STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555494	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Mountain Post Acute	11970 4th St Yucaipa, CA 92399

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate care and services, which were consistent with the resident's needs and choices, for residents who are unable to carry out Activities of Daily Living (those needed for self-care and mobility and include activities such as bathing, dressing, grooming, oral care, ambulation, toileting, eating, transferring, and communicating) independently for one of three sampled residents (Resident 1) when Resident 1, who was dependent for self-care and mobility, was repositioned by a Certified Nursing Assistant (CNA 1) in bed by himself, dishonoring Resident 1's Wife's preference for Resident 1 for a two-person assist (safe patient handling technique in healthcare where two trained caregivers help someone move, transfer, or perform daily activities when they can't do it alone). This failure resulted in Resident 1 to fall out of bed, posing a potential risk to Resident 1's health and safety.Findings: A review of Resident 1's face sheet (contains demographic and medical information) indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included anoxic brain damage (the brain is completely deprived of oxygen leading to severe damage), tracheostomy status (a patient has a surgically created opening in their neck leading to the windpipe to provide an airway), and gastrostomy status (a person has a tube (a G-tube) going through their belly directly into their stomach, creating a shortcut for food, liquids, and medicine).A review of Resident 1's Fall Risk Evaluation (a healthcare process to identify factors increasing someone's chance of falling), dated October 2, 2025, indicated a score of 11. (If the total score is 10 or greater, the resident should be considered at High risk for potential falls.)A Review of Resident 1's Care Plan for Activity Living, initiated on October 5, 2025, indicated Resident 1 .Requires Total Assistance ADLs Non-Ambulatory Wife Prefers 2 person assist: Bed mobility (turning/repositioning) transfers, and oob (out of bed). Further reviewed indicated TRANSFER: The resident is totally dependent on (2) staff for transferring.A review of Resident 1's MDS (Minimum Data Set - federally mandated process for clinical assessment of all residents in Medicare or Medicaid-certified nursing homes), dated October 9, 2025, under Section GG (specifically measures the resident's functional abilities, such as transfer, walking, and self-care), indicated Resident 1 had score of one (1) for self-care and mobility. (Score of 1 means the resident is dependent. Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.)A review of Resident 1's SBAR (a written communication tool focused on Situation, background, assessment, recommendation), dated November 8, 2025, indicated, resident had witnessed fall and all 3 set of vitals were abnormal.A review of Resident 1's Nurse Notes, dated November 8, 2025, at 6:05 AM, indicated, at approximately 0545 (5:45 AM) nursing aid (CNA 1) approached the charge nurse and reported his resident is on the floor. Resident was sent out (transferred to the hospital) for witnessed fall, all 3 vitals were abnormal, B/P (Blood Pressure) 79/66, Pulse 124, Oxygen saturation 85%, notified family (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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	representative and MD (Medical Doctor).A review of Resident 1's General Acute Care Hospital (GACH) Discharge summary, dated [DATE], indicated, .Date of admission November 8, 2025.Patient was transferred from a post-acute facility after a witnessed fall from bed during transfer. It is unclear if the patient struck his head.A review of Resident 1's GACH Care Assessments, dated November 10, 2025, it indicated Safety recommendations 2 Person Total Assist for bed mobility.During interview on January 8, 2026, at 12:05 PM, with the Assistant Director of Nursing (ADON), the ADON stated Resident 1 had a fall incident on November 8, 2025, while being assisted solely by CNA 1.During a telephone interview on January 8, 2026, at 2:33 PM, with CNA 1, CNA 1 stated that on November 8, 2025, he was changing Resident 1's incontinence pad alone due to a lack of assistance and the impending end of his shift. He further stated he noted that Resident 1 was positioned very close to the edge of the bed, and when he turned Resident 1 onto his side, Resident 1 fell off the bed. He stated that the protocol requires a two-person assist for Resident 1, as he was total care. He acknowledged that it was incorrect for him to assist the resident alone. A review of the facility's policy and procedure (P&P), dated April 2025, titled Activities of Daily Living (ADLs), Supporting, indicated, .5. Appropriate care and services are 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.