STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555737	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshire San Dimas Post-Acute	1740 S San Dimas Ave San Dimas, CA 91773

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a change in condition (COC, an alteration in a resident's physical health that differed from their previous baseline) was reported to the Medical Doctor (MD) 1 in a timely manner for one of one sampled resident (Resident 1).This deficient practice resulted in delayed treatment for Resident 1 who had a displaced femoral fracture (a break in the thigh bone where the fragments shift out of their normal alignment).During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including metabolic encephalopathy (change in how the brain works caused by an underlying medical condition rather than direct injury), rhabdomyolysis (condition where muscle breakdown releases harmful substances into the blood), osteoarthritis (degenerative joint disease in which the tissues in the joints break down over time), and a history of falling.During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 5/9/2026, the MDS indicated Resident 1 had intact cognition (ability to understand and process information) and was dependent (helper does all of the effort) on staff for personal hygiene and the ability to transfer to and from a bed to a chair.During a review of Resident 1's Physical Therapy Treatment Encounter Notes (PTTEN), dated 6/10/2026, the PTTEN indicated under complexities/ barriers impacting session: left lower extremity positioning with increased adductor tone (inner thigh muscles are tighter) when in sitting and external rotation (when the thigh and foot rotate outwards away from the body) when supine (lying flat on one's back with the face and torse facing upwards.) Increased difficulty actively moving the left lower extremity. PT discussed concerns with nursing.During a review of Resident 1's eInteract Situation, Background, Assessment, and Recommendation (SBAR Summary- standardized, communication to help professionals share clear, concise, and critical information with one another), dated 6/12/2026 at 5:59 PM, the SBAR indicated Resident 1 had a change in condition. The SBAR indicated nursing (unidentified) observed, evaluated, and recommended Resident 1 was given a x-ray based on a report given by a therapist (unidentified). The SBAR indicated Resident 1's [left hip] was not aligned. The SBAR indicated Resident 1 received an x-ray result of the left hip, indicating a fracture. The SBAR further indicated, MD 1 ordered for Resident 1 to be sent to the General Acute Care Hospital (GACH) via non-emergency transport since Resident 1 was stable.During a review of Resident 1's facility x-ray result titled, Patient Report (PR), dated 6/12/2026, the PR indicated Resident 1 had an x-ray of the left hip with results for an acute displaced intertrochanteric fracture of the left femur (type of broken hip).During a review of Resident 1's Physician Orders (PO), dated 6/12/2026, the PO indicated Resident 1 to have a left hip x-ray only time only.During a review of Resident 1's PO, dated 6/15/2026, the PO indicated Resident 1 transferred to GACH for further evaluation due to a left hip fracture.During a review of Resident 1's Progress Notes Type: IDT (PN) dated 6/15/2026 at 4:22 PM, the PN indicated on 6/12/2026, during an attempt to assist Resident 1 with standing, PT 1 observed Resident 1's lower extremities appeared uneven while seated and the hip/leg did not appear to be aligned. PT 1 noted Resident 1's left knee shortened more than the right while seated and with the left leg adducted and externally rotated. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1 was also unable to bear weight. Nursing staff (unidentified) were notified of these findings at 11:00 AM and an x-ray was ordered at 11:15 AM for further evaluation that resulted at 4:45 PM. MD 1 was notified of the results at 5:17 PM and ordered to send Resident 1 to GACH for further assistance. Resident 1 was transferred at approximately 8:00 PM.During an interview on 7/1/2026 at 11:07 AM, with Physical Therapist (PT) 1, PT 1 stated Resident 1 received physical therapy five times a week but did not always with the same therapist. PT 1 stated [on 6/10/2026] Resident 1 was in the rehabilitation room sitting up in a wheelchair when PT 1 noticed the position of Resident 1's left leg was in an unexpected position. PT 1 stated PT 1 did not perform any weight bearing exercises that day and instead performed an assessment of Resident 1's legs and hips. PT 1 stated PT 1 wheeled Resident 1 in a wheelchair to the nurse's station and spoke to a nurse (unidentified) about concerns regarding Resident 1 having a possible hip dislocation (a serious emergency where the ball -shaped head of the thighbone is forced entirely out of the ball-shaped socket in the pelvis). PT 1 stated, [on the same day], while PT 1 was taking Resident 1 back to Resident 1's room, multiple nurses at the station looked at Resident 1 but did not take any further action. PT 1 stated two days later [6/12/2026], Resident 1 was in the rehabilitation room again, sitting up in a wheelchair to receive physical therapy and PT 1 observed Resident 1's left leg appeared shorter than the right leg. PT 1 stated PT 1 then involved the Director of Rehabilitation (DOR) and PT 2 for their opinion on PT 1's observations and Resident 1's therapies did not continue.During an interview on 7/1/2026 at 1:47 PM, with Family Member (FM) 1, FM 1 stated Resident 1 complained of pain in Resident 1's left leg before Resident 1 was admitted to the facility. FM 1 stated Resident 1 could not move the left leg or foot very much due to pain and FM 1 spoke with the DOR (no date recollection) regarding pain management before the fracture was discovered.During an interview on 7/2/2026 at 9:56 AM, with the DOR, the DOR stated on [6/12/2026], PT 1 asked the DOR to asses Resident 1 based on observations made by PT 1. The DOR stated Resident 1 was assessed and Resident 1 denied having pain and denied any recent falls. The DOR stated Resident 1 had a bony prominence (area of the body where the bone lies very close to the surface of the skin) on the left hip and the left knee was more forward than the other which was not a usual posture [for Resident 1]. The DOR stated the DOR spoke to the Registered Nurse Supervisor (RNS) and suggested an X-ray (a type of high-energy radiation that can pass through the body to create images of your internal bones and organs) for Resident 1. The DOR stated the DOR had not been made aware of any previous (two days prior) concerns brought up by PT 1. During an interview on 7/2/2026 at 12 PM, with the RNS, the RNS stated the RNS worked Monday through Friday from 7 AM to 3 PM. The RNS stated charge nurses (in general) often sat at the station along with the RNS. The RNS stated the RNS did not recall having a conversation with PT 1 about concerns related to Resident 1's left leg. The RNS stated there was no documentation in Resident 1's medical record indicating PT 1's concerns were communicated to Resident 1's doctor and the RNS did not know who PT 1 spoke to. The RNS stated if a concern was brought up to nursing, nursing would have completed a COC form and implemented an intervention immediately.During a telephone interview on 7/2/2026 at 12:22 PM, with Medical Doctor (MD) 1, MD 1 stated MD 1 was not notified of PT 1's concerns noted on 6/10/2026. MD 1 stated MD 1 should have been kept informed of any changes in condition and PT 1's concerns should have been reported to MD 1 because there might have been an additional intervention done or MD 1 may have decided to assess the resident themself if the initial concern was reported on 6/10/2026.During a review of the facility's policy and procedure (P&P) titled, Change in Resident's Condition or Status, dated 2/2021 the P&P indicated the nurse will notify the resident's attending physician or physician on call when there has been a(an): [.]d. significant change in the resident's physical/ emotional/ mental condition;e. need to alter the resident's medical treatment significantly. [.]2. A significant change of condition is a major decline or improvement in the resident's status that:a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting). [.]5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.