

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: 555521	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER Rancho Mesa Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9333 LA Mesa Dr Alta Loma, CA 91701	
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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to provide the services of a Registered Nurse (RN) for 8 consecutive hours for 15 sampled days during the fiscal year Quarter 4 of 2024 (July 1 - September 30) and Quarter 3 of 2025 (April 1 - June 30). This failure had the potential for all residents living in the facility to not receive services and advanced care activities specifically performed by a registered nurse including resident assessments, administration of intravenous medications, and general oversight of the residents' clinical needs either directly by the RN or indirectly by the Licensed Vocational Nurses or Certified Nursing Assistants for whom the RN was responsible for overseeing resident care. During a review of the facility's report titled, Payroll-Based Journal Staffing Data Report (PBJ report- a reporting system for staffing data), dated Fiscal Year (FY) Quarter 4, 2024 (July 1 - September 30), the PBJ report indicated the facility had no RN coverage for eight consecutive hours on six days (August 4, 10, 11, 31 of 2024; September 21, and 22 of 2024). During a review of the facility's report titled Payroll-Based Journal Staffing Data Report, dated FY Quarter 3, 2025 (April 1 - June 30), the PBJ report indicated the facility had no RN coverage for eight consecutive hours on nine days (April 20, 27 of 2025; May 11, 18 of 2025; June 16, 17, 18, 19, 20 of 2025). During an interview on September 18, 2025, at 10:54 AM with the Director of Staff Development (DSD), the DSD stated he was the individual who calculated the Direct Hours Per Patient Day (DHPPD - Direct Care Service Hours Per Patient Day - a staffing standard for skilled nursing facilities in California that specifies the minimum number of direct care hours performed by direct caregivers per patient, per day). The DSD was asked to provide documentation to show the facility had a Registered Nurse working for eight consecutive hours on the sampled dates of August 4, 2024 (from FY Quarter 4, of 2024) and May 11, 2025 (from FY Quarter 3, of 2025). The DSD stated the facility used a DHPPD calculation worksheet (a worksheet used to calculate the total number of DHPPD hours) and payroll records for the calculation. The DSD further stated he would provide copies of the DHPPD worksheet and for both sampled dates. During a review of the DHPPD calculation worksheets and payroll records, dated August 4, 2024, and May 11, 2025, there was no documented evidence of any RN had worked at all on either of the two sampled days. During a concurrent interview and record review with the Assistant Director of Nursing (ADON) on September 18, 2025, at 12:18 PM, the DHPPD calculation worksheets and payroll records, dated August 4, 2024, and May 11, 2025, were reviewed. The ADON acknowledged there was no documented evidence that an RN worked in the facility on those dates (August 4, 2024, and May 11, 2025) and stated on the dates sampled, she was the Director of Nursing (DON) at that time and although they had an RN scheduled to work on those days, they had call-offs and did not have RN coverage at all. The ADON further stated that the facility had some trouble with RN coverage on the weekends in the past as was indicated on the PBJ staffing report. During a follow up interview on September 18, 2025, at 1:45 PM, with the ADON, the ADON stated the RNs in the facility were responsible for tasks such as administering intravenous medications (medications administered into the veins), admitting patients, assessment of residents and provided supervision and clinical oversight for all Certified Nursing Assistants (CNAs) and Licensed Vocational Nurses (LVNs). During an interview on September 18, 2025, at 1:52 PM, with the Administrator (ADMIN), the (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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	ADMIN stated an RN was supposed to be working in the facility every day, seven days a week, for at least 8 consecutive hours. The ADMIN further stated he was not currently aware the facility had issues with RN coverage on the weekends and stated he himself had only been working at the facility since August 4, 2025 (about a month and a half prior to the interview). During a review of the facility's job description for a Registered Nurse titled, RN Nurse Supervisor, (undated), the job description indicated, The primary purpose of your position is to supervise the day-to-day clinical activities of the facility to ensure that the highest quality of care is maintained at all times. Such supervision must be in compliance with all current federal, state, and local laws, rules, regulations, and guidelines. During a review of the facility policy and procedure titled, Staffing, Sufficient and Competent Nursing, Revised August 2022, the policy indicated, Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment.3. A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week. RNs may be scheduled more than eight (8) hours depending on the acuity needs of the resident.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 10) reviewed for pressure ulcers (injury to skin and underlying tissues that develops as a result of prolonged pressure, shear, or friction) had a low air loss mattress (LAL mattress - a specialized mattress which is air filled and is designed to help prevent and treat pressure ulcers) which was programmed for Resident 10's weight. Additionally, documentation regarding verification for the settings the low air loss mattress was incomplete in Resident 10's clinical record. These failures resulted in the low air loss mattress to not have the most therapeutic effect for the prevention and treatment of pressure ulcers and for Resident 10 to have increased risk for the development of new pressure ulcers and a delay in wound healing. During a review of Resident 10's admission Record (contains medical and demographic information) indicated Resident 10 was admitted to the facility on [DATE], with diagnoses which included muscle wasting and atrophy (loss of muscle tissue and mass), protein-calorie malnutrition (inadequate intake of protein and calories), and dementia (condition which causes a decline in mental functioning that can interfere with daily life). During a review of Resident 10's physician's orders, an order dated August 22, 2025, indicated, LAL mattress every shift for wound management. During a review of Resident 10's physician's orders, an order dated September 1, 2025, indicated, Set LAL [mattress] setting according to patients weight every shift. During a review of Resident 10's care plan (an individualized plan for the medical care of a resident) titled, At risk for skin breakdown and/or development of pressure injury due to: Impaired ADL [activities of daily living] function. thin and fragile skin . dated July 21, 2025, the care plan included the goal, skin will remain free from tissue or skin injury through preventative nsg [nursing] measures x 3 months [for three months]. Interventions for the care plan included, .maintenance tx [treatment] as ordered [as ordered by the physician]. During a review of Resident 10's care plan titled, The resident has potential/actual impairment to skin integrity r/t [related to] fragile skin. The goal of the care plan indicated, the resident will maintain or develop clean and intact skin by the review date. Interventions listed included, follow facility protocols for treatment of injury, identify/document potential causative factors and eliminate/resolve where possible. During a review of Resident 10's History and Physical Examination, (H&P) dated August 22, 2025, the H&P indicated Resident 10 weighed 153 pounds (lbs - unit of measure). During a review of Resident 10's Treatment Administration Record (TAR - a document used to record the completion of treatments and tasks), dated September 1, 2025, through September 30, 2025, the TAR indicated the following: -For the task LAL mattress every shift for wound management, there were six out of 15 days where staff did not document completion of the task for at least one shift (September 1, 2, 3, 7, 11, 14) and the documentation was blank. -For the task Set LAL setting according to patient's weight every shift, there were 48 out of 51 shifts where staff did not document completion of the task and the documentation was left blank. During an observation on September 18, 2025, at 9:20 AM, in Resident 10's room, Resident 10 was lying in a bed with a LAL mattress. The LAL mattress had a setting for 150 lbs but it was not set to that setting and instead was set to 210 lbs. During an interview on September 18, 2025, at 9:27 AM, with the Wound Care Nurse 1 (WCN 1), WCN 1 confirmed Resident 10's low air loss mattress was set to 210 lbs incorrectly and stated it should have been set to 150 lbs but it wasn't. WCN 1 further stated she changed the weight setting when she noted it was incorrect. During a concurrent interview and record review on September 18, 2025, at 9:51 AM, with the DON, Resident 10's TAR dated September 1, 2025, through September 30, 2025, was reviewed. The DON stated It was important that LAL mattresses are set to the correct weight because the weight setting changes the airflow of the mattress to be most beneficial to the resident. The DON further acknowledged there were blanks on the TAR for the tasks LAL mattress every shift for wound management, and set LAL mattress according to patient's weight every shift, and stated the LAL (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mattress was supposed to be documented by staff to ensure it was programmed for the correct weight but the documentation was missing on multiple shifts. During a review of the facility's policy and procedure titled, Support Surface Guidelines, revised September 2013, the policy indicated, The purpose of this procedure is to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk of skin breakdown. 4. Elements of support surfaces that are critical to pressure ulcer prevention and general safety include pressure redistribution, moisture control, shear reduction, heat dissipation/temperature control, friction control, infection control. 1. Any individual at risk for developing pressure ulcers should be placed on a redistribution support surface, such as foam, gel, static air, alternating air, or air-loss or gel when lying in bed. During a review of the facility's policy and procedure titled, Charting and Documentation, revised July 2017, the policy indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. 3. Documentation in the medical record will be objective, complete, and accurate.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 6) reviewed for accidents had a fall mat (a cushioned mat which may aid in lessening the severity of injury during a fall) on both sides of her bed as was specified in the resident's care plan (an individualized plan for the medical care of a resident), and physician's orders. In addition, documentation verifying the placement of the fall mats was inconsistent in Resident 6's clinical record. This failure had the potential for Resident 6 to sustain a serious injury during a fall in which the severity of the injury may have been lessened if the fall mat had been in place. During a review of Resident 6's admission Record (contains medical and demographic information), the admission Record, indicated Resident 6 was admitted on [DATE], with diagnoses which included dementia (a brain disorder that causes a progressive decline in memory, thinking, and social abilities), hypertension (high blood pressure), unspecified psychosis (when a person presents with hallucinations, delusions, or disorganized thinking or behavior without a clear underlying cause), and disorders of bone density and structure (conditions that weaken bones, making them more susceptible to fractures). During an interview on September 16, 2025, at 10:09 AM, with Resident 6's family representative (FR), FR stated Resident 6 sustained a fall in the facility but could not recall when it occurred. FR further stated Resident 6 had an accident which left her with neurological damage (damage affecting the brain, spinal cord, and/or nerves) and as a result, Resident 6 constantly felt as though she was experiencing the feeling of falling. During an observation on September 18, 2025, at 2:43 PM, in Resident 6's room, with Wound Care Nurse 1 (WCN 1), Resident 6 was observed to be lying on her left side while in her bed. Resident 6 had a fall mat on one side of her bed while the other side of her bed had no fall mat. WCN 1 acknowledged Resident 6 only had a fall mat on only one side of her bed and stated she did not know why the resident did not have a fall mat on each side of the bed. During an interview on September 18, 2025, at 2:55 PM, with the Assistant Director of Nursing (ADON), the ADON stated Resident 6 was supposed to have floor mats on each side of her bed. During an interview on September 18, 2025, at 3:22 pm, with the Director of Nursing (DON), the DON stated the purpose of floor mats next to a resident's bed was to help prevent injury in case the resident experienced a fall. During a review of Resident 57's physician's orders, an order dated August 26, 2025, indicated May have bilateral padded floor mats as safety precaution R/T [related to] fall risk. Monitor placement every shift. During a concurrent interview and record review on September 18, 2025, at 4:23 PM, with the ADON, Resident 6's Medication Administration Record (MAR - a document used to record the administration of medications) dated September 1, 2025, through September 30, 2025, was reviewed. The MAR indicated, May have bilateral padded floor mats as safety precaution R/T [related to] fall risk. Monitor placement every shift. The responses to this were either Y (yes) or N (no) and 11 out of 52 shifts indicated N (no) for the verification of bilateral floor mats. The ADON acknowledged there were multiple shifts where N was documented and the ADON stated nursing staff was not correctly documenting the verification of floor mats in Resident 6's clinical record. During a review of Resident 57's care plan titled Risk for falls, dated July 27, 2025, the care plan goal indicated, Her [Resident 6's] risk for fall will be reduced. Interventions for this care plan included, .Bilateral Padded floor mats. During a review of the facility's policy and procedure titled, Falls and Fall Risk, Managing, revised March 2018, the policy indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. will implement a resident - centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. During a review of the facility's policy and procedure titled, Charting and Documentation, Revised July 2017, the policy indicated, .3. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Licensed Vocational Nurse 1 (LVN 1) administered medications within 1 hour of their scheduled administration time for one of twelve (12) sampled residents (Resident 57) reviewed for medication administration when Resident 57 received two medications (omeprazole - a medication used to decrease the amount of acid in the stomach, and empagliflozin - a medication used to treat diabetes [condition characterized by high blood sugar] or heart failure) one hour and twenty five minutes before they were scheduled to be administered on September 16, 2025. This failure resulted in the medications to not be administered in accordance with the facility's policy and procedure and for the omeprazole to not be administered as specified by the physician's orders (30 minutes prior to a meal). This had the potential for the omeprazole medication to have a diminished effect in preventing acid reflux. A review of Resident 57's admission Record (contains medical and demographic information), indicated Resident 57 was admitted to the facility on [DATE], with diagnoses which included morbid (severe) obesity (overweight), heart failure (condition where the heart cannot pump blood effectively enough to meet the body's needs), and dependence on supplemental oxygen (requires the use of oxygen when breathing). During an observation on September 17, 2025, at 5:03 AM, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 was preparing to administer medications to Resident 57. LVN 1 was reviewing the electronic Medication Administration Record (MAR - a document used to record medications administered to the resident which includes scheduled administration times of medications). LVN 1 stated Resident 57's Omeprazole and empagliflozin medications were scheduled to be administered at 0630 but he was going to administer it now (at 5:05 am). During an observation on September 17, 2025, at 5:05 AM, with LVN 1, LVN 1 administered one capsule of Omeprazole 20 milligrams (mg - unit of measure) DR (delayed release) and one tablet of empagliflozin 25 mg to Resident 57 by mouth. During an interview on September 17, 2025, at 5:41 AM, with LVN 1, LVN 1 acknowledged he administered Resident 57's omeprazole and empagliflozin medications one hour and twenty five minutes prior to their scheduled administration time and stated he did it because the resident preferred to receive all her medications as soon as she woke up. During an interview on September 17, 2025, at 5:42 AM, with the Infection Preventionist (IP), the IP stated medications were only supposed to be administered up to one hour before or one hour after their scheduled administration time. The IP further stated if a resident had a preference to receive their medications at a different time than was scheduled, the facility was supposed to get a physician's order to administer the meds at a different time or the facility could change the scheduled administration time on the MAR. During a follow up interview on September 17, 2025, at 5:50 AM, with the IP, the IP stated she reviewed Resident 57's physicians orders and was unable to find an order indicating it was ok acceptable to administer medications more than one hour prior to their scheduled administration time. During a concurrent observation and interview on September 17, 2025, at 8:39 AM, with Resident 57, in Resident 57's room, a staff member brought in Resident 57's breakfast food tray. Resident 57 stated she had not received food or snacks after she took her am medications at 5:05 AM (over three and a half hours had passed since she was given omeprazole to the time she received her breakfast tray). Resident 57 stated she occasionally gets acid reflux (heartburn) and stated she had never told anybody she prefers to receive her omeprazole at 5:00 AM. Resident 57 further stated, that's just the time they have given it to me since I've been here. During a review of Resident 57's MAR dated September 1, 2025, through September 30, 2025, the MAR indicated Resident 57's omeprazole and empagliflozin medications were both scheduled to be administered at 6:30 AM (LVN 1 had administered both medications one hour and twenty five minutes early). During a review of Resident 57's physician's orders, an order dated April 18, 2025, indicated Omeprazole oral tablet delayed release 20 mg. give 1 tablet by mouth one time a (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	day for acid reflux.give 30 mins (minutes) before meals.During an interview on September 17, 2025, at 9:16 AM, with the Director of Nursing (DON), the DON stated medications were supposed to be administered up to one hour before or one hour after their scheduled administration time.During a review of the facility's policy and procedure titled, Administering Medications, revised April 2019, the policy indicated, .Medications are administered in a safe and timely manner, and as prescribed.4. Medications are administered in accordance with prescriber orders, including any required time frame. 5. Medication administration times are determined by resident need and benefit, not staff convenience.7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5% when the medication error rate was 7.69%, with two errors in 26 opportunities, when Licensed Vocational Nurse 1 (LVN 1) administered two medications (Omeprazole - a medication used to help prevent acid reflux [condition where stomach contents flow back up to the esophagus causing irritation and inflammation] and Jardiance - a medication used to treat people with heart failure or diabetes [condition characterized by high blood sugar] to one of 12 sampled residents observed for medication administration (Resident 57). This failure resulted in the medications to not be administered in accordance with the facility's policy and procedure and for the omeprazole to not be administered as specified by the physicians' orders (30 minutes prior to a meal). This had the potential for the omeprazole medication to have a diminished effect in preventing acid reflux. A review of Resident 57's admission Record (contains medical and demographic information), indicated Resident 57 was admitted to the facility on [DATE], with diagnoses which included morbid (severe) obesity, heart failure, dependence on supplemental oxygen (requires the use of oxygen). During an observation on September 17, 2025, at 5:03 AM, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 was preparing to administer medications to Resident 57. LVN 1 was reviewing the electronic Medication Administration Record (MAR - a document used to record medications administered to the resident which includes scheduled administration times of medications). LVN 1 stated Resident 57's Omeprazole and empagliflozin medications were scheduled to be administered at 0630 but he was going to administer it now (at 5:05 am). During an observation on September 17, 2025, at 5:05 AM, with LVN 1, LVN 1 administered one capsule of Omeprazole 20 milligrams (mg - unit of measure) DR (delayed release) and one tablet of empagliflozin 25 mg to Resident 57 by mouth. During an interview on September 17, 2025, at 5:41 AM, with LVN 1, LVN 1 acknowledged he administered Resident 57's omeprazole and empagliflozin medications one hour and twenty five minutes prior to their scheduled administration time and stated he did it because the resident preferred to receive all her medications as soon as she woke up. During an interview on September 17, 2025, at 5:42 AM, with the Infection Preventionist (IP), the IP stated medications were only supposed to be administered up to one hour before or one hour after their scheduled administration time. The IP further stated if a resident had a preference to receive their medications at a different time than was scheduled, the facility was supposed to get a physician's order to administer the meds at a different time or the facility could change the scheduled administration time on the MAR. During a follow up interview on September 17, 2025, at 5:50 AM, with the IP, the IP stated she reviewed Resident 57's physicians orders and was unable to find an order indicating it was ok acceptable to administer medications more than one hour prior to their scheduled administration time. During a concurrent observation and interview on September 17, 2025, at 8:39 AM, with Resident 57, in Resident 57's room, a staff member brought in Resident 57's breakfast food tray. Resident 57 stated she had not received food or snacks after she took her am meds at 5:05 AM (over three and a half hours had passed since she was given omeprazole to the time she received her breakfast tray). Resident 57 stated she occasionally gets acid reflux (heartburn) and stated she had never told anybody she prefers to receive her omeprazole at 5:00 AM. Resident 57 further stated, that's just the time they have given it to me since I've been here. During a review of Resident 57's MAR dated September 1, 2025, through September 30, 2025, the MAR indicated Resident 57's omeprazole and empagliflozin medications were both scheduled to be administered at 6:30 AM (LVN 1 had administered both medications one hour and twenty five minutes early). During a review of Resident 57's physician's orders, an order dated April 18, 2025, indicated Omeprazole oral tablet delayed release 20 mg.give 1 tablet by mouth one time a day for acid reflux.give 30 mins (minutes) before meals. During an interview on September 17, 2025, at 9:16 AM, with the Director of Nursing (DON), the DON stated medications were supposed to be administered up (continued on next page)		

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to one hour before or one hour after their scheduled administration time. During a review of the facility's policy and procedure titled, Administering Medications, revised April 2019, the policy indicated, .Medications are administered in a safe and timely manner, and as prescribed.4. Medications are administered in accordance with prescriber orders, including any required time frame. 5. Medication administration times are determined by resident need and benefit, not staff convenience.7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one discontinued medication was removed from the Intravenous (IV) medication cart when one box of Bio Patches (specialized disc dressings that are used to prevent insertion site infections) were expired and available for use. This failure had the potential for the medication to be administered incorrectly which may cause harm to 56 residents. Findings: During a concurrent observation and interview on [DATE], at 2:20 PM, with a Licensed Vocational Nurse (LVN), the LVN inspected a box of Bio Patches from the IV medication cart. The box contained 10 patches, and the label indicated an expiration date of [DATE]. The LVN stated, Yes they are expired. During a concurrent interview and observation on [DATE], at 3:15 PM, with the Director of Nursing (DON), the DON inspected and acknowledged the expiration date of the Bio Patches. The DON further stated the expired box should not have been in the IV cart. During a concurrent interview and record review on [DATE], at 3:45 PM, with the DON, the facility's policy and procedure (P&P), titled, [name of the pharmacy] Policy and Procedure Manual, dated, [DATE] was reviewed. The P&P indicated, Procedures. m. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures shall be immediately removed from stock, disposed of according to procedures for medication disposal (and reordered from the pharmacy if a current order exists). The DON stated the policy was not followed. During a concurrent interview and record review on [DATE], at 4:00 PM, with the DON, the P&P titled, Medication Labeling and Storage, dated February 2023, was reviewed. The P&P indicated, . 3. If the facility has discontinued, outdated, or deteriorated [medications or biologicals], the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. The DON stated the policy was not followed.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff followed infection control policies and procedures when:1) Licensed Vocational Nurse 2 did not perform hand hygiene (hand washing or the use of alcohol-based hand rub [ABHR]) between the administration of medications to two Residents (Residents 53 and 47). In addition, Resident 47 was on Enhanced Barrier Precautions (EBP - a set of infection control practices designed to reduce the spread of multidrug-resistant organisms (MDROs) in nursing homes. They focus on using personal protective equipment (PPE) like gowns and gloves during specific high-contact resident care activities for residents at increased risk of acquiring or known to be colonized or infected with an MDRO).2) Licensed Vocational Nurse 2 (LVN 2) only had one glove on when checking Resident 47's blood sugar (measurement of the amount of blood glucose [sugar] by pricking the finger and obtaining a drop of blood for sampling). Additionally, LVN 2 also only wore one glove when administering a shot of insulin (medication administered under the skin to help regulate blood sugar levels).These failures resulted in increased risk for the cross contamination (the spread of microorganisms from one surface to another) of infectious microorganisms within the environment and amongst a vulnerable population of 57 residents who lived in the facility.1)A review of Resident 53's admission record, indicated Resident 53 was admitted to the facility on [DATE], with diagnoses which included muscle weakness, anxiety disorder (a mental health condition characterized by excessive and persistent worry, fear and nervousness that can interfere with daily life, and schizophrenia (a mental health condition that affects how people think, feel and behave). A review of Resident 47's admission Record (contains medical and demographic information), indicated Resident 47 was admitted to the facility on [DATE], with diagnoses which included Chronic viral Hepatitis C (a long-term liver infection caused by the Hepatitis C virus), hemiplegia and hemiparesis (weakness and paralysis) affecting right dominant side, and hypertension (high blood pressure).During an observation on September 17, 2025, at 5:30 AM, with LVN 2, in Resident 53 and Resident 47's shared room, the doorway leading into the room had a sign which indicated Resident 47 was on EBP. LVN 2 administered an oral (by mouth) medication levothyroxine (medication used to treat low thyroid activity) to Resident 53. LVN 2 did not perform hand hygiene after administering the medication and went to the medication cart (med cart - a cart which contains medications) and retrieved Resident 47 pantoprazole (medication used to decrease the amount of acid in the stomach).During continued observation on September 17, 2025, at 5:32 AM, with LVN 2, in Resident 53 and Resident 47's shared room, LVN 2 administered Resident 47 pantoprazole medication and had not performed hand hygiene at any time after administering medications to Resident 53.During an interview on September 17, 2025, at 5:42 AM, with the Infection Preventionist (IP), the IP stated staff were supposed to perform either hand washing or use hand sanitizer between residents.During an interview on September 18, 2025, at 2:31 PM, with the Director of Nursing (DON), the DON stated it was important that staff perform hand hygiene between residents to help prevent the spread of infection. The DON further stated residents on EBP have a history of infection or have an indwelling medical device that makes them susceptible to infection.During a review of Resident 47's physician's orders, an order dated September 15, 2025, indicated Resident 47 had a foley catheter (a thin, flexible tube inserted into the bladder to drain urine).During further review of Resident 47's physician's orders, an order dated September 15, 2025, indicated, Foley catheter use: monitor for s/s [signs and symptoms] of infection.During a review of the facility's policy and procedure titled, Handwashing/Hand Hygiene, revised August 2019, the policy indicated, This facility considers hand hygiene the primary means to prevent the spread of infections.2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: .b. (continued on next page)		

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Before and after direct contact with residents; c. Before preparing or handling medications.2) A review of Resident 47's admission Record (contains medical and demographic information), indicated Resident 47 was admitted to the facility on [DATE], with diagnoses which included Chronic viral Hepatitis C (a long-term liver infection caused by the Hepatitis C virus), hemiplegia and hemiparesis (weakness and paralysis) affecting right dominant side, and hypertension (high blood pressure).During an observation on September 17, 2025, at 5:35 AM, with LVN 2, in Resident 47's room, LVN 2 put on one glove on his right hand and did not put a glove on his left hand. LVN 2 then checked Resident 47s blood sugar by using his ungloved hand to hold a lancet (a device which creates a pinprick to create a drop of blood) and prick Resident 47's finger. After lancing Resident 2's finger, LVN 2 then used his ungloved hand to grasp a glucometer (device which tests blood for blood sugar measurement) and test Resident 47's drop of blood. After LVN 2 was finished checking Resident 47's blood sugar, he removed his glove and discarded it.During an observation on September 17, 2025, at 5:38 AM, with LVN 2, in Resident 47's room, LVN 2 obtained two units of Insulin into a syringe with needle. LVN 2 then put on one glove on his right hand and did not put a glove on his left hand. LVN 2 then used his ungloved hand to administer Resident 47's shot of insulin subcutaneously. As LVN 2 was administering the shot, the Infection Preventionist (IP) walked into Resident 47's room and observed LVN 2 administer the insulin injection to Resident 47 with an ungloved hand.During an interview on September 17, 2025, at 5:41 AM, with LVN 2, LVN 2 acknowledged he only used an ungloved hand when checking Resident 47's blood sugar and when administering Resident 47's subcutaneous shot of insulin. LVN 2 further stated he only put on one glove during these two tasks because he was so focused on ensuring he was performing handwashing correctly.During an interview on September 17, 2025, at 5:42 AM, with the IP, the IP stated staff were supposed to wear two gloves when checking residents' blood sugar levels and when administering injections and staff were not supposed to only have one gloved hand.During an interview on September 18, 2025, at 2:30 PM, with the Director of Nursing (DON), the DON stated staff should be wearing two gloves when performing a task which requires the use of gloves which included administering an injection or using a glucometer to check blood sugar levels.During a review of the facility's policy and procedure titled, Personal Protective Equipment - Gloves, dated 2001, the policy indicated, .3. The use of gloves will vary according to the procedure involved. The use of disposable gloves is indicated: a. when it is likely that the employee's hands will come in contact with blood, body fluids, secretions, excretions, mucous membranes, and/or non-intact skin while performing the procedure; .g. During invasive procedures.		