

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555135	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Highland Springs Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 ensure contact isolation precautions (define - steps used to stop the spread of germs by touch, requiring a private room, gloves, and a gown) were implemented in accordance with the policies and procedures, for one of four sampled residents who required contact isolation precautions (Resident 2), when the facility staff provided services to Resident 2 without the use of Personal Protective Equipment (PPE - refers to specialized clothing or gear worn by individuals to minimize exposure to hazards that cause serious workplace injuries, illnesses, or infections): This failure had the potential to increase the spread of scabies (a contagious, tiny mite infestation, skin condition) and cause serious bacterial infection and severe skin damage to individuals. Findings: On July 15, 2026, at 10:18 a.m., a signage was observed at the front, locked gate of the facility, which indicated there was restricted visitation due to a highly contagious rash. On July 15, 2026, at 10:23 a.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated Resident 2 tested positive for scabies on July 14, 2026. On July 15, 2025, at 10:46 a.m., an observation of Resident 2's room was conducted. Three signage and stocked PPE were observed outside Resident 2's room. The first and second signages indicated sequence on how to don and doff PPE. The third signage indicated instructions for contact precautions, .Contact Precautions. Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and Staff Must Also. Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use Dedicated or disposable equipment. clean and disinfect reusable equipment before use on another person. Licensed Vocational Nurse (LVN) 1 was observed entering Resident 2's room without donning gloves and gown, carrying a pitcher with ice, placed it on Resident 2's bedside table, then exited Resident 2's room. On July 15, 2025, at 11:01 a.m., during an interview with LVN 1, LVN 1 stated the facility provided training on infection control, transmission-based precautions, hand hygiene and reading the isolation precaution signage prior to entering the residents' rooms to understand what type of isolation, which PPE was required and how to don and doff the PPE. LVN 1 stated during the beginning of their shift, a staff huddle was conducted to update the staff that residents had a rash and were on contact isolation precautions. LVN 1 stated that the expectation was to don a gown and gloves prior to entering a resident's room that had contact isolation precautions. LVN 1 stated she should have donned a gown and gloves prior to entering Resident 2's room to deliver the ice cube pitcher. On July 15, 2025, at 11:16 a.m., CNA 1 was observed entering Resident 2's room without donning gloves or gown. CNA 1 touched Resident 2's call light on Resident 2's bed, then walked away from Resident 2's bed with a used cup and straw to dispose in the trash in Resident 2's room prior to exiting. On July 15, 2025, at 11:17 a.m., a concurrent interview and record review was conducted with CNA 1. CNA 1 stated she was instructed (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 555135	Facility ID: 555135 If continuation sheet Page 1 of 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555135	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Highland Springs Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to wear personal protective equipment (PPE) every time the staff enter a contact isolation room. CNA 1 stated the staff were to discard the PPE in the resident's room before leaving the room in the designated trash bin. CNA 1 stated the staff were required to sanitize their hands upon exiting then to go to the nurse's station to wash their hands. CNA 1 stated the expectation was to wear a gown and gloves prior to entering Resident 2's room, regardless of direct patient care was to be provided or not. CNA 1 stated she went to answer Resident 2's call light and should have donned gown and gloves due to contact isolation precautions. On July 15, 2025, at 2:21 p.m., a concurrent interview and record review was conducted with the Infection Preventionist (IP). The IP stated the expectation with a contact isolation room was that all staff were required to use the required personal protective equipment (PPE) before stepping into the residents' room regardless of if the staff member was providing direct patient care or just answering the call light. The IP stated the staff were required to change their PPE in between each resident in that room as well. The IP stated Resident 2 was placed on contact isolation on July 14, 2026, for 14 days. The IP stated the concern was the high risk of transmission and spreading an outbreak. The IP stated LVN 1 should have been wearing PPE prior to entering room to deliver the ice pitcher to Resident 2, who was positive for scabies. CNA 1 should have been wearing PPE prior to entering room to answer Resident 2's call light and to dispose of Resident 2's used cup and straw, who was positive for scabies. Resident 2's record was reviewed. Resident 2 was admitted to the facility on [DATE], with diagnoses which included seizures (sudden, uncontrolled burst of electrical activity in the brain) and dysphagia (trouble swallowing). A review of Resident 2's Minimum Data Set (MDS - an assessment tool), dated May 21, 2026, indicated Resident 2 had a BIMS (Brief Interview of Mental Status) score of 6 (severe cognitive impairment). A review of Resident 2's Scabies examination results, dated July 14, 2026, indicated, .scabies mites seen. A review of Resident 2's Physician Orders, dated July 14, 2026, indicated, .Contact Isolation Precaution. Quarantine x (times). 14 days for confirmed. via skin scraping. scabies. every shift for 14 days. A review of Resident 2's Care Plan, dated July 15, 2026, indicated, .Scabies. resident currently receiving treatment for scabies. resolve itching, current rash, and further risk of recurrence through appropriate interventions. maintain good hand-washing practices. A review of Resident 2's Care Plan, dated July 15, 2026, indicated, .Contact isolation. r/t (related to) scabies on July 14, 2026. reduce risk of complications, infections daily. contact isolation x 14 days. A review of the facility's policy and procedure titled, Isolation-Categories of Transmission-Based Precautions, revised date September 2022, indicated, .transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected. contact precautions are implemented for residents known or suspected to be infected. with microorganisms that can be transmitted by direct contact with the resident. or indirect contact with environmental surfaces. or resident-care items in the resident's environment. staff and visitors wear gloves (clean, non-sterile) when entering the room. while caring for a resident. staff avoid touching potentially contaminated environmental surfaces. or items in the resident's room after gloves are removed. staff and visitors wear a disposable gown. upon entering the room and remove before leaving the room. and avoid touching potentially contaminated surfaces with clothing after gown is removed. A review of the facility's policy and procedure titled, Scabies Identification, Treatment and Environment Cleaning, revised date April 2026, indicated, .the purpose of this procedure. is to treat residents infected with. and sensitized to. Sarcoptes scabiei (microscopic bug that causes a rash). and to prevent the spread of scabies to other residents and staff. individuals who come into contact with the infected resident. or with potentially contaminated bedding or clothing. should wear a gown and gloves or other protective clothing. as established by the facility's infection and exposure control programs.		