

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

Printed: 07/18/2026
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 08/29/2025
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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed for four of six residents reviewed for weight loss (Residents 12, 11, 33, and 32) the following: 1. For Resident 12, who was not on a planned weight loss program (an approach to losing and maintaining weight characterized by a reduced-calorie, nutritionally balanced eating plan, regular physical activity, and a behavior change component to promote sustained lifestyle habits), the facility failed to assess the continued weight loss from 153 pounds (lbs.-unit of measurement) to 131 lbs. since January 2025, and initiate interventions to prevent further loss. This failure resulted in Resident 12 losing weight since admission to the facility. Resident 12 lost 24 lbs. since admission. (admission weight 153, in January 2025, and was 129 lbs. in August 2025). 2. For Resident 11, who was not on a planned weight loss program, the facility failed to assess the continued weight loss from 247 lbs. to 217 lbs. since February 3, 2025, and initiate interventions to prevent further loss. In addition, the facility did not update and did not develop a person-centered nutrition care plan to meet Resident 11s' needs. This failure resulted in Resident 12 losing 30 lbs. (247 lbs in February 2025, and was 217 lbs. in August 2025). These failures could contribute for Residents 12 and 11 to have further weight loss and affect overall health condition. 3. For Resident 33, the facility's IDT weight variance committee (committee that addresses issues of weight variance) failed to document and monitor the effectiveness of the nutritional interventions. This failure can lead to serious health complications, and poor patient outcomes such as worsening malnutrition, slower wound healing, and increased risk of chronic diseases. 4. For Resident 32, the facility's IDT weight variance committee failed to document and monitor the effectiveness of nutritional interventions for Resident 32. This failure can lead to serious health complications, and poor patient outcomes such as worsening malnutrition, slower wound healing, and increased risk of chronic diseases. Findings: 1. According to a review of the web article titled American Academy of Family Physicians, published on February 15, 2002, which indicated, .Involuntary weight loss can lead to muscle wasting (thinning or loss of muscle tissue) .depression (mood disorder) and an increased rate of disease complications. Various studies demonstrated a strong correlation between weight loss and morbidity (having a disease or a symptom of disease) and mortality (death). One study showed that nursing home patients had a significantly higher mortality rate in the six months after losing 10 percent of their body weight, irrespective of diagnoses or cause of death. In another study, institutionalized elderly patients who lost 5 (five) percent of their body weight in one month were found to be four times more likely to die within one year . According to a review of the web article titled Journal of the American Dietetic Association (currently called the Academy of Nutrition and Dietetics), published October 2010, which indicated, .Unintended weight loss is defined as a gradual, unplanned weight loss that may occur slowly over time or have a rapid onset. In older adults, a 5% or more unplanned weight loss in 30 days often results in protein-energy undernutrition as critical lean body mass is lost . (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 0692 Level of Harm - Actual harm Residents Affected - Few	A research titled Dehydration in the Elderly, published by A. Koberinger, in 2011, indicated, .weight loss is a strong indicator of malnutrition and poor nutrition status . On August 25, 2025, starting at 12:06 p.m., Resident 12 was observed sitting at Table 4 with other residents during lunch meal observation. Resident 12's lunch meal was set up in front of the resident and Licensed Vocational Nurse (LVN) 6 was observed feeding Resident 12. Resident 12 was observed getting up during lunch and wandering (traveling aimlessly from place to place) around the dining room. Resident 12 was redirected back to her seat twice by a staff member to continue her meal. Resident 12 continued to get up from the chair and wander around the dining room then proceeded to the dining room exit. A review of Resident 12's record was conducted. A review of Resident 12's admission Record, indicated Resident 12 was admitted to the facility on [DATE], with diagnosis including dementia (a progressive impairment of intellectual functioning, memory, and abstract thinking), oropharyngeal dysphagia (swallowing problems occurring in the mouth and or the throat), hypertension (HTN - high blood pressure), gastro esophageal reflux disease (GERD - a condition in which acidic gastric fluid flows backward into the esophagus - connects the throat to the stomach, resulting in heartburn), mood disorder (mood swings that range from the lows of depression to elevated periods of emotional highs), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), wandering, and metabolic encephalopathy (a diffuse brain dysfunction caused by systemic metabolic disturbances). A review of Resident 12's Nutrition/Dietary Note, indicated the following: a. February 10, 2025, completed by Registered Dietitian (RD) 1, indicated, RD Weekly Weight Review: Ideal Body weight (IBW is a guideline used to estimate a healthy weight based on height, and gender): (90-110#); (1/27/2025) Wt.: 153 # (lbs.); (2/3/2025) Wt. 149 #/- (loss) 4 # x 1 week (wk) (2.6%) .Weight loss may be due to varied PO intake, Therapeutic/Mechanically altered diet (prescribed meal plan for individuals with chewing or swallowing difficulties), fluid shifts, advanced aging, Medical diagnosis (DX) Metabolic encephalopathy, heart disease, GERD, dementia. Current weight over IBWR (Ideal body weight range) and BMI (Body Mass Index is a formula weight(kg) / height(m)&sup2; used for assessing weight status, health risk, obesity) nearing obesity, weight loss may be beneficial. PO intake good and weight stable since 2/3/2025 (February 3, 2025). Diet Rx (prescription): NAS diet.PO 0-100%, mostly 80% with meal refusals. b. April 15, 2025, completed by RD 1, indicated, RD Monthly Weight/Quarterly Review: Current wt. 141# .Noted with &ndash; (loss) 7# (4.7%) x 1 month, -12 # (7.8%) x 3 months.Current weight over IBWR and BMI overweight, Resident may benefit from weight loss.Diet Rx: NAS diet.PO: 50-100%, mostly 70-100%.; a. June 3, 2025, completed by RD 1, indicated, RD Monthly Weight Review. Current Wt. 136 # .Noted w/-3 (2.2%) x 1 month, -12 (8.1%) x 3 months.Current weight over IBWR and BMI overweight, resident may benefit from weight loss. PO intake good. Diet Rx: NAS diet PO: 60-100%, mostly 70-100% .; b. July 1, 2025, completed by the RD 1, indicated, RD Monthly Weight/Quarterly Review: Current Wt. 131 #, IBW (90-110#). Noted w/-5# (3.7%) x 1 month, -10# (7.1%) x 3 months, -22# (14.4%) x 6 months.Current weight over IBWR and BMI overweight, Res may benefit from weight loss. PO intake good.Diet Rx: NAS diet.PO: 0-100%, mostly 70% w/2 meal refusals.; (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	c. August 2, 2025, completed by the RD 1, indicated, RD Monthly Weight Review: Current Wt. 133 #, IBW (90-110#). Noted w/ gained (+) 2 # (1.5%) x 1 month, -6 # (4.3%) x 3 months, -16 # (10.7%) x 6 months. Weight loss may be due to: Varied PO intake, Therapeutic/Mechanically Altered diet, Fluid shifts, Medical Dx (Metabolic encephalopathy, muscle wasting, muscle weakness, heart disease, GERD, dementia, psychosis.) Current weight over IBWR and BMI overweight, Resident may benefit from weight loss. PO intake good. Diet order: NAS (No Added Salt) diet, Mechanical soft texture .PO: 50-100%, mostly 80-100%.Labs: 8/1 (August 1, 2025) CMP/CBC (complete metabolic panel/complete blood count [laboratory test to check electrolytes in the body)-WNL (within normal limits) except low total protein; Altered labs d/t acute state.Recommend (Rec) : 30 ml LiquaCel (liquid protein supplement) QD (once a day) x 30 days for Low Protein labs . d. July 1, 2025, completed by the RD 1, indicated, RD Monthly Weight/Quarterly Review: Current Wt. 131 #, IBW (90-110#). Noted w/-5# (3.7%) x 1 month, -10# (7.1%) x 3 months, -22# (14.4%) x 6 months.Current weight over IBWR and BMI overweight, Res may benefit from weight loss. PO intake good.Diet Rx: NAS diet.PO: 0-100%, mostly 70% w/2 meal refusals.; and e. August 2, 2025, completed by the RD 1, indicated, RD Monthly Weight Review: Current Wt. 133 #, IBW (90-110#). Noted w/ gained (+) 2 # (1.5%) x 1 month, -6 # (4.3%) x 3 months, -16 # (10.7%) x 6 months. Weight loss may be due to: Varied PO intake, Therapeutic/Mechanically Altered diet, Fluid shifts, Medical Dx (Metabolic encephalopathy, muscle wasting, muscle weakness, heart disease, GERD, dementia, psychosis.) Current weight over IBWR and BMI overweight, Resident may benefit from weight loss. PO intake good. Diet order: NAS (No Added Salt) diet, Mechanical soft texture .PO: 50-100%, mostly 80-100%.Labs: 8/1 (August 1, 2025) CMP/CBC (complete metabolic panel/complete blood count [laboratory test to check electrolytes in the body)-WNL (within normal limits) except low total protein; Altered labs d/t acute state.Recommend (Rec) : 30 ml LiquaCel (liquid protein supplement) QD (once a day) x 30 days for Low Protein labs . A review of the nutrition assessments and nutrition dietary notes indicated weight loss may be beneficial; however, there was no documented evidence indicating the resident was placed on a planned weight loss, nor documented evidence of a weight goal for the resident, Resident 12. A review of Resident 12's Minimum Data Set (MDS - a standardized assessment tool), dated April 24, 2025, and July 21, 2025, indicated Resident 12 was not on a physician-prescribed weight loss regimen, with BIMS (Brief Interview for Mental Status- assessment of cognitive function) score of 3, indicating severely impaired cognition, and good appetite. A review of Resident 12's weights indicated the following: - January 24, 2025; 153 lbs.; admission weight; - February 3, 2025; 149 lbs.; - March 3, 2025; 148 lbs.; - April 1, 2025; 141 lbs.; 7 lbs. weight loss/4.72 % in 1 month from March 3, 2025; 12 lbs. weight loss/7.8 % a severe weight loss in 3 months from January 24, 2025; - May 1, 2025; 139 lbs.; (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	- June 3, 2025; 136 lbs.; 12 lbs. weight loss/8.10 % severe weight loss in 3 months from March 3, 2025); - June 21, 2025; 136 lbs.; - July 1, 2025; 131 lbs.; 5 lbs. weight loss/3.68 % in 1 month from June 3, 2025. 22 lbs. weight loss/14.37 % severe weight loss from admission January 24, 2025; - July 14, 2025; 129 lbs.; - July 21, 2025; 130 lbs.; - August 1, 2025; 133 lbs.; 16 lbs./10.7 % weight loss in 6 months from February 3, 2025); - August 12, 2025; 131 lbs.; - August 18, 2025; 129 lbs.; A review of Resident 12's physician's orders, dated August 28, 2025, indicated the following orders: a. Diet: No added salt (NAS: no salt package with meals) Mechanical soft texture (a modified diet consisting of soft, easy-to-chew foods that require minimal chewing or preparation), order dated January 23, 2025; and b. RNA (Restorative Nursing Assistant - provides specialized rehabilitation care to help patients regain functional abilities and independence after illness or injury, focusing on activities of daily living (ADLs) like bathing, dressing, and mobility) Feeding Program (cueing and redirections to encourage residents to eat) at Breakfast and Lunch order dated April 3, 2025. A review of Resident 12's IDT - WEIGHT MANAGEMENT, indicated the following: a. April 3, 2025, completed by Licensed Vocational Nurse (LVN) 4, indicated, Resident noted weight loss of 7 lbs. 4.72 % x 30 days; weight loss of 12 lbs. 7.84% x 90 days, Resident current weight (4/1/2025) 141 Lbs. above IBW 90-100-110 (range of IBW), Weight loss possibly due to (d/t) Varied PO intake, with Medical Dx: Metabolic encephalopathy, heart disease, GERD, dementia, fatigue. Weight loss may be beneficial. Resident compliance with diet NAS diet Mechanical soft texture thin consistency able to consume 80-100 % .MD notified with (w/) order for weekly weights x 4 weeks (wks) for wt management (mgmt.), RNA feeding program breakfast & lunch.; b. June 18, 2025, completed by LVN 4, indicated, Resident current weight (6/3/25) 136 Lbs. above IBW range 90-100-110, BMI- 26.56 above normal range, weight loss of 3 Lbs. 2.15 % x 30 days, weight loss 12 lbs. 8.10% x 90 days. Weight loss possibly d/t varied PO intake, Medical Dx: Metabolic encephalopathy, heart disease, GERD, dementia, fatigue). weight loss may be beneficial d/t (due to) weight remains above IBW. Resident compliance on diet current diet NAS diet Mechanical soft texture ate 80-90%. Resident wanders around the hallways.; and c. July 3, 2025, completed by LVN 4, indicated, Resident current weight (7/1/2025) 131 Lbs. above IBW range 90-100-110, BMI- 25.58 above normal range. weight loss of 5 Lbs. 3.67 % x 30 days, weight loss 10 lbs. 7.09% x 90 days, weight loss 22 lbs. 14.37 % x 180 days. Weight loss maybe d/t varied PO (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	intake, with Medical Dx: metabolic encephalopathy, heart disease, GERD, dementia, fatigue. Resident compliance on diet current diet NAS, Mechanical soft ate 65-80% meal. Per RD resident may benefit from weight loss, weight remains above IBWR. review of Resident 12's IDT - WEIGHT MANAGEMENT CARE PLAN, dated August 8, 2025, completed by LVN 4, indicated, Resident current weight (8/1/25) 133 Lbs. above IBW range 90-100-110, BMI- 25.97 above normal range. weight gain of 2 Lbs. 1.52 % x 30 days, weight loss 6 lbs. 4.31% x 90 days, weight loss 16 lbs. 10.73 % x 180 days. Weight loss may be beneficial d/t weight remains above IBWR of 90-100-110 lbs. w/ Varied PO intake, w/ Medical Dx: Metabolic encephalopathy, muscle wasting, muscle weakness, heart disease, GERD, dementia, psychosis. Resident compliance on diet. Currently on NAS diet Mechanical soft texture. ate 90-100%. A review of the IDT - WEIGHT MANAGEMENT notes addressed weight loss as may be beneficial, however, there was no documented evidence indicating the resident was placed on a planned weight loss. There was no documented evidence of how much the residents would need to lose. A review of Resident 12's MD's progress notes, dated January 24, 2025, February 14, 2025, March 15, 2025, April 19, 2025, May 3, 2025, June 7, 2025, July 12, 2025, August 2, 2025, and August 9, 2025, did not address any weight loss issues or that the weight loss was planned and/or desirable. A review of Resident 12's Care Plan, last care plan review completed on August 25, 2025, indicated, Resident 12 has alteration in nutritional status related to.7/8/25 (July 8, 2025) noted with a 22 # weight loss in 6 months from 153# to 131#. Noted weigh loss to be progressive -5 # in a month, 10 # in 3 months, 22 # in 6 months was 153 # in January 2025, 131 # in 7/2/25 (July 2, 2025) .Goal: Minimize any unplanned weight changes daily until the next assessment; Will minimize further weight loss every month in the next 3 months . The care plan goal indicated minimizing further weight loss, however there was no documentation of actions that would be taken to mitigate the weight loss. On August 27, 2025, at 3:14 p.m., a concurrent interview and Resident 12's record review was conducted with LVN 4. Concurrently reviewed Resident 12's IDT-Weight Management Care plan notes completed by LVN 4 on April 3, 2025, April 15, 2025, June 18, 2025, July 3, 2025, August 8, 2025, and RD 1 Nutrition notes on June 3, 2025, July 1, 2025, August 2, 2025, with LVN 4. LVN 4 stated she was unaware of Resident 12's plan of care for weight change. LVN 4 stated a plan of care for weight changes would be the responsibility of RD 1 and the DON. LVN 4 stated the IDT relied on RD 1 to determine a goal weight for Resident 12. On August 28, 2025, starting at 9:14 a.m., an interview was conducted with the IDT weight variance committee (RD 2, MDSN, LVN 4, and the CDM). RD 2 stated the standard of practice for weight management are the following process: -Assess the reason or cause of the weight loss including PO intake, overall health condition; -Recommend interventions to address the weight loss; -Follow up monitoring of the interventions recommended for its effectiveness; -Update the care plan when there are significant weight changes; -Should have a weight goal and to discuss the weight goal and interventions to meet the goal to the resident and/or resident representative; (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	- Expectation was everyone on the IDT weight variance committee should be aware of the residents' plan of care for weight change. On August 28, 2025, at 9:58 a.m., during a concurrent interview and record review with the MDSN, the MDSN stated Resident 12 had wandering behavior and needed assistance with ADLs (Activities of Daily Living - fundamental self-care tasks required to function independently, such as bathing, dressing, eating, mobility, and toileting). The MDSN stated that Resident 12 ate irregularly, often leaving her seat during meals. The MDSN verified that there was no nutrition intervention found for Resident 12 between April 15, 2025, and August 8, 2025, to address unplanned weight loss. On August 28, 2025, at 10:15 a.m., RD 2 reported that Resident 12's significant weight loss was unplanned and undesirable. It was noted that Resident 12 required additional queueing and assistance during meals, and snacks should have been provided. RD 2 stated the Interdisciplinary Team (IDT) was unable to provide any physician progress notes indicating the weight loss from January 2025 to August 2025 was beneficial. A review of the facility's policy and procedure titled, Weight Assessment and intervention, dated 2001, the P&P indicated, Policy Statement: Resident weights are monitored for significant weight loss .General Guidelines.The facility will conduct weight management and document in the IDT-weight management care plan, including . interventions. 2.On August 27, 2025, at 2 p.m., an interview was conducted with Resident 11. Resident 11 was in his room, alert, and was sitting at the edge of the bed. Resident 11 shrugged his shoulders when asked if he was aware he had a significant weight loss and if he participated in the IDT team discussion regarding his significant weight loss. Resident 11 did not respond to further interview questions regarding his weight loss. On August 27, 2025, Resident 11's record was reviewed. A review of Resident 11's admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses including dementia, dysphagia (difficulty in swallowing), muscle wasting and atrophy (decrease in size of a body part, cell, organ, or other tissue). A review of Resident 11's Weight and Vital's Summary, indicated the following: - 02/03/2025 (February 3, 2025); 247 lbs.; - 03/03/2025 (March 3, 2025); 248 lbs.; - 04/17/2025 (April 17, 2025); 238 lbs.; 10 lbs./4% weight loss in a month; (readmission from general acute hospital stay) - 05/01/2025 (May 1, 2025); 241 lbs.; - 05/05/2025 (May 5, 2025); 255 lbs.;17 lbs./7.14% weight gain in a month; - 06/03/2025 (June 3, 2025); 229 lbs; 26 lbs./10.19% weight loss in a month; 19 lbs./7.66% weight loss in 3 months; - 06/09/2025 (June 9, 2025); 237 lbs.; (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	- 07/01/2025 (July 1, 2025); 233 lbs.; and - 08/01/2025 (August 1, 2025); 217 lbs.; 16 lbs./6.8% weight loss in a month; 24 lbs./9.95% weight loss in 3 months; 30 lbs./12.14% weight loss in 6 months. A review of Resident 11's, MD Progress Note, dated April 19, 2025, indicated, .with history of dementia, anxiety.re-admitted .DECISION MAKING CAPACITY.Fluctuating.PLAN.Hydration. A review of Resident 11's, Order Summary Report, active physician orders as of August 28, 2025, indicated the following diet orders: - CCHO (Controlled Carbohydrate &ndash; prescribed diet aimed to reduce intake to manage blood sugar level and lose weight) mechanical soft texture, thin consistency diet (Order Date April 16, 2025); - Fruit Cup (No dessert with lunch and dinner) with meals (Order Date April 23, 2025); and - Non-fat milk with meals for weight management. A review of Resident 11's, IDT., completed by the IDT Team (Nursing, Activity, Dietary, and Social Service) dated April 17, 2025, indicated, .Related Diagnosis.dysphagia.muscle wasting and atrophy.Most Recent Weight.238.0.IBW (Ideal Body Weight) Range 133-148-163.No unplanned nor significant weight changes noted. A review of Resident 11's, Nutritional Assessment, completed by Registered Dietician (RD) 1, dated April 22, 2025, indicated the following: - Diagnosis.DEMENTIA.MUSCLE WASTING AND ATROPHY.; -Most Recent Weight.238.IBW (Ideal Body Weight - the estimated weight range considered optimal for health and well-being, based on factors such as height, age, and body composition) Range 128-156# (lbs).BMI (Body Mass Index - a calculation used to estimate body fat percentage based on a person's height and weight).38.4.; -Diet Provides.CCHO diet, Mechanical soft texture, Thin consistency.; - PO (by mouth) 75 to 100%, mostly 90-100% .; -PROBLEMS.Dementia.At Risk for Malnutrition. - WT (weight) loss may be d/t (due to) recent hospitalization, Varied PO intake, therapeutically/Mechanically altered diet, advance aging, fluid shifts .Wt loss is unavoidable due to underlying conditions .Current weight over IBWR and BMI >35, res (resident) may benefit from weight loss. PO intake good .; -SUMMARY LEVEL OF CARE.Moderate .Wt fluctuates. Lab data consistent with potential for malnutrition. Medical condition stable. Food intake fluctuates.; -Implementation Plan.Replace Whole Milk with Non-Fat Milk for all meals for weight mgmt. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	(management).Replace Dessert with Fruit Cup (Lunch/Dinner) for weight mgmt.Continue to monitor. A Review of Resident 11's, Care Plan Report, created December 9, 2024, and revised July 12, 2025, indicated, .Anticipated weight loss related to: significant weight changes, cognitive impairment, medical diagnosis/condition.Above IBW (Ideal Body Weight) Range.diet: Mechanical altered, Therapeutic.Goal.Lab values will be within normal limits for age until the next assessment.Interventions.4/23/25- NF (Non Fat) MILK.4/23/25-FRUIT CUP LUNCH AND DINNER.8/5/25-CCHO diet Mechanical soft texture.Diet as ordered.Review of medication regimen and clinical conditions.Monthly weights.Lab tests as ordered.Notification of physician of significant weight variances. Further review of the Care Plan Report, dated December 9, 2024, for anticipated weight loss, did not indicate Resident 11 to be placed on a planned weight loss program and there was no weight goal set by the IDT as a parameter of an acceptable weight change. A review of Resident 11's Weight and Vital's Summary, indicated Resident 11 had a weight gain of 17 lbs. from April 17, 2025, to May 5, 2025. A review of Resident 11's, IDT-WEIGHT MANAGEMENT CARE PLAN, completed by the IDT team, dated May 7, 2025, indicated the following: -Recent Weight Gain.Most Recent Weight 255.IBW Range 128-156#.; -Unavoidable weight gain.no signs and symptoms of edema (swelling or accumulation of excess fluid in the body tissues), congestion, nor fluid retention.; -ADDITIONAL COMMENTS .Resident current weight 255 Lbs. Above IBW range 128-142-156, BMI 41.15 above normal range .weight gain 14 lbs. 5.80%. Resident on CCHO, mechanical soft diet coffee with meals, nf (non-fat) milk all meals, fruit cup lunch and dinner.Po (PO &ndash; by mouth) 80-100%. Resident refuse to follow prescribed diet, frequent asking for milk, snacks in the kitchen. Resident consume (sic) 100% of most of his meals .MD (medical doctor) notified no order given, IDT made aware, will continue plan of care . Further review of Resident 11's record indicated there was no documented evidence that a resident-centered care plan was developed and/or updated to address the 14 lbs. weight gain in a week. A review of Resident 11's Weight and Vital's Summary, indicated Resident 11 had a weight loss of 26 lbs. from May 5, 2025 (255 lbs.), to June 3, 2025 (229 lbs.). A review of Resident 11's, RD Weekly Weight Review, completed by RD 1 and dated June 3, 2025, indicated the following: -Current Wt. 229#, IBW (128-156#), Noted w/ (with) -12# (weight loss) x (times) 1 month, -19# x 3 months. -Weight loss may be due to: Previous hospitalization, Good PO intake, Fluid shifts.Medical Dx (Diagnosis).; (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-Current weight over IBWR and BMI > 35, res may benefit from weight loss. PO intake good; -CCHO diet, mechanical soft texture.SMALL PORTION.Fruit bowl two times a day for 6 months at Lunch and Dinner.; and -Continue to monitor PO intake, weight, skin, and labs (laboratory). Further review of Resident 11's RD Weekly Weight Review, dated June 3, 2025, indicated there was no further assessment conducted to determine the root cause of the 26 lbs. weight loss on Resident 11 from May 5 to June 3, 2025, as there were no changes in the resident's condition. A review of Resident 11's MD Progress Note, dated June 7, 2025, indicated, .with history of dementia, anxiety.DEMENTIA.MUSCLE WASTING AND ATROPHY.ANXIETY DISORDER.PLAN.Hydration. The MD progress notes did not indicate if a clinical assessment was conducted to determine the cause of the 26 lbs. weight loss on Resident 11 from May 5 to June 3, 2025. Further review of Resident 11's record did not indicate the nutrition care plan was updated to address the weight fluctuations from May 5, 2025 (255 lbs.) to June 3, 2025 (229 lbs.). A review of Resident 11's, Care Plan Report, dated June 18, 2025, indicated, .CHANGE OF CONDITION m/b (manifested by) Resident noted weight loss 19 lbs. (pounds) 7.66 % x 90 days.Goal.Resident and/or Responsible Party will understand the change of condition is anticipated and unavoidable due to diagnoses and risk factors identified by 7-14 days Resident change of condition will resolve or at least improve if resolution is not possible by 7-14 days.Resident will receive timely assessment of change in condition and follow-through by licensed nurse daily until the next assessment.Interventions.Notify Attending Physician and Resident/Resp Party.Provide standard nursing care, reassurance and alleviate pain or discomfort as needed.Resident will be assessed by licensed nurse. There was no documented evidence Resident 11's nutrition care plan was updated to indicate how the facility staff would implement and monitor interventions, evaluate for effectiveness, to achieve their short-term goal as indicated on June 18, 2025, care plan report. A review of Resident 11's, Weight and Vital's Summary, indicated Resident 11 had a weight loss of 16 lbs/6.8% in 1 month from July 1, 2025 (233 lbs) to August 1, 2025 (217 lbs), 24 lbs/9.95% weight loss in 3 months (from May 5, 2025 to August 1, 2025); 30 lbs/12.14% weight loss in 6 months (from February 3, 2025 to August 1, 2025). A review of Resident 11's, MD Progress Note, dated August 2, 2025, did not indicate an assessment was conducted by the physician to determine and address the cause of the significant weight loss of Resident 11. A review of Resident 11's, RD Monthly Weight Review, completed by RD 1, and dated August 2, 2025, indicated the following: -Current Wt. 217#, IBW (128-156#). Noted w/-16# (6.9%) x 1 month, -24# (10.0%) x 3 months, -30# (12.1%) x 6 months; -Weight loss may be due to: Fluid shifts, Therapeutic/Mechanically altered diet, advanced aging, (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Medical Dx (diagnosis) .Dementia, dysphagia, muscle wasting, schizophrenia (type of behavioral disorder); -Current weight over IBWR (Ideal Body Weight Range) and BMI Body Mass Index) 35, res (resident) may benefit from weight loss. PO (by mouth) intake excellent. texture, Thin consistency, SMALL PORTION; -[NAME] (Nourishment) Rx (Prescribed) .Fruit Bowl two times a day for 6 Months . @ (at) Lunch & Dinner .4 oz (Ounce - unit of measurement) Non-fat milk with meals .PO 80-100%, mostly 100% . -Rec (Recommendation) .Remove Small Portions from Diet Rx for weight mgmt. (management).Diet Rx: CCHO diet, Mechanical soft texture, Thin consistency. Continue to monitor PO intake, weight, skin, and labs.Reassess as needed. A review of Resident 11's, IDT & Weight Management Care Plan, completed by the IDT team and dated, August 7, 2025, indicated the following: -Weight Loss .Beneficial weight loss .No signs of symptoms of acute illness, dehydration, nor excessive fluid loss noted at this time.Dx/Conditions placing resident at risk for Unavoidable Weight Loss .Alzheimer's Dementia (a progressive brain disorder that causes memory loss, confusion, and other cognitive decline.: -TEAM RECOMMENDATIONS .Resident's current weight change is not an immediate detriment to resident's health status/condition at this time .No change. Resident is receiving nutritional support at this time, continue with present dietary plan of care .Dietary/RD Consult.; -ADDITIONAL COMMENTS .Resident current weight 217 Lbs. Above IBW range 128-142-156, BMI- 35.02 above normal range .weight loss 16 lbs. 6.86% x 30 days, weight loss 24 lbs. 9.95% x 90 days. weight loss 30 lbs. 12.14% x 180 days. Resident may benefit from weight loss. Resident with Medical Dx: Dementia, dysphagia, muscle wasting .Currently on CCHO diet Mechanical soft texture .ate 85-100% most meals. Resident alert & able to make needs known, no respiratory distress, no signs of dehydration .MD notified no order given @ (at) this time, IDT made aware. A review of Resident 11's, Care Plan Report, dated August 7, 2025, indicated, .CHANGE IN CONDITION m/b Resident noted w/ (with) weight loss 24 lbs. 6.86% x 30 days, weight loss 24 lbs. 9.95% x 90 days, weight loss 30 lbs. 12.14 % x 180 days.Goal.Resident and/or Responsible Party will understand the change of condition is anticipated and unavoidable due to diagnoses and risk factors identified by 7-14 days.Resident change of condition will resolve or at least improve if resolution is not possible by 7-14 days.Resident will receive timely assessment of change in condition and follow-through by licensed nurse daily until the next assessment.Interventions.Notify Attending Physician and Resident/Resp Party.Provide standard nursing care, reassurance and alleviate pain or discomfort as needed.Resident will be assessed by licensed nurse. Further review of the care plan report on the significant weight loss, did not indicate how the facility staff would implement and monitor		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement and document non-pharmacological interventions (NPI), for four of four sampled residents (Resident 3, 9, 12, and 61) receiving psychotropic medications. In addition, for Resident 61, the facility failed to document the NPI were attempted prior to initiating psychotropic medications. These failures had the potential to place residents at risk of unnecessary psychotropic medication use and adverse side effects, such as sedation and falls. Findings: 1. On August 27, 2025, a review of Resident 3's admission Record, indicated Resident 3 was admitted to the facility on [DATE], with diagnoses which included schizophrenia (a chronic mental illness characterized by significant disruptions in thought processes, perceptions, emotions, and social behaviors), anxiety, and mild cognitive impairment (trouble with thinking skills, like memory, concentration, problem-solving). A review of Resident 3's Order Summary Report, indicated the following physician's orders: - Mirtazapine (generic for Remeron, an antidepressant medication to treat depression) 7.5 mg (milligram - unit of measurement), one (1) tablet by mouth at bedtime for depression M/B (manifested by) verbalizing feelings of sadness, order dated July 31, 2025; and - Risperidone (generic for Risperdal, an antipsychotic medication to treat various mental and thought disorder including altered sense of reality) 3 mg, one (1) tablet by mouth at bedtime for grandiose delusions (false belief of having great power, importance, or identity) as evidenced by verbalizing he is Jesus Christ, order dated June 20, 2025. A review of Resident 3's medical record titled Care Plan Report, for Remeron and Risperdal, dated July 21, 2025, indicated .Goal: .Resident's episodes will be minimized through appropriate interventions daily through next assessment. A review of Resident 3's medical record titled NP (Nurse Practitioner)/PA (Physician Assistant) Progress Notes, dated August 11, 2025, indicated .Plan: .Continue nonpharmacological intervention and continue to monitor behavioral and weight changes. A review of Resident 3's medical record titled Medication Administration Record (MAR), for the month of August 2025, indicated there was no documented evidence the facility implemented and monitored the NPI for Resident 3 receiving psychotropic medications (Mirtazapine and Risperidone). 2. On August 27, 2025, a review of Resident 9's admission Record, indicated Resident 9 was admitted to the facility on [DATE], with diagnoses which included schizophrenia, dementia (loss of cognitive functioning, thinking, remembering and reasoning), insomnia (difficulty sleeping), bipolar (a chronic mental health condition characterized by extreme mood swings between periods of mania [elevated mood] and depression [low mood]), major depressive disorder (depression), and anxiety. A review of Resident 9's Order Summary Report, indicated the following physician's orders: - Divalproex Sodium (generic for Depakote, a medication to treat mental/mood disorder) Oral Tablet Delayed Release (a tablet designed to release the drug later after ingestion rather than immediately) 250 mg, give one (1) tablet by mouth every 8 hours for mood disorder m/b poor impulse control, order dated August 11, 2025; - Mirtazapine 7.5 mg, give one (1) tablet by mouth at bedtime for depression m/b loss of appetite (meal intake of <50%), order dated August 5, 2025; and - Quetiapine Fumarate (generic for Seroquel, an antipsychotic medication to treat various mental and thought disorder including altered sense of reality) 150 mg, give one (1) tablet by mouth two times a day for schizophrenia m/b kicking, scratching, and spitting, order dated August 11, 2025. A review of Resident 9's Care Plan Report for Depakote, Remeron, and Seroquel, dated July 23, 2025, indicated .Goal: .Resident's episodes will be minimized through appropriate interventions daily. A review of Resident 9's NP/PA Progress Notes, dated August 11, 2025, indicated .Plan .Continue to utilize nonpharmacological interventions and monitor closely for any behavioral and weight changes. A review of Resident 9's MAR for the month of August 2025 indicated there was no documented evidence the facility implemented and monitored the NPI for Resident 9 receiving psychotropic medications (Divalproex, Mirtazapine and Quetiapine). 3. On August 27, 2025, a review of Resident 12's (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admission Record, indicated Resident 12 was admitted to the facility on [DATE], with diagnoses which included dementia, mood disorder, unspecified psychosis (a psychotic disorder characterized by a loss of contact with reality).A review of Resident 12's Order Summary Report, indicated the following physician's orders:- Depakote Sprinkles Delayed Release 125 mg (Divalproex Sodium), give six (6) capsules by mouth in the morning for Mood disorder M/B severe restlessness, dated February 25, 2025; and- Depakote Sprinkles Delayed Release 125 mg (Divalproex Sodium), give six (6) capsules by mouth at bedtime for Mood disorder M/B severe restlessness, dated August 18, 2025.A review of Resident 12's Care Plan Report for Depakote, dated July 21, 2025, indicated .Goal: .Reduce the episodes of behavior daily through the next assessment.Assess what may cause behavior and what may trigger behavior; attempt to reduce/eliminate those triggers if possible. Provide redirections as needed.A review of Resident 12's medical record titled NP/PA Progress Notes, dated April 9, 2025, June 6, 2025, and August 17, 2025, indicated .Plan: .Continue nonpharmacological interventions.A review of Resident 12's MAR for the month of August 2025 indicated there was no documented evidence the facility implemented and monitored the NPI for Resident 12 receiving psychotropic medication, Depakote.4. On August 27, 2025, a review of Resident 61's admission Record, indicated Resident 61 was admitted to the facility on [DATE], with diagnoses which included vascular dementia (loss of memory and thinking skills), Alzheimer's disease (progressive memory loss, type of dementia), unspecified psychosis, mood disorder, and anxiety.A review of Resident's 61s Order Summary Report, indicated the following physician's orders:- Divalproex Sodium Oral Tablet Delayed Release 250 MG (Divalproex Sodium), Give 1 tablet by mouth one time a day for Mood Disorder M/B mood disturbances, dated July 31, 2025; - Divalproex Sodium Oral Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium), Give 3 capsules by mouth at bedtime for Mood Disorder M/B mood disturbances, dated July 31, 2025; and- Remeron Oral Tablet 15 MG (Mirtazapine), Give 1 tablet by mouth at bedtime for Depression m/b poor appetite (meal intake of <50%), dated August 5, 2025.A review of Resident 61's medical record titled Psychotropic assessment did not include any behavior interventions attempted prior to initiation of Divalproex and Mirtazapine.A review of Resident 61's Care Plan Report for Remeron and Depakote, dated June 27, 2025, indicated .Goal: .Resident's episodes will be minimized through appropriate interventions daily through the next assessment.A review of Resident 61's NP/PA Progress Notes, dated April 11, 2025, June 6, 2025, July 8, 2025, and August 11, 2025, indicated .Plan: .Continue.nonpharmacological interventions.A review of Resident 61s MAR for the month of August 2025 indicated there was no documented evidence the facility implemented and monitored the NPI for Resident 61 receiving psychotropic medications (Divalproex and Remeron).On August 28, 2025, at 9:15 a.m., during a concurrent interview and record review with Minimum Data Set (MDS - a resident assessment tool) Nurse (MDSN), the MDSN confirmed there was no documented evidence the NPI was implemented while Residents 3, 9, 12, and 61 were receiving psychotropic medications. The MDSN stated the NPI should be implemented to redirect the residents' behaviors and minimize the use of psychotropic medications. On August 28, 2025, at 11:25 a.m., during a concurrent interview and record review with the Assistant Director of Nursing (ADON), the ADON confirmed there was no documented evidence the NPI were attempted prior to the initiation of Resident 61's psychotropic medications (Mirtazapine and Divalproex). The ADON also acknowledged there was no documented evidence of quantifiable monitoring implemented for NPI while the residents were receiving psychotropic medications for Residents 3, 9, 12, and 61's use of psychotropic. However, the ADON stated there were no physician orders directing staff to document these interventions after they were attempted, so staff did not record them.On August 29, 2025, at 10:39 a.m., during an interview with Psychiatric Nurse Practitioner (PNP), the PNP stated he was unaware that the facility was not documenting NPI. The PNP further stated, as noted in the PNP's progress notes and discussed during monthly IDT meetings, NPI should be applied consistently when psychotropic medications were being used, and although NPI may be ineffective initially, repeated use of NPI could benefit the residents' behavior management.A review of the facility's policies and (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	procedures titled, Psychotropic Medication Use, dated March 2023, indicated, .non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure discontinued medications were not stored in the medication cart readily available for use. This failure has the potential for the residents to receive discontinued medications. Findings: On August 27, 2025, at 10:06 a.m., an observation, with a concurrent interview and record review was conducted with Licensed Vocational Nurse (LVN) 3. LVN 3 stated medications stored in Medication Cart 1 were readily available for use. The following medications were found stored at the bottom drawer of the medication cart: - For Resident 38, 30 tablets of hydroxyzine HCl (medication used to treat anxiety and allergic skin reaction) 25 milligrams (mg - unit of measurement) give one tablet orally every six hours as needed for anxiety manifested by crying and wringing of hands for 10 days (date ordered July 24, 2025). In a concurrent interview, LVN 3 stated this medication was discontinued on July 30, 2025; - For Resident 50, 14 patches of Lidoderm Patch (topical pain medication) 5% to apply to painful area in the morning for arthritis (swelling or tenderness in one or more joints, causing joint pain or stiffness) pain (date ordered April 22, 2025). In a concurrent interview, LVN 3 stated this medication was discontinued on May 30, 2025; and - For Resident 55, 15 tablets of ibuprofen tablet (pain medication) 600 mg orally every six hours as needed for pain for seven days (date ordered July 22, 2025). In a concurrent interview, LVN 3 stated this medication was discontinued on July 29, 2025. LVN 3 stated the discontinued medication should have been pulled out from the medication cart. LVN 3 stated discontinued medications should not have been stored in the medication cart readily available for use. LVN 3 stated there could be a potential for medication error if a discontinued medication was given to a resident. The facility's policy and procedure titled, Storage of Medications, dated March 2023, was reviewed. The policy indicated, . The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destructed as indicated.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to follow its policy and procedure in preparation of pureed food by methods to conserve nutritive value, for 16 out of 16 residents who received pureed foods. This failure had the potential for the residents to receive food with inadequate nutritive value and could potentially place the residents at risk for compromised nutritional status. Findings: On August 25, 2025, at 9:28 a.m., a concurrent observation and interview was conducted with Certified Dietary Manager (CDM) in front of oven inside the kitchen. Several serving pans of foods were observed holding inside the oven. The CDM took out some of the serving pans and stated they had finished preparing pureed food items (meat ball, zucchini, and pasta) for the lunch meal. On August 25, 2025, at 10:03 a.m., an interview was conducted with [NAME] 1. [NAME] 1 stated he needed to cook all regular food items on the menu first and store them inside the oven and then scooped out those regular food items to prepare the pureed foods. [NAME] 1 stated he started preparing the lunch meal with pureed food items at 8:45 a.m. today. On August 26, 2025, at 8:41 a.m., a concurrent observation and interview was conducted with [NAME] 1. [NAME] 1 was observed to prepare pureed vegetable (spinach) for lunch meal. [NAME] 1 stored all cooked food items (beef, mashed potatoes, spinach) including pureed food items into the oven at holding temperature. [NAME] 1 stated he usually tried to complete all his lunch meal preparation before 9:30 a.m. On August 26, 2025, at 3:25 p.m., an interview was conducted with Registered Dietitian (RD) 2. RD 2 confirmed [NAME] 1 did not follow the Facility's Food Preparation Policy. RD 2 stated the serving time for the facility should be at 11:30 a.m. RD 2 stated [NAME] 1 completed all the lunch meal preparation before 9:30 a.m., which was not as close as possible to serving time for lunch meal. RD 2 stated meals prepared earlier than serving time could affect the consistency, taste, and nutritive value of foods, especially prolonged cooking temperature of pureed foods could deplete nutritive values. During a review of the facility's provided Diet Type Report, dated August 28, 2025, indicated Residents 4,14,17,24, 25, 30,37, 41, 43, 46, 47, 48, 66, 67, 74, and 78 (16 residents) were receiving pureed diet. A review of the facility's policy and procedure titled, Food Preparation Policy, undated, indicated, .POLICY: Food is to be prepared in such a manner as to maximize flavor, appearance, and nutritional value. PROCEDURE: 1. All food will be prepared by methods that preserve nutritive value, flavor, and appearance, and will be attractively served at the proper temperature and in a form to meet the individual needs of the resident. 8. Food should be prepared as close as possible to serving time to ensure flavor, freshness, and nutritional value.		

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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 maintain a sanitary environment, prepare, and serve food in accordance with professional standards for food service safety when:1. The reach-in refrigerator ventilator had dust;2. The reach-in refrigerator storage shelves had chipping paint;3. Two opened food items were found unsealed in the freezer; and4. Hamburger buns were not stored according to manufacturer's guidelines.These failures had the potential to result in the spread of food borne illness within the facility due to the contamination and improper storage of food. Findings:1. On August 25, 2025, at 9:28 a.m., an inspection was conducted in the kitchen with the Certified Dietary Manager (CDM). Upon inspection of the reach in refrigerator, dust was observed in the refrigerator ventilator. The CDM stated that the reach in refrigerator was cleaned last month and that staff are .supposed to clean it. The CDM stated that they need to clean it more frequently.On August 26, 2025, at 3:20 p.m., the CDM stated that it was not acceptable to have dust in the ventilator. The CDM stated that dust in the ventilator was a sanitation issue and can get into the food.A review of the facility's undated policy titled, Kitchen Cleanliness and Sanitation Policy, indicated, .To ensure the safety and well-being of residents, staff, and visitors, this facility is committed to maintaining a clean, sanitary, and complaint kitchen environment. All equipment, surfaces, and food preparation areas must be cleaned and sanitized regularly.2. On August 25, 2025, at 9:28 a.m., an inspection was conducted in the kitchen with the CDM. Upon inspection of the reach in refrigerator, three refrigerator storage shelves were observed to have chipping paint. The CDM stated that the chipping paint could contaminate food.On August 26, 2025, at 3:20 p.m., the CDM stated that it was not acceptable for the refrigerator shelves to have chipping paint. The CDM stated that chipping of refrigerator shelves should be fixed due to sanitary reasons.A review of the facility's undated policy titled, Kitchen Cleanliness and Sanitation Policy, indicated, .To ensure the safety and well-being of residents, staff, and visitors, this facility is committed to maintaining a clean, sanitary, and complaint kitchen environment. All equipment, surfaces, and food preparation areas must be cleaned and sanitized regularly.Staff must ensure equipment, shelves, utensils, and prep areas are clean and in good working condition.3. On August 25, 2025, at 10:40 a.m., the walk-in freezer was inspected. Upon inspection, honey wheat rolls and breadsticks were observed opened in boxes. The opened food items were not sealed and placed inside the opened packaging.On August 26, 2025, at 3:20 p.m., the CDM stated open food items in the freezer need to be properly sealed and not exposed. The CDM stated that improperly stored food items are a sanitation concern because exposed food can cause cross contamination and freezer burn.A review of the facility's undated policy titled, Storage of Open Food Items, indicated, .Keep in original packaging if intact and sealed.If opened, rewrap tightly in moisture-proof material or transfer to a freezer-grade container/bag.4. On August 25, 2025, at 3:20 p.m., the walk-in refrigerator was inspected with the CDM. Upon inspection, nine (9) packs of eight (8) hamburger buns were observed stored in the walk-in refrigerator. A review of the (name of manufacturer) hamburger buns packaging label titled, QUALITY GUARANTEE, indicated, .Our bakery products retain their best quality if stored at room temperature.On August 26, 2025, at 3:20 p.m., the CDM stated that the facility should follow manufacturer's guidelines for bread storage.A review of the facility's undated policy titled, Storage of Open Food Items, indicated, .To ensure the safe storage of food items after opening, all food items, once opened, must be stored in a manner that protects them from contamination, maintain quality, and preserves freshness.Bread and Baked Goods.Label with the date opened and discard date per manufacturer's label or the storage guidelines.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview and record review, the facility failed to ensure the proper maintenance of essential equipment, when the walk-in freezer had icicles built up. This failure had a potential risk to affect the quality of food stored in the walk-in freezer. Findings: On August 25, 2025, at 10:45 a.m., a concurrent observation of the walk-in freezer inside the kitchen and interview with the Certified Dietary Manager (CDM) was conducted. Icicles built up were observed around the connection of black pipe inside the walk in freezer. Foods were observed stored under the black pipe. The CDM stated she just noticed the icicles built up and it was not usual to have icicles built up inside the walk-in freezer. On August 25, 2025, at 3:32 p.m., an observation was conducted at the walk-in freezer in the kitchen. Some new icicles were built up were observed around the connection of the black pipe and there was ice built up on the wall under the black pipe too. On August 26, 2025, at 9:20 a.m., a concurrent observation and interview was conducted with Registered Dietitian (RD) 2 at the walk-in freezer in the kitchen. Some icicles built up were observed on the black pipe. RD 2 stated the facility did not have manufacturer manual for the walk-in freezer. On August 26, 2025, at 3:20 p.m., an interview was conducted with RD 2. RD 2 stated there should not be any icicles and ice built up in walk-in freezer. The RD 2 stated her expectation was to contact the vendor to fix the walk-in freezer. A review of the facility's undated policy and procedure titled, Maintenance Inspections, indicated, .POLICY.fixtures.Should any of the above be.defective.the Administrator will have them immediately repaired by the maintenance supervisor or appropriate serving company. All staff members report immediately any broken, loose, or otherwise defective safety equipment or fixtures to their immediate supervisor and/or the Administrator.		

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

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to ensure an effective pest control program was in place, when house flies were observed flying and landing on a resident's meal during lunch in the dining room on August 25, 2025. This failure had the potential to spread food borne illness within the facility due to the contamination and inadequate pest control. Findings: On August 25, 2025, at 12:28 p.m., three flies were observed flying around table two in the dining room. One fly landed on the rim of Resident 45's drinking glass. On August 25, 2025, at 12:32 p.m., Licensed Vocational Nurse (LVN) 1 was observed assisting Resident 46 with her meal. The flies were still observed flying around table two. LVN 1 stated that flies should not be in the dining room and that it was unsanitary. On August 25, 2025, at 12:42 p.m., Certified Nursing Assistant (CNA) 4 was observed swatting the flies away. CNA 4 stated flies are unsanitary and considered an infection control issue. On August 26, 2025, at 10:52 a.m., the Infection Preventionist (IP) was interviewed. The IP stated that there was a pest control issue recently and has been noticing flies. The IP stated flies come in because residents go in and out and do not keep the door closed. The IP stated flies are not acceptable to have in the dining room. The IP stated flies land on different things such as dirty things .trash .dog feces . The IP stated that flies present a risk for infection, disease, and the contamination of food. A review of the facility's undated policy titled, Pest Control Policy, indicated, .facility shall maintain an effective pest control program.to ensure that the building is kept free from insects and rodents.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 accommodate the resident's individualized needs, for two of 19 residents reviewed when:1. For Resident 31, the facility did not provide a wheelchair that was properly cleaned, comfortable, and safe to accommodate his needs. This failure resulted in Resident 31, not to have a full support of his buttocks during transfer from bed to wheelchair or from wheelchair to bed when the wheelchair seat was worn out and sagging (losing firmness and drooping) in the middle. In addition, the wheelchair had a built-in whitish stain embedded at the cloth material; and2. For Resident 86, the facility did not replace his rollaway walker when the seat cover had multiple tears and the middle vinyl seat cover had a large tear exposing the foam material from inside. This failure resulted in Resident 31 not to have a comfortable walker for daily use when the seat cover had exposed foam materials to seat on and multiple tears of vinyl material were touching his pants.Findings:1. On August 25, 2025, at 11:53 a.m., a concurrent observation and interview was conducted with Resident 31. Resident 31 was observed lying in bed, awake, alert, and able to verbalize his needs. A manual wheelchair was observed at Resident 31's bedside with a non-skid piece of material covering the seat of the wheelchair. Resident 31 stated a staff member of the facility provided him the non-skid material to place on the seat of his wheelchair, to prevent him from slipping off from his wheelchair. The wheelchair seat was observed with worn faded cloth material covered with whitish stain and was sagging in the middle. Resident 31 stated he had the same wheelchair since he came to the facility. The wheelchair did not have Resident 31's name and room number.A review of Resident 31's admission Record, indicated Resident 31 was admitted to the facility on [DATE], with diagnoses which included traumatic brain injury (TBI - a brain dysfunction usually caused by violent blow to the head), pneumonia (lung infection) and unsteadiness of feet.A review of Resident 31's Minimum Data Set (MDS - an assessment tool), dated June 11, 2025, indicated the following- Brief Interview of Mental Status (BIMS - a cognitive ability assessment) score of 13 (cognitively intact); and- Resident 31's mobility and activity of daily living (ADLs) indicated maximum assistance of one person, during transfer. Resident 31 was able to propel his wheelchair outside his room. On August 27, 2025, at 10:35 a.m., Resident 31 was observed being cared for by Certified Nursing Assistant (CNA) 1 at the bedside. On August 27, 2025, at 10:45 a.m., a concurrent observation and interview was conducted with CNA 1. CNA 1 was observed to transfer Resident 1 from the wheelchair to the edge of the bed. CNA 1 was observed to remove the non-skid material from the seat of Resident 31's wheelchair. CNA 1 stated the wheelchair seat had multiple old stains, the cloth was faded, and was sagging. CNA 1 stated the wheelchair was missing both footrests. CNA 1 stated she did not notice the condition of Resident 31's wheelchair until now. CNA 1 stated she did not know why the non-skid material was used on top of the wheelchair seat.On August 27, 2025, at 10:59 a.m., a concurrent observation and interview was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated Resident 31's wheelchair seat was drooping in the middle, did not have a firm seat for support, and looked worn out. LVN 1 stated he did not receive any work order to replace Resident 31's wheelchair from CNAs.On August 27, 2025, at 11:03 a.m., a concurrent observation and interview was conducted with the Treatment Nurse (TN). The TN stated the non-skid material was part of fall prevention. The TN stated Resident 31's wheelchair needed to be replaced.On August 27, 2025, at 11:45 a.m., a concurrent interview and review of the maintenance log was conducted with the Maintenance Supervisor (MS). The MS stated there was no request from nursing staff to replace Resident 31's wheelchair since he was admitted on [DATE]. The MS stated Resident 31's wheelchair should have his name and room number. On August 27, 2025, at 12:48 p.m., a concurrent interview and review of Resident 31's wheelchair images was conducted with the Administrator. The Administrator acknowledged the condition of Resident 31's wheelchair was not appropriate to accommodate his needs, and the wheelchair needed to be replaced. She stated the (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNAs and Licensed Nurses were responsible for identifying the appropriate wheelchair for Resident 31 on admission. A review of the facility's policy and procedure titled, Accommodation of Needs, revised March 2021, indicated, .The resident's individual needs and preferences .are evaluated upon admission and reviewed on an on going basis .providing a variety of types .chairs .firmness .so that residents with varying degrees of strength and mobility can independently arise to a standing position .2. On August 25, 2025, at 12 p.m., a concurrent observation and interview was conducted with Resident 86. Resident 86 was observed sitting at the edge of his bed, alert and able to verbalize his needs. A rollaway walker was observed at the bedside with multiple tears on the seat cover and the middle area was a big tear exposing the foam materials of the cushion pad. Resident 86 stated he brought the rollaway walker from home. Resident 86 asked if he could have a new walker, since the seat was torn and not comfortable to seat on. Resident 86 stated he asked the staff multiple times about his walker but did not get any answer. Resident 86 stated he did not know who was the right person to order a new walker for him. On August 26, 2025, at 11:58 a.m., Resident 86 was observed ambulating in the hallway using his rollaway walker with the torn cushion pad. A review of Resident 86's admission Record, indicated Resident 86 was admitted to the facility on [DATE], with diagnoses which included compression fracture of the first vertebrae (a break in the spine bone) and anxiety disorder. A review of Resident 86's Physician's History and Physical, dated August 21, 2025, indicated Resident 86 had the capacity to make decisions. A review of Resident 86's Minimum Data Set (MDS - an assessment tool), dated August 26, 2025, indicated minimal assistance with his activity of daily living (ADLs) and independent in his mobility. Resident 86 had been ambulating using his rollaway walker. On August 27, 2025, at 10:29 a.m., Resident 86 was observed ambulating in the hallway in front of the nurse's station using his rollaway walker. A concurrent observation and interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 observed Resident 86's walker and stated the seat cushion had a big tear in the middle and the cushion foam from inside was coming out. CNA 2 stated the walker belonged to Resident 86 and needed replacement. On August 27, 2025, at 10:35 a.m., a concurrent observation and interview was conducted with the treatment nurse (TN). The TN acknowledged the seat cover of Resident 86's walker was badly torn. The TN stated the staff should have contacted the Social Service Director (SSD) to order a new walker for Resident 86. On August 28, 2025, at 12:48 p.m., a concurrent interview and review of Resident 86's rollaway walker images was conducted with the Administrator (ADM). The ADM acknowledged Resident 86 needed a new walker. The ADM stated the staff should have notified the SSD to order a new walker for Resident 86. A review of the facility's policy and procedure titled, Accommodation of Needs, revised on March 2021, indicated, .Our facility's environment and staff behaviors are directed towards assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being .The resident's individual needs and preferences .are evaluated and reviewed on an ongoing basis .		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure the licensed nurse followed the manufacturer's instructions for priming an insulin pen, for one of six residents observed during medication administration (Resident 30). This failure had the potential to result in inaccurate insulin dosing and adverse effects, such as poor glycemic control. Findings: On August 25, 2025, at 11:39 a.m., during a medication administration observation with Licensed Vocational Nurse (LVN) 1, LVN 1 was observed pricking Resident 30's right middle finger to obtain a blood sample. On August 25, 2025, at 11:55 a.m., LVN 1 was observed removing an insulin pen Insulin Lispro KwikPen (a prefilled pen containing insulin lispro, a rapid-acting insulin used to lower blood glucose) from the medication cart. LVN 1 removed the pen cap, attached a new needle to the pen hub without wiping the rubber seal with an alcohol swab, then turned the dose knob to select two (2) units to prime (a process of removing air from the insulin pen and needle before each injection) the pen. LVN 1 then quickly pushed the dose knob while holding the pen with the needle pointing downward, instead of upright. LVN 1 then turned the dose knob to 4 units and injected the insulin into Resident 30's abdomen. A review of Resident 30's physician's order, dated August 20, 2025, indicated, Insulin Lispro Injection Solution (Insulin Lispro), Inject 4 unit subcutaneously (Sub-Q, injection into the fatty tissue under the skin) before meals for DM2 (Diabetes Mellitus type 2, a condition where the body has trouble regulating blood sugar levels), Give TID (three times a day) before meals. Hold if BS (blood sugar) is < 70 mg/dL (milligram per deciliter - unit of measurement). On August 26, 2025, at 9:20 a.m., during an interview with LVN 1, LVN 1 confirmed the insulin pen was held with the needle pointing downward during priming. LVN 1 stated he was unaware that the manufacturer's instructions require the pen to be positioned upright when priming. On August 26, 2025, at 3:10 p.m., during an interview with Infection Preventionist (IP), the IP stated the insulin pen should be primed with two (2) units while holding the pen upright and pressing the dose knob until fluid appears at the needle tip. The IP further stated priming with the pen pointed downward may not remove air bubbles and could affect the amount of insulin medication injected after priming. On August 28, 2025, at 11:43 a.m., during an interview with the Assistant Director of Nursing (ADON), the ADON stated pointing the insulin pen needle downward was not the appropriate priming technique. The ADON stated the pen should be primed with two (2) units with the needle facing upward, while holding the dose knob in for five (5) seconds. A review of the manufacturer's package inserts (PI - document included in the package of a medication that provides information about that drug and its use), dated July 2023, indicated: .Step 6: To prime your pen, turn the Dose Knob to select two (2) units. Step 7: Hold your pen with the needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Step 8: Continue holding your pen with Needle pointing up. Push the Dose Knob in until it stops, and 0 is seen in the Dose window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle. If you do not see insulin, repeat priming steps 6 to 8, no more than 4 times. If you still do not see insulin, change the Needle and repeat priming steps 6 to 8.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary care and services for two of 19 residents reviewed (Residents 40 and 14) when:1. For Resident 40, the fingernails on both hands were long and had blackish materials embedded underneath the resident's nailbeds; and2. For Resident 14, had dried food debris on the mouth, beard, and chin.These failures had the potential to negatively impact the physiological and psychological well-being of Residents 40 and 14. Findings: 1. On August 25, 2025, at 11:44 a.m., Resident 40 was observed lying in bed, awake, and able to answer simple questions. Resident 40 was observed with long fingernails on both hands with blackish materials underneath the nailbeds. In a concurrent interview with Resident 40, he stated he wanted his nails trimmed. On August 26, 2025, at 10:45 a.m., Resident 40 was observed sitting in his wheelchair at the lobby. Resident 40 was observed to still have long fingernails. On August 27, 2025, at 12:15 p.m., a concurrent observation and interview was conducted with Licensed Vocational Nurse (LVN) 1. Resident 40 showed both hands to LVN 1. LVN 1 stated Resident 40 had long fingernails and the nailbeds were dirty. LVN 1 stated Resident 40's fingernails measured approximately 0.5 centimeters (cm &ndash; unit of measurement) to 1 cm from the nailbed. On August 27, 2025, at 12:34 p.m., a concurrent interview and observation of Resident 40's fingernails was conducted with the Infection Preventionist (IP). The IP stated Resident 40's fingernails were long and needed to be trimmed. The IP stated the dirt underneath the nail beds could be a source of infection. A review of Resident 40's admission Record, indicated Resident 40 was admitted to the facility on [DATE], with diagnoses which included dementia (memory loss), cerebral infarction (stroke) and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduced blood flow to the legs). A review of Resident 40's Order Summary Report, included a physician's order, dated July 26, 2021, which indicated, .Podiatry (the treatment of the feet and their ailments) care q2 (every 2) months and PRN (as needed). A review of Resident 40's care plan, date initiated June 3, 2022, and revised August 5, 2025, indicated, .Resident at risk for not being treated related to refusing hand hygiene and nail care.interventions.Educate patient on risks and benefits of trimming nails and good hygiene.Follow up with Podiatrist regarding long nails (fingernail and toes) as needed. A review of the facility document titled, (name of company) Podiatric Evaluation & (and) Treatment Report, dated May 16, 2024, indicated Resident 40's fingernails were filed by the podiatrist per staff request. There was no documented evidence Resident 40's fingernails were trimmed after May 16, 2024. A review of the facility's policy titled, Fingernails/Toenails Care of, dated March 2023, indicated, (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.clean the nailbeds .keep nails trimmed and prevent infection .nail care includes daily cleaning and regular trimming .trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin . A review of the facility's policy and procedure titled, Activities of Daily Living (ADLs), dated March 2023, indicated .Residents will be provided with care, treatment and services as appropriate to maintain or improve their activities of daily living .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with.hygiene .grooming.If resident with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause .approaching the resident in a different way or at the different time or have other staff member speak with the resident may be appropriate . 2. On August 25, 2025, at 3:25 p.m., Resident 14 was observed in bed, with dried food debris around his mouth, beard, and chin. Resident 14 was alert and was not responding to simple questions. On August 25, 2025, at 4:41 p.m., an observation with a concurrent interview was conducted with LVN 2. Resident 14 was observed with dried, light brown and pink colored food particles on his mouth, beard, and chin. LVN 2 stated the CNA's should conduct oral care and ensure that chin and beards were clear of food particles after each meal. LVN 2 stated the dried food particles that were not cleaned from Resident 14's beard, from his lunch meal was not acceptable. On August 25, 2025, a review of Resident 14's Lunch Meal Menu on August 25, 2025, included Swedish Meatballs, Egg Noodles, Fresh Zucchini and Carrots, Wheat Roll, Raspberry Parfait Square. A review of Resident 14's admission Record, indicated Resident 14 was admitted to the facility on [DATE], with diagnoses which included Parkinsonism (neurological disorders characterized by motor symptoms), lack of coordination (inability to control and execute movements), adult failure to thrive (condition characterized by significant unintentional weight loss, muscle wasting, and decreased activity levels in older adults), and Alzheimer's Disease (a progressive and irreversible brain disorder that causes memory loss, cognitive decline, and behavioral changes). A review of Resident 14's History and Physical, dated July 26, 2025, indicated Resident 14 did not have the capacity to understand and make decisions. A review of Resident 14's care plan, dated July 28, 2025, indicated, .Focus: Resident has self care deficits .Goal: Resident will be clean, dry, well groomed, daily .Interventions: Assist with ADLs as needed . A review of Resident 14's Minimum Data Set (MDS &ndash; a resident assessment tool), dated July 25, 2025, indicated, .self care .oral hygiene .needed some help .partial/moderate assistance . A review of facility's policy and procedure titled, Activities of Daily Living (ADLs) Supporting, dated March 2023, indicated, .Residents will be provided with care, treatment and services .appropriate to maintain or improve their ability .carry out activities of daily living (ADL) .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming .If resident with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause .approaching the resident in a different way or at different time or have another staff member speak with the resident may be appropriate .		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow the physician order for oxygen administration, for one of 19 residents reviewed (Resident 13). This failure had the potential for Resident 13 to receive ineffective oxygen therapy, and had increased risk of hospitalization and adverse outcomes including death for Resident 13. Findings: On August 25, 2025, at 10:05 a.m., a concurrent observation and interview was conducted with Resident 13. Resident 13 was observed wearing an oxygen mask over his nose and mouth, with the oxygen concentrator (a device that concentrates oxygen from the air into a highly purified, breathable form to provide supplemental oxygen therapy to individuals with low blood oxygen levels) at the right side of his bed. Resident 13 observed receiving 3.5 L/min of oxygen (LPM - liters per minute; unit of measurement). Resident 13 stated he used oxygen all the time, including when he sleeps. A review of Resident 13's admission Record, indicated Resident 13 was admitted to the facility on [DATE], with diagnoses which included chronic atrial fibrillation (condition where the heart's upper chambers (atria) beat irregularly and rapidly for an extended period), secondary hypertension (high blood pressure that is caused by another medical condition), anemia (condition where the body does not have enough healthy red blood cells (erythrocytes) to carry oxygen efficiently throughout the body). A review of Resident 13's oxygen care plan, dated May 14, 2024, indicated, .Focus: Oxygen .receiving continuous oxygen therapy due to respiratory failure .Goal: will be free of adverse effects related to use of PRN oxygen .Interventions .Check rate of oxygen flow qshift (every shift) .monitor O2 saturation as ordered .provide oxygen as ordered .A review of Resident 13's History and Physical, dated August 9, 2024, indicated Resident 13 had the capacity to understand and make decisions. A review of Resident 13's Medication Administration Record, for the month of August 2025, included a physician's order, dated August 9, 2024, which indicated, .Administer O2 (oxygen) at 2 L/min via (through) NC (nasal cannula - a thin, flexible tube inserted into the nostrils to deliver supplemental oxygen). May titrate up to 5 L/min for O2 saturations less than 93% every shift. A review of Resident 13's MAR, for the month of August 2025, indicated Resident 13's oxygen saturations from August 1, 2025, to August 26, 2025, ranged from 95-99%. On August 26, 2025, at 9:09 a.m., a concurrent observation, interview, and record review was conducted with LVN 3. LVN 3 was observed assessing Resident 12 oxygen flow meter. LVN 3 stated the oxygen level was almost 4L/min. LVN 3 stated Resident 12's physician order, dated August 9, 2024, indicated to administer oxygen at 2L/min and may titrate up to 5 L/min for O2 saturations less than 93% every shift. LVN 3 verified Resident 13's oxygen rate at 4LPM was documented at 96% on the day shift of August 25, 2025. LVN 3 stated there was no documentation regarding the indication for 4LPM on August 26, 2025. LVN 3 obtained Resident 13's oxygen saturation, results of 99% at 3.5 LPM. On August 27, 2025, at 4:40 p.m., an interview with the Assistant Director of Nursing ADON was conducted. The ADON stated the oxygen saturation should be monitored if the resident had an order for oxygen administration. The ADON stated the charge nurse was responsible in monitoring the resident's oxygen saturation every shift. The ADON stated the charge nurse should check the oxygen liters to verify with the physician order for oxygen. The ADON stated the charge nurse would titrate the oxygen rate to an additional 1-2 liters from the original oxygen order if the oxygen saturation is below the oxygen saturation parameter. The ADON stated there should be documentation on the MAR (medication administration record) of the oxygen saturation if it resulted to below 93% and if the oxygen rate was titrated above 2 LPM. The ADON stated if the MD gave new orders, then there should be a progress note by the charge nurse, a change of condition documentation and care plan updated. A review of the facility's policy and procedure titled, Oxygen Administration Policy, date revised October 2010, indicated, .review the physician's order .assess vital signs .record in resident's medical record .rate of oxygen flow, route, and rationale .		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure dental care services and follow up treatment was provided, for one of 19 residents reviewed (ResidentThis failure had the potential for pain, infection, poor nutrition, and further decline in oral health for Resident 18. Findings:On August 26, 2025, at 9:42 a.m., an observation and concurrent interview was conducted with Resident 18. Resident 18 was observed with a left lower side tooth missing and a partial, blackened tooth remaining in the gums. Resident 18 stated he felt discomfort chewing his food. Resident 18 stated he wanted to know the status of his dental appointment. Resident 18 stated he could not recall the last time he saw the dentist.On August 27, 2025, at 12:50 p.m., an interview with Certified Nursing Assistant (CNA) 3 was conducted. CNA 3 stated the CNAs provide oral hygiene care for residents. CNA 3 stated if he found a resident with a broken tooth or denture, he would report it to the charge nurse.On August 27, 2025, at 3:57 p.m., an interview with the Assistant Director of Nursing (ADON) was conducted. The ADON stated the Registered Nurse Supervisor (RNS) and the admitting nurse would conduct a comprehensive head to toe assessment, which should include the resident's dental status. The ADON stated if any issues were noted, it will be documented in the initial assessment. The ADON stated that if a resident had an issue with their teeth or denture, it would be considered a change of condition. The ADON stated the nurse should notify the physician. The ADON stated the care plan should be updated as well.A review of Resident 18's admission Record, indicated Resident 18 was admitted to the facility on [DATE], with diagnoses which included chronic atrial fibrillation (condition where the heart's upper chambers (atria) beat irregularly and rapidly for an extended period), lack of coordination (an inability to control and execute movements smoothly and precisely), peripheral vascular disease (condition that affects the blood vessels outside of the heart and brain). A review of Resident 18's Order Summary Report, included a physician's order, dated August 18, 2022, which indicated, .Dental consult and treatment PRN (as needed) for dental problems.A review of Resident 18's initial admission assessment, MDS section L: oral/dental status, indicated no dental issues. A review of Resident 18's care plan, dated July 25, 2024, indicated, .focus: alteration in oral/dental status .complaints of gum pain .related to dentures not fitting properly .Goal: will not have unrecognized s/s of oral or dental problems daily .Interventions.Notify MD (doctor of medicine) of residents dental concern .request change of diet texture .SS (Social Service) to notify dentist for referral.ensure good oral hygiene .assess for s/s of pain or discomfort .medicate as ordered .A review of Resident 18's Progress Notes, indicated the following:-July 25, 2024, at 12:25 p.m.; .Received order from (name of physician) d/c (discontinue) diet order change to.Mechanical soft texture d/t denture issue.Resident will be seen by (name of dental services);.-May 22, 2025, at 3:48 p.m.; .Received call from dental office in regard to resident having teeth extractions for dentures. They are asking about resident apixaban (blood thinner) order, the medication will need to be placed on hold for a few days before.hold apixaban 2days (sic - two days) prior to appointment and then restart the day after procedure. (name of dental services) to call back and schedule appointment;.-June 24, 2025, at 1:24 p.m.; .Resident unable to receive dental tx (treatment) as of 6/12/25 (June 12, 2025), will try next visit with RP (responsible party);.-July 24, 2025, at 1:52 p.m.; .(name of dental services) in today, declined full mouth X-ray (radiologic examination) even after encouragement was offered.Further review of Resident 18's record indicated there was no dental assessment and treatment conducted by the dentist after July 25, 2024, when Resident 18 complained about his dentures, not until June 24, 2025 (11 months after).On August 28, 2025, at 4:43 p.m., an interview was conducted with the ADON. The ADON stated she noted three teeth at the bottom were not there, one tooth to the right lower jaw and two teeth to the left lower jaw. The ADON stated the teeth look pretty bad and, decayed. The ADON stated Resident 18 reported that the left two lower jaw teeth had pain occasionally with pressure. A review of Resident 18's chart, there was no change of condition documentation for left (continued on next page)		

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

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lower tooth. On August 29, 2025, at 10:22 a.m., The ADON stated she did not know when the teeth were identified broken or missing. The ADON stated it should have been identified upon initial comprehensive admission assessment, or if the resident complained of oral pain, or during daily oral care. The ADON stated there should be a change of condition documentation, physician notified, 72-hour monitoring with documentation in the progress notes, follow up with physician orders, if dental consult ordered then notify SSD (social service department), update care plan based on findings. On August 29, 2025, at 10:55 a.m., a concurrent observation and interview with the LVN/MSDS. The LVN/MSDS stated Resident 18's left lower tooth looks decayed and, blackened. A review of the facility's policy and procedure titled, Dental Services, revised date December 2016, indicated, .Routine and emergency dental services are available to meet the resident's oral health services .in accordance with .resident's assessment and plan of care .direct care staff will assist residents .with denture care .all dental services provided are recorded .in resident's medical record .		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the appropriate food texture was provided, for one out of one resident reviewed (Resident 25), when Resident 25's meal was not fully pureed and had chunks in his meal during lunch on August 25, 2025. This failure had the potential for Resident 25 to aspirate and cause harm to Resident 25. Findings: On August 25, 2025, at 12 p.m., a dining observation was conducted in the designated RNA (Restorative Nurse Assistant) Feeding Program Room. Resident 25 was observed to have puree food and was spitting out a few chunks of his food onto his napkin. In a concurrent interview with Resident 25, he stated that he did not know what the chunks were. Resident 25's meal ticket was reviewed and indicated that Resident 25 was on a puree diet. On August 25, 2025, at 12:21 p.m., an interview was conducted with Licensed Vocational Nurse (LVN) 4 who sat next to Resident 25 during his meal. LVN 4 stated the puree food should be smooth and with no solids or chunks. LVN 4 stated the resident could be placed at risk for difficulty chewing the food and could choke the resident if the pureed food was not smooth and prepared with the appropriate consistency. A review of Resident 25's admission Record, indicated Resident 25 was admitted to the facility on [DATE], with diagnoses which included dysphagia (difficulty chewing), and unspecified dementia (memory loss). A review of Resident 25's Progress Notes, dated July 12, 2025, indicated. HISTORY AND PHYSICAL. DECISION MAKING CAPACITY. Cannot make decisions. A review of Resident 25's physician order, dated July 17, 2025, indicated, .Puree texture. On August 26, 2025, at 3:20 p.m., the Certified Dietary Manager (CDM) was interviewed. The CDM stated puree food should be puree texture and completely smooth. The CDM stated chunks put residents on puree diets at high risk for aspiration (inhalation of foreign matter (like food, liquid, or saliva) into the lungs, or withdrawal of fluid or tissue from the body using suction, such as with a needle or tube). A review of the facility document titled, REGULAR PUREED DIET, dated 2020, indicated, .designed for residents who have difficulty chewing and/or swallowing. The texture of the food should be of a smooth and moist consistency.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure the infection prevention and control practices were implemented in accordance with its policy and manufacturer's instructions, when: 1. For Resident 67, a licensed nurse did not properly clean and disinfect the shared stethoscope before and after use, as required by the facility's policy; and 2. For Resident 30, a licensed nurse did not disinfect the rubber seal of an insulin pen prior to attaching a needle, in accordance with the manufacturer's instructions for use. These failures had the potential to cause the spread of infection, placing residents at risk, and compromise their health and well-being. Findings:1. On August 25, 2025, at 9:17 a.m., during a medication administration observation with Licensed Vocational Nurse (LVN) 6, LVN 6 was observed using a shared blood pressure cuff and stethoscope to measure Resident 67's blood pressure (BP). LVN 6 disinfected the shared blood pressure cuff before and after use with a Micro-Kill One Germicidal Wipes (Environmental Protection Agency [EPA] - registered one-step cleaning and disinfectant wipes approved for use on hard, non-porous surfaces to kill bacteria and other microorganisms). However, LVN 6 was observed using a single alcohol swab pad (a small antiseptic wipe saturated with 70% isopropyl alcohol intended for cleaning small surface areas) to wipe all parts of the shared stethoscope before and after use for Resident 67, instead of using the EPA-registered disinfectant wipes. On August 25, 2025, at 10:41 a.m., during an interview with LVN 6, LVN 6 confirmed an alcohol swab pad was used to clean all parts of stethoscope and an EPA-registered disinfectant wipe was used to clean the BP cuff before and after use for Resident 67. LVN 6 acknowledged the diaphragm (the flat, firm-surfaced side of the stethoscope used to hear high-pitched sounds) of the stethoscope was placed directly on the resident's skin to measure the BP, then disinfected with an alcohol swab pad and stored in the medication cart for use with other residents. When asked about the facility's policies and procedures regarding cleaning and disinfecting shared resident care items, LVN 6 stated the stethoscope should have been disinfected with the sanitizing wipes, Micro-Kill One Germicidal Wipes available in the medication cart. On August 26, 2025, at 3:10 p.m., during an interview with the Infection Preventionist (IP), the IP stated the EPA-registered disinfectant wipes should be used to clean the shared medical equipment, including stethoscope. The IP further stated an alcohol swab pad is not an EPA-registered disinfectant and did not meet the facility's policy for disinfecting shared stethoscope. On August 28, 2025, at 11:43 a.m., during an interview with the Assistant Director of Nursing (ADON), the ADON stated the expectation was for staff to follow the facility's Infection Control and prevention policies and procedures. The RNS further stated the shared equipment, including stethoscopes, should be sanitized before and after each resident use with appropriate wipes. A review of the facility's policies and procedures titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated 2001, indicated: .Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection. Non-critical items are those that come in contact with intact skin. Non-critical items require cleaning followed by either low- or intermediate-level disinfection following manufacturers' instructions. Disinfection is performed with an EPA-registered disinfectant labeled for use in healthcare settings. All applicable label instructions on EPA-registered disinfectant products are followed. Reusable items are cleaned and disinfected between residents (e.g., stethoscopes, durable medical equipment) .A review of the facility's policies and procedures titled, Isolation - Categories of Transmission-Based Precautions, dated April 2023, indicated: .When transmission-based precautions are in effect, non-critical resident-care equipment items such as a stethoscope. will be dedicated to a single resident (or cohort of residents) when possible. If re-use of items is necessary, then the items will be cleaned and disinfected according to current guidelines before use with another resident. A review of the Center for Disease Control and Prevention's (CDC - the national public health agency that provides guidance on infection prevention and control) guidelines titled, Guideline for Disinfection and Sterilization in (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Healthcare Facilities, 2008, last updated on June 2024, indicated .Medical equipment surfaces (e.g., blood pressure cuffs, stethoscopes.) can become contaminated with infectious agents and contribute to the spread of health-care-associated infections. For this reason, noncritical medical equipment surfaces should be disinfected with an EPA-registered low- or intermediate-level disinfectant . Ensure that, at a minimum, noncritical patient-care devices are disinfected when visibly soiled and on a regular basis (such as after use on each patient or once daily or once weekly) .2. On August 25, 2025, at 11:39 a.m., during a medication administration observation with LVN 1, LVN 1 was observed pricking Resident 30's right middle finger to obtain a blood sample.On August 25, 2025, at 11:55 a.m., LVN 1 was observed removing an insulin pen Insulin Lispro KwikPen (a prefilled pen containing insulin lispro, a rapid-acting insulin used to lower blood glucose) from the medication cart. LVN 1 removed the pen cap, attached a new needle to the pen hub without disinfecting the rubber seal with an alcohol swab pad, and then proceeded to prime (a process of removing air from the insulin pen and needle before each injection) the pen and administered four (4) units of insulin to Resident 30. A review of Resident 30's physician's order, dated August 20, 2025, indicated: Insulin Lispro Injection Solution (Insulin Lispro), Inject 4 unit subcutaneously (Sub-Q, injection into the fatty tissue under the skin) before meals for DM2 (Diabetes Mellitus type 2, a condition where the body has trouble regulating blood sugar levels), Give TID (three times a day) before meals. Hold if BS (blood sugar) is <70 mg/dL (milligram per deciliter - unit of measurement).On August 26, 2025, at 9:20 a.m., during an interview with LVN 1, LVN 1 stated he was unaware that the manufacturer's instructions require the rubber seal of the insulin pen to be disinfected with an alcohol swab prior to attaching a needle. LVN 1 acknowledged it should have been disinfected as required.On August 26, 2025, at 3:10 p.m., during an interview with the Infection Preventionist (IP), the IP stated there is a potential for contamination that could cause infection if the rubber seal of an insulin pen is not disinfected with alcohol swab. The IP further stated disinfecting the rubber seal of an insulin pen was the same practice as disinfecting the rubber stopper of an injectable vial with an alcohol swab before inserting a needle.On August 28, 2025, at 11:43 a.m., during an interview with the ADON, the ADON stated the expectation is for staff to disinfect the rubber seal of an insulin pen with an alcohol swab after removing the cap and before attaching the needle.A review of the manufacturer's package inserts (PI - document included in the package of a medication that provides information about that drug and its use), dated August 2024, indicated, .Step 1: Pull the pen cap straight off.Wipe the Rubber Seal with an alcohol swab. Step 2: Check the liquid in the pen.Step 3: Select a new needle. Pull off the Paper Tab from the Outer Needle Shield. Step 4: Push the capped needle straight onto the Pen and twist the Needle on until it is tight.		