DON stated the RD recommendations should be acted upon as soon as possible. The DON stated, the purpose of RD recommendation was to ensure the resident's nutritional needs were met as recommended. The DON stated if the RD recommendation was not acted upon, Resident 3's needs and goals would not be met as recommended. During a review of the facility's P&P titled, Nutritional and Dietary Supplements, dated 12/19/2022, the P&P indicated, It is the policy of the facility that nutritional and dietary supplements will be used to complement a resident's dietary needs in order to maintain adequate nutritional status and resident's highest practicable level of well-being. Resident's nutritional status will be accurately and consistently assessed upon admission and on an as needed basis to identify a resident at nutritional risk and address risk factors for impaired nutritional status. Supplements may be recommended by a Registered Dietitian and implemented post physician orders.

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	04/24/2026

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

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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. Based on observation, interview, and record review, the facility failed to provide necessary care and services for a resident on oxygen therapy (treatment that provides supplemental, or extra oxygen) and breathing treatments (medicine delivered via nebulizer [device that turns liquid medicine into fine mist]) in accordance with professional standards of practice for one of two sampled residents (Resident 22). This failure placed Resident 22 at risk of infections which could lead to respiratory complications. Findings: During a review of Resident 22's admission Record (AR), the AR indicated the facility admitted Resident 22 on 12/22/2025 with diagnoses including acute respiratory failure (ARF, respiratory system suddenly fails to exchange gas) with hypoxia (deficiency in the amount of oxygen reaching body tissues), heart failure (HF, a heart disorder which causes the heart to not pump blood efficiently) and anxiety (feeling of fear, dread, and apprehension). During a review of Resident 22's untitled Care Plan (CP) dated 12/22/2025, the CP indicated Resident 22 was on oxygen therapy related to shortness of breath. The CP goals indicated for Resident 22 not to have signs and symptoms of poor oxygen absorption. During a review of Resident 22's Order Summary Report (OSR) dated 12/22/2025, the OSR indicated Resident 22 had an order for oxygen via nasal cannula (NC, a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) at two liters per minute (l/min) and an order for breathing treatment of albuterol solution, three milliliters (ml- unit of measurement) to be administered via nebulizer every six hours for shortness of breath or wheezing (abnormal breath sound) dated 12/23/2025. During a review of Resident 22's Minimum Data Set (MDS, a resident assessment tool) dated 12/26/2025, the MDS indicated Resident 22 had moderately impaired cognition (ability to understand and process information). The MDS indicated Resident 22 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating, supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral hygiene, upper body dressing and personal hygiene and partial/moderate assistance (helper did less than half the effort) with toileting, shower and lower body dressing. During a concurrent observation of Resident 22's room and interview on 4/21/2026 at 9:18 am with Licensed Vocational Nurse 3 (LVN 3), Resident 22 was not in the room. Resident 22's nebulizer mask was left hanging on the bedrail and the oxygen tubing was left on the bed. LVN 3 stated that the nebulizer mask and oxygen tubing should be stored inside the transparent bag intended for storage of respiratory supplies when not in use to prevent contamination and spread of infection. During an interview on 4/23/2026 at 3:52 pm with the Director of Nursing (DON), the DON stated all respiratory supplies should be placed inside the clear, transparent bag when not in use for infection control. During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration, revised on 5/20/2024, the P&P indicated, Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include to keep delivery services covered in plastic bag when not in use.