STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555135	A. Building B. Wing	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Springs Care Center	1441 Michigan Avenue Beaumont, CA 92223

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure for one of one residents (Resident 1) was appropriately monitored by their sitter in two instances when:Certified Nursing Assistant (CNA) 1 was not fully implementing a 1:1 (one sitter/staff member assigned to closely watch one resident) monitoring on Resident 1; andCNA 2 left Resident 1 unattended during 1:1 monitoring.These failures had the potential to cause harm to Resident 1 and to fellow residents.Findings: On July 14, 2025, at 8:22 a.m., an unannounced visit was made at the facility in order to investigate a complaint stating Resident 1's Certified Nurse Assistant (CNA) was reported asleep while on a 1:1 monitoring duty during the morning of July 4, 2025.1. On July 14, 2025, at 8:35 a.m., Resident 1 was observed asleep in her bed without a staff member nearby. On July 14, 2025, at 12:10 p.m., Resident 1's medical records were reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses including dementia (memory loss) and anxiety disorder. The facility document titled, NC-IDT (Interdisciplinary Team Conference), dated July 3, 2025, indicated a 1:1 sitter watch was initiated on Resident 1 due to an altercation with another resident.On July 14, 2025, at 4 p.m., the Director of Nursing (DON) was interviewed. The DON stated sitters (one individual assigned to closely monitor one resident) on 1:1 were expected to continuously stay close to their assigned resident to prevent harm. The DON stated a sitter used the monitoring log sheet to log the resident's location every 30 minutes. The DON stated the sitter assigned to conduct 1:1 monitoring must stay in arm's length of the resident in order to intervene if needed. The DON stated the sitter cannot leave the resident alone and must use the call light or call out for help. The DON stated sitters on breaks should be relieved by other staff members. The DON stated she was aware of the incident on July 4, 2025 where CNA 1 was the assigned sitter for Resident 2 and was reported asleep during the 1:1 monitoring. The DON stated according to their investigation, CNA 1 had claimed she was resting her eyes and was not asleep. The DON stated CNA 1 was not paying 100% attention to Resident 1 and that CNA 1's behavior was not acceptable. The DON stated that a guard (Guard 1) had witnessed CNA 1 with her eyes closed and notified the manager on duty.On July 15, 2025, at 12:13 p.m., Guard 1 was interviewed via telephone. Guard 1 stated he worked as a guard on July 4, 2025. On his way to the patio, Guard 1 saw CNA 1 and Resident 2 sitting next to each other on a bench. Guard 1 stated that he saw CNA 1's eyes closed for approximately two to three minutes while on sitter duty for Resident 1. After observing CNA 1 with her eyes closed, Guard 1 notified the Social Services Director (SSD) who then confronted CNA 1. Guard 1 stated a sitter was expected to consistently watch their resident and to remain within one arm's length away.The facility's policy titled, Routine Resident Checks, revised July 2013, indicated .Staff shall make routine resident checks to help maintain resident safety and well-being. 2. On July 14, 2025, at 8:35 a.m., an observation with a concurrent interview was conducted with Resident 1 and CNA 2. Resident 1 was observed asleep in her bed without a staff member nearby. CNA 2 was observed down the hallway from Resident 1's room. In a concurrent interview, CNA 2 stated he was assigned to monitor Resident on 1:1.CNA 2 stated he went to grab supplies and that he should not have left unattended in her room. CNA 2 stated that it was not okay for him to leave Resident 1 unattended. CNA 2 stated he should have asked other staff for help instead of leaving Resident 1.On July 14, 2025, at 12:10 p.m., Resident 2's medical records were reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses including dementia (memory loss) and anxiety disorder. The facility document titled, NC-IDT (Interdisciplinary Team Conference), dated July 3, 2025, indicated a 1:1 sitter watch was initiated on Resident 1 due to an altercation with another resident.On July 14, 2025, at 4:00 p.m., the Director of Nursing (DON) was interviewed. The DON stated sitters (one individual assigned to closely monitor one resident) on 1:1 were expected to continuously stay close to their assigned resident to prevent harm. The DON stated a sitter used the monitoring log sheet to log the resident's location every 30 minutes. The DON stated that the sitter assigned to conduct 1:1 monitoring must stay in arm's length of the resident in order to intervene if needed. The DON stated the sitter cannot leave the resident alone and must use the call light or call out for help. The DON stated sitters on breaks should be relieved by other staff membersThe facility's policy titled, Routine Resident Checks, revised July 2013, indicated .Staff shall make routine resident checks to help maintain resident safety and well-being.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure, for one of three residents (Resident 1):1.The depakote (medication to treat mood disorder) dosage recommended by the general acute hospital (GACH) was carried out when Resident 1 was re-admitted back to the facility; and2.The facility psychiatry nurse practitioner (PNP- an advanced practice registered nurse specializing in mental health care) review the acute hospital assessment and medication adjustment recommendations.These failures had the potential to contribute to unmanaged behavior of Resident 1 and affect overall behavioral condition of the resident. Findings:On July 14, 2025, at 8:38 a.m., Resident 1 was observed awake and lying on bed, with a Certified Nursing Assistant (CNA) sitting outside Resident 1's room.On July 14, 2025, Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses which included dementia (memory loss) with behavior disturbance.A review of Resident 1's Medication Administration Record (MAR), for the month of June 2025, indicated, Divalproex Sodium (Depakote) Delayed Release 250 MG (milligram - unit of measurement).two times a day for dementia.M/B (manifested by) scratching and kicking.; order date June 6, 2025, to June 19, 2025.A review of Resident 1's COC (Change of Condition)/INTERACT ASSESSMENT FORM, dated June 17, 2025, at 12:38 p.m., indicated, .At approximately 1015 910:15 a.m.) this morning the housekeeper heard a commotion in the hallway, as she was walking towards room [ROOM NUMBER]. The housekeeper saw (name of another resident) on the corner and the resident reported to her that (name of Resident 1) approached her and pulled her hair and began slapping her on the face.A review of Resident 1's hospital records indicated the following:- June 17, 2025; .brought in by transport services to (name of GACH) Emergency Department (ED) with concern for psychiatric evaluation. Patient placed on 5150 (a section of the state's Welfare and Institutions Code that allows a designated individual (like a peace officer or authorized professional) to involuntarily confine someone for up to 72 hours for mental health evaluation).Per transfer note, patient aggressive towards staff at her SNF (Skilled Nursing Facility). Patient also went to roommate and started slapping her, pulling her hair unprovoked.Upon arrival to ED.noted to be agitated and aggressive, attempting to kick ED staff.Psychiatry consulted for psych eval.;- June 20, 2025, discharge instructions, indicated the following orders for Depakote (valproic acid):- .valproic acid 250 mg capsule.Take 2 (two) capsules (500 mg total) by mouth every evening ; and- .valproic acid 250 mg capsule. Take 1 (one) capsule (250 mg total) by mouth daily.A review of Resident 1's MAR, for the month of June and July 2025, indicated, Valproic Acid (Depakote) Oral capsule 250 MG.Give 1 (one) capsule by mouth one time a day., order date June 20, 2025, to July 16, 2025. There was no documented evidence the PNP evaluated Resident 1 after the altercation incident on June 17, 2025, and after returning back to the facility from GACH on June 20, 2025.A review of Resident 1's Progress Notes, documented by Licensed Vocational Nurse, dated July 2, 2025, at 10:42 p.m., indicated, .At approximately 1930 (7:30 p.m.), a CAN brought the victim to the nurse's station to inform the charge nurse of this resident's (Resident 1) actions. Resident B (victim) reported that this resident (Resident 1) had started hitting her with their shoe and scratching at her face while yelling in Spanish.When charge nurse went to assess this resident, they were pacing around the room with their (sic) shoe in their (sic) hand. Resident then began hitting charge nurse with the shoe and grabbing her clothes and arms with her hands.A review of Resident 1's Progress Notes, documented by PNP, dated July 8, 2025, at 7:20 p.m., indicated, .Chief complaint: Resident to Resident Altercation.Patient has a hx (history) of aggressive behavior, scratching and kicking during care. Behavior still fluctuates. Staff reported that patient was involved in resident-to-resident altercation on 7/2/25 (July 2, 2025, with another roommate, where this patient happened to be the aggressor. Per staff, this resident hit the roommate in the face with a shoe.Plan.Patient was sent to the hospital for further evaluation r/t (related to) aggressive behavior and back to the facility.Order clarification.Valproic Acid oral Capsule 250 MG.Give 1 (one) capsule by mouth one time a day for mood disorder.On June 22, 2025, at 10:18 a.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated the following regarding Resident 1's order for Depakote:- Ordered for Depakote 250 mg twice daily prior to June 6, 2025, to June 17, 2025;- Physician's order for Depakote 250 mg daily since June 20, 2025 (readmitted from GACH);- Hospital discharge instructions of Depakote 250 mg 2 (two) capsules = 500 mg in the evening and 250 mg 1 (one) capsule in the morning, for a total of 750 mg a day- The hospital discharge instructions should be reviewed when a resident is admitted to the facility and carried out. The DON stated the hospital discharge instructions for