STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555492	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Glen Post Acute	9246 Avenida Miravilla Cherry Valley, 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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46145 Based on interview and record review, the facility failed to: 1. Complete baseline care plans (Initial care plans, including mental, physical & psychosocial care needs, based on current health status) within 48 hours of admission for two out of three sampled residents (Residents 1 and 2), and 2. Provide resident and/or resident representative a copy of their baseline care plans, for two out of three sampled residents (Residents 1 and 3). This failure had the potential to result in a lack of communication between staff and residents, leading to inconsistencies in delivery of care. Findings: On December 6, 2024, an unannounced visit was made to the facility for a quality-of-care issue. 1. On December 9, 2024, at 6:09 p.m., an interview was conducted with the Director of Nursing (DON), who stated, baseline care plans were to be completed, within 48 hours of the resident ' s admission. The DON further stated, the members of the IDT, (Interdisciplinary team -Social Services, Rehabilitation, Dietary & Activity department supervisors) completed their portions of the baseline care plans separately, within the 48-hour time frame. a. A review of Resident 1's medical records, titled, Resident Information, dated, December 11, 2024, indicated, the resident was admitted to the facility on [DATE], with a diagnosis of muscle wasting, and a Brief Interview for Mental Status ({BIMS}- A cognitive assessment) score of 10 (Moderate cognitive impairment). Further review indicated, a representative was legally appointed to make Resident 1's medical care decisions. A review of Resident 1's Baseline Care Plans, initiated on November 25, 2024, at 10:10 p.m., indicated, the care plans were not completed within 48-hours of admission, as Rehabilitation and Dietary services, had not completed their baseline care plans, until November 30, 2024. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On December 10, 2024, at 8:19 a.m., a concurrent interview with the Rehabilitation Director (RD), and review of Resident 1's rehabilitation evaluation, & baseline care plans were conducted. The RD stated, it was the facility policy to complete baseline care plans within 48 hours of a resident ' s admission. The RD stated, his process for completing his portion of a resident's baseline care plans involved completing a rehabilitation evaluation within 24 hours of admission and then using the evaluation to complete the baseline care plans within 48 hours. The RD stated, Resident 1 was admitted to the facility on [DATE], and he did not complete Resident 1's baseline care plans until November 30, 2024. The RD stated he should have completed the resident ' s baseline care plan within 48 hours. On November 10, 2024, a concurrent interview with the Dietary Supervisor (DS), and review of Resident 1's baseline care plans were conducted. The DS stated, it was the facilities policy to complete baseline care plans within 48 hours. The DS stated, her process involved completing a dietary evaluation within 24 hours of a resident ' s admission and then using that information to complete the baseline care plans. The DS stated, she completed Resident 1 ' s baseline care plans late, as the resident was admitted on [DATE], and the care plan was not completed until November 30, 2024. The DS stated, she completed the baseline care plan past the 48-hour time frame. b. A review of Resident 2's medical records, titled, Resident Information, dated, December 11, 2024, indicated, resident was admitted to the facility on [DATE], with a diagnosis of history of falling. A review of Resident 2's, Baseline Care Plans, initiated on, December 4, 2024, at 9:44 p.m., indicated, the RD and the Social Service Director had not completed the baseline care plan within 48 hours. On December 10, 2024, at 8:19 a.m., a concurrent interview with the RD, and review of Resident 2's rehabilitation evaluation, & baseline care plans were conducted. The RD stated, it was the facility policy to complete baseline care plans, within 48 hours of admission. The RD stated, his process for completing baseline care plans included completing a rehabilitation evaluation within 24 hours and then using the evaluation to complete the baseline care plans within 48 hours. The RD stated, Resident 2 was admitted to the facility on [DATE] and Resident 2's baseline care plans were not completed until December 7, 2024 (past the 48 hour time frame). On December 10, 2024, at 9:21 a.m., a concurrent interview with SSD, and review of Resident 2's baseline care plans were conducted. The SSD stated, it was the facility's policy to complete baseline care plans within 48 hours of a resident's admission. The SSD further stated, she meets with the resident/representative within 48 hours of their admission, then uses that information to complete the baseline care plans. The SSD stated, Resident 2 was admitted to the facility on [DATE], and she had not yet completed resident ' s baseline care plans. A review of the facility Policy, titled, Care Plans - Baseline, revised, March 2022, indicated, . A baseline plan of care to meet the resident ' s immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission . (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On December 9, 2024, at 6:09 p.m., an interview was conducted with the DON, who stated, it is her expectations all IDT members to give a copy of their completed portion of the resident ' s baseline care plans, to the resident/representative at their initial IDT conference. The DON stated, the process of the initial IDT conference includes, being held within 7-days of the resident 's admission, at which time, the resident 's care plans & goals are discussed. DON further stated, she would expect IDT members to document in a progress note, if a copy of the resident 's baseline care plans were given, and/or offered to the resident/representative, during their initial IDT conference. a. A review of Resident 1's medical records, titled, Resident Information, dated, December 11, 2024, indicated, the resident was admitted to the facility on [DATE], with a diagnosis of muscle wasting, and a BIMS score of 10 (Moderate cognitive impairment). Further review indicated, a Representative was legally appointed to make Resident 1's medical care decisions. A review of Resident 1's initial, IDT meeting, dated, November 27, 2024, at 5:16 p.m., indicated, IDT met to discuss plan of care . Further review of Resident 1's records indicated, there was no documentation, verifying a copy of the residents baseline care plans, was provided/offered to resident/representative during the IDT meeting. b. A review of Resident 3's medical record titled, Resident Information, dated, December 11, 2024, indicated, resident was admitted to the facility on [DATE], with a diagnosis of a fractured left (Hip), and a BIMS score of 12 (moderate cognitive impairment). A review of Resident 3's, initial IDT meeting, dated, November 21, 2024, at 2:35 p.m., indicated, . IDT meeting held with resident . (Plan of care) reviewed . Further review indicated, there was no documentation, verifying a copy of the residents baseline care plans were provided/offered to resident/representative during the IDT meeting. On December 10, 2024, at 8:02 a.m., an interview was conducted with the Activities Director (AD), who stated, she evaluates a resident within 24 hours of their admission, then she uses the information to complete the activities portion of the resident's baseline care plans. AD verified, she does not provide a copy of the activities baseline care plans to the resident/representative and does not provide a copy at their initial IDT conference. On December 10, 2024, at 8:19 a.m., an interview was conducted with the RD, who stated, he does not provide a copy of the rehabilitation's portion of the resident's baseline care plans to the resident/representative, and does not provide a copy at their initial IDT conference. On December 10, 2024, at 8:52 a.m., an interview was conducted with the DS, who stated, the dietary portion of the resident's baseline care plans, are reviewed at the resident's initial IDT meeting, and she does not provide a copy of the baseline care plans to the resident/representative and does not provide a copy at their initial IDT conference. On December 10, 2024, at 9:21 a.m., an interview was conducted with the SSD, who stated, the Social Services portion of the resident's baseline care plans are reviewed at the resident ' s initial IDT meeting. SSD further stated, she does not provide a copy of the resident baseline care plans to the resident/representative at their initial IDT meeting. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On December 10, 2024, 3:41 p.m., an interview was conducted with the DON, who verified, a copy of the resident's baseline care plans, is currently not being given/offered to the resident/representative, during the resident's initial IDT conference. A facility Policy, titled, Care Plans - Baseline, revised, March 2022, indicated, . 1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standard of quality care and must include the minimum healthcare information necessary to properly care for the resident . 4. The resident and /or representative are provided a written summary of the baseline care plan (in a language that the resident/representative can understand) . 5. Provision of the summary to the resident/and or resident representative is documented in the medical record .