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	04/09/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop and implement a comprehensive, individualized, person-centered care plan (CP), for two of two sampled residents (Resident 1 and Resident 53), that addressed:A. The use of an anticoagulant medication [Eliquis] apixaban (medication used to treat and prevent harmful blood clots from forming or getting bigger) for Resident 1.B. The use of an anticoagulant (medications used to help prevent harmful blood clots) medication [Xarelto] rivaroxaban (a medication that helps keep the blood from forming dangerous clots) for Resident 53.This deficient practice had the potential to result in unmet individualized anticoagulant therapy needs for Residents 1 and 53 and the potential to affect the resident's physical well-being.Findings: A. During a review of Resident 1's admission Record (AR), the AR indicated the facility originally admitted Resident 1 on 2/11/2026 with diagnoses including acute (sudden) respiratory failure (a medical condition that happens when your lungs cannot get enough oxygen), pulmonary embolism (a blood clot that travels to the lungs and blocks blood flow) without acute cor pulmonale (a condition where longˆterm high blood pressure in the lungs causes the right side of the heart to become enlarged and weak), and unspecified atrial fibrillation (an irregular, fast heartbeat). During a review of Resident 1's History and Physical (H&P), dated 2/16/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 2/18/2026, the MDS indicated Resident 1's cognitive (the ability to think and process information) skills for daily decision making were moderately impaired (makes poor decisions requiring cues or supervision). The MDS indicated Resident 1 required supervision or touching assistance with eating and was dependent on oral and personal hygiene, toileting, showering, and dressing. During a review of Resident 1's Order Summary Report (OSR), dated active as of 4/9/2026, the OSR indicated Resident 1 had a physician's order for Eliquis 5 milligrams (mg-a unit of measurement) to be given two times a day for atrial fibrillation, order date of 2/11/2026. During a review of Resident 1's anticoagulant CP, initiated 4/9/2026, the CP indicated drug therapy: Eliquis. During a concurrent interview and record review on 4/9/2026 at 10:13 AM with the Registered Nurse (RN), Resident 1's CPs were reviewed. The RN stated Resident 1 had a CP in place for Eliquis which was initiated [today] 4/9/2026. The RN stated Resident 1's Eliquis was ordered on 2/11/2026. The RN stated it was the policy of the facility to create an anticoagulant CP when the anticoagulant was (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ordered. The RN stated it was important to have an anticoagulant CP in place for Resident 1 because it ensured Resident 1's specific needs were monitored. B. During a review of Resident 53's AR, the AR indicated the facility admitted Resident 53 on 4/2/2026, with diagnoses including atrial fibrillation, abnormalities of gait (manner of walking) and mobility, and encounter for other orthopedic aftercare (care provided after bone, joint, or muscle injury or surgery). During a review of Resident 53's admission Initial Eval (AIE), dated 4/2/2026, the AIE indicated Resident 53 required partial/moderate assistance (helper does less than half the effort) with activities of daily living (ADL-term used in healthcare that refers to self-care activities) and mobility was not attempted due to medical condition and/or safety concerns. During a review of Resident 53's OSR, dated active as of 4/13/2026, the OSR indicated a physician's order, order date 4/2/2026, start date 4/3/2026, for Xarelto (rivaroxaban) oral tablet 15 mg to give 1 tablet by mouth one time a day for deep vein thrombosis (DVT-a blood clot that forms in a deep vein, usually in the leg) prophylaxis (action taken to prevent disease, especially by specified means or against a specified disease). During a review of Resident 53's H&P, dated 4/6/2026, the H&P indicated Resident 53 did not have the capacity to understand and make decisions. During a review of Resident 53's Medication Administration Record (MAR), dated 4/2026, the MAR indicated Resident 53 received Xarelto 15 mg from 4/3/2026 through 4/8/2026. During an interview and concurrent record review on 4/8/2026 at 3:07 PM, Resident 53's OSR, MAR, and CPs were reviewed with the RN. The RN stated there was no CP in place addressing Resident 53's use of rivaroxaban (Xarelto). The RN stated that due to the high-risk nature of the medication, a CP should have been developed. The RN stated Resident 53 was admitted on [DATE] and remained without individualized interventions addressing anticoagulant therapy. The RN stated this demonstrated a lack of timely development and implementation of a person-centered CP. The RN stated that failure to implement appropriate interventions for anticoagulant use had the potential to result in adverse outcomes, including increased risk of bleeding, delayed identification of complications, and compromised resident safety. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 12/2016, the P&P's policy statement indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P's policy interpretation and implementation indicated, The comprehensive, person-centered care plan will: Include measurable objectives and timeframes; Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Additionally, the P&P indicated, The comprehensive, person-centered care plan is developed within seven days of the completion of the required comprehensive assessment (MDS).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure:a. Their process for OTC product self-administration (the process where patients manage and take their own medications) of medications was followed, for two of two sampled residents (Resident 12 and Resident 9), when Resident 12 and Resident 9 had a non-legend product (drug that can be purchased over-the-counter [OTC] without a prescription) at their bedside without a physician's order or a consent (permission for something to happen or an agreement to do something) for self-administration.b. One of one sampled resident's (Resident 47) physician was notified of Resident 47's, who was newly admitted to the facility, soiled surgical dressing on 4/7/2026.This deficient practice had the potential to result in misuse and side effects (SE, an unwanted, unintended, or secondary effect that occurs in addition to the desired therapeutic effect of a drug) of the OTC products to Resident 12 and Resident 9 and the potential for OTC product sharing with other residents (in general) by Resident 12 and Resident 9. Additionally, the deficient practice had the potential to result in skin maceration (softening and whitening of skin surrounding a wound, caused by prolonged exposure to moisture, such as wound fluid, sweat, or urine) and an infection (the invasion and growth of germs in the body) to Resident 47's surgical site.Findings:a. During a review of Resident 12's admission Record (AR), the AR indicated Resident 12 was admitted to the facility on [DATE] with multiple diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke - loss of blood flow to a part of the brain) affecting left dominant side, and type 2 diabetes mellitus (DM II - adult onset disorder characterized by difficulty in blood sugar control and poor wound healing) without complications.During a review of Resident 12's History and Physical Examination (H&P), dated 3/11/2026, the H&P indicated Resident 12 had the capacity to understand and make decisions.During a review of Resident 12's Minimum Data Set (MDS - a resident assessment tool), dated 3/16/2026, the MDS indicated Resident 12's cognition (ability to think and process information) was moderately impaired (decisions poor; cues/supervision required). The MDS indicated Resident 12 was dependent (helper does all of the effort) for activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During a review of Resident 12's Order Summary Report (OSR), active orders as of 4/8/2026, the OSR did not indicate an order for Eucerin Advanced Repair Lotion, (an OTC dermatologist [skin doctor] -recommended, lightweight, fast absorbing body moisturizer designed to intensively repair very dry skin).During a review of Resident 9's AR, the AR indicated Resident 9 was admitted to the facility on [DATE] with multiple diagnoses including need for assistance with personal care, and essential (primary) hypertension (HTN - high blood pressure).During a review of Resident 9's H&P, dated 3/25/2026, the H&P indicated Resident 9 had the capacity to understand and make decisions.During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 9 required substantial/maximal assistance (helper does more than half the effort) to supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for ADL.During a review of Resident 9's OSR, active orders as of 4/8/2026, the OSR did not indicate an order for Gold Bond Medicated Original Strength Body Powder Anti-Itch Menthol 0.15% Triple Action Formula, (an OTC body powder used to treat minor skin irritations and relive itching).During a concurrent observation and interview on 4/7/2026 at 9:42 AM with Resident 12, inside Resident 12's room, Resident 12 had a 16.9 Fl. Oz. (fluid ounce - a measurement of volume) of Eucerin Advanced Repair Lotion, labeled with Resident 12's name. The lotion was located on top of Resident 12's nightstand. Resident 12 stated, Resident 12 was using the Eucerin lotion brought by Resident 12's mother (unidentified). Resident 12 stated the facility did not inform (educate) Resident (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12 about OTC products.During an observation on 4/7/2026 at 10:08 AM inside Resident 9's room, an unlabeled 10 oz. of Gold Bond Medicated Original Strength Body Powder Anti-Itch Menthol 0.15% Triple Action Formula was located on top of Resident 9's nightstand.During a concurrent observation and interview on 4/8/2026 at 7:33 AM with Resident 9, inside Resident 9's room, Resident 9 had an unlabeled 10 oz. of Gold Bond Medicated Original Strength Body Powder Anti-Itch Menthol 0.15% Triple Action Formula on top of Resident 9's nightstand. Resident 9 stated, Resident 9 had been using the Gold Bond body powder for Resident 9's itching since admission to the facility. Resident 9 stated, Resident 9's son (unidentified) brought the Gold Bond body powder to the facility since the facility was out of Johnson's Baby Powder [a brand of baby powder]. Resident 9 stated Resident 9 did not have permission by the facility to use the Gold Bond body powder, but staff (unnamed) knew Resident 9 was using the Gold Bond body powder.During a concurrent interview and record review on 4/8/2026 at 7:57 AM with the Registered Nurse (RN), Resident 12 and Resident 9's medical records were reviewed. The RN stated, the Eucerin lotion and Gold Bond body powder were OTC products that the facility did not provide to Resident 12 and Resident 9. The RN stated a physician's order and a consent to self-administer OTC products were required for residents (in general) to ensure staff monitored residents for SE and to prevent sharing of OTC products with other residents. The RN stated Resident 12 and Resident 9 did not have a physician's order or consent to self-administer the OTC products. The RN stated, staff should be checking resident rooms for OTC products, when we do our rounds.During an interview on 4/9/2026 at 8:06 AM with the Director of Nursing (DON), the DON stated, obtaining a physician's order for OTC products was important to ensure the OTC products were allowed, ask the doctor if it's ok for residents to use.During a review of the facility's policy and procedure (P&P) titled, Self-Administration of Medications, revised December 2016, the P&P indicated, residents had the right to self-administer medications if the interdisciplinary team determined it was clinically appropriate and safe for the resident to do so. The P&P indicated, staff should identify and give to the charge nurse any medications found at the bedside that were not authorized for self-administration, for return to the family or responsible party.b. During a review of Resident 47's AR, the AR indicated, Resident 47 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including encounter for other orthopedic (medical specialty dealing with conditions affecting the bones or muscles) aftercare, and displaced intertrochanteric fracture (type of a broken hip) of right femur (thigh bone), subsequent encounter for closed fracture (a broken bone that does not break the skin) with routine healing.During a review of Resident 47's Nurse Kardex (NK), dated 4/6/2026, from the General Acute Care Hospital (GACH), the NK indicated Resident 47 had surgery on 4/3/2026 for insertion nail intertrochanteric: intramedullary nailing of right intertrochanteric fracture (right) (fixing a broken hip on the right side by inserting a metal rod inside the thigh bone).During a review of Resident 47's admission Initial Eval (AIE), dated 4/6/2026, timed at 6:04 PM, the AIE indicated Resident 47 arrived at the facility on 4/6/2026 at 5:51 PM with two intact [not soiled] surgical dressings (a piece of material such as a pad applied to a wound to promote healing and protect the wound from further harm) on Resident 47's right hip. The AIE indicated multiple required admission care plans (CP) including a CP titled, Fracture Care Plan, indicating Resident 47 was at risk for further decline and incision infection. The CP's interventions indicated to change surgical incision dressing as per order and PRN (as needed).During a review of Resident 47's H&P, dated 4/8/2026, the H&P indicated Resident 47 did not have the capacity to understand and make decisions.During a concurrent observation and interview on 4/7/2026 at 10:21 AM with Resident 47 in Resident 47's room, Resident 47 was in bed, anxious, appeared uncomfortable, and fidgeted at times while pointing to Resident 47's right hip area. Resident 47 stated, Resident 47 did not feel, not too good. Resident 47's right hip area's surgical dressing was moderately (75%) saturated with red to serosanguineous [pink to light red] bloody drainage and the dressing's transparent clear cover was peeling off at the edges. Resident 47 stated, they didn't change it [surgical dressing].During a concurrent observation and interview on 4/7/2026 at 10:37 AM with Certified Nursing Assistant (CNA) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4, in Resident 47's room, Resident 47's right hip area's surgical dressing was moderately saturated, and the dressing's transparent clear cover was peeling off at the edges. CNA 4 stated, the surgical dressing needed to be changed, it's old, dirty.During a review of Resident 47's medical records on 4/8/2026 at 9:20 AM, there was no documented evidence indicating Resident 47's physician was notified of Resident 47's soiled dressing.During an interview on 4/8/2026 at 9:26 AM with the Treatment Nurse (TN), the TN stated orthopedic physicians (in general) usually did not want staff to remove the surgical dressing until the resident's (in general) follow-up appointment with the orthopedic physician. The TN stated Resident 47's surgical dressing was soiled, and staff should have notified Resident 47's physician (unidentified) to obtain an order to change the surgical dressing. The TN stated changing Resident 47's soiled surgical dressing was important to prevent infection and the risk of maceration. During an interview on 4/9/2026 at 8:06 AM with the Director of Nursing (DON), the DON stated assessing Resident 47's surgical dressing and verifying with the orthopedic physician was important because Resident 47 was newly admitted to the facility and Resident 47's surgical site [dressing] needed to be monitored.During a review of the facility's P&P titled, admission Assessment and Follow Up: Role of the Nurse, revised September 2012, the P&P indicated, to notify the supervisor and the Attending Physician of immediate needs the resident may have.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to provide appropriate interventions to prevent the development or worsening of existing pressure injuries (PI, lesion/wound caused by unrelieved pressure usually over a bony area that results in damage of underlying tissue) for two of two sampled residents (Residents 29 and 46) when:a. Resident 29's alternating pressure pump (APP - a device that inflates and deflates parts of a mattress to reduce pressure on the body and help prevent PIs, redistributing weight and improving circulation) was not set according to Resident 29's weight or Resident 29's comfort level.b. Resident 46's, who had multiple PIs, low air loss mattress (LALM, special type of mattress used for both the prevention and treatment of PI, prioritizes moisture control and temperature regulation to prevent skin breakdown) was not set to the correct setting.These failures had the potential to result in skin breakdown to Resident 29 and the potential to affect Resident 29's psychosocial well-being. Additionally, the failures had the potential to result in delayed wound healing, worsening of Resident 46's PIs, and the development of new PIs or skin breakdown to Resident 46. Findings: a. During a review of Resident 29's admission Record (AR), the AR indicated the facility admitted Resident 29 on 1/16/2026, and readmitted the resident on 2/21/2026, with diagnoses including moderate protein-calorie malnutrition (not getting enough nutrients and calories, leading to weight and muscle loss), muscle wasting and atrophy of the right upper arm (loss of muscle mass and strength in the right arm), muscle wasting and atrophy of the left upper arm, and need for assistance with personal care (requiring help with daily activities such as bathing, dressing, and hygiene). During a review of Resident 29's Skin care plan (CP), initiated 2/23/2026, the CP indicated Resident 29 was at risk for impaired skin integrity related to decreased mobility and had a redistribution/reduction mattress on the bed for prevention of skin breakdown as an intervention/task. During a review of Resident 29's Minimum Data Set (MDS- a resident assessment tool), dated 2/28/2026, the MDS indicated Resident 29's cognition (the ability to think and process information) was moderately impaired. The MDS indicated Resident 29 was dependent (helper does all of the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and was dependent on mobility. During an observation on 4/7/2026 at 12:53 PM, Resident 29's APP was set at 200 pounds (lbs.-a unit of weight). During an observation on 4/8/2026 at 10:45 AM, Resident 29's APP was set at 200 lbs. During an interview on 4/8/2026 at 10:47 AM with Resident 29, Resident 29 stated Resident 29's mattress was very firm and uncomfortable to lie on. Resident 29 stated staff never asked Resident 29 how the mattress firmness felt and did not adjust it to Resident 29's comfort level. Resident 29 stated Resident 29 remained uncomfortable while in bed and was not aware of any attempts, made by staff, to reassess the mattress setting or make adjustments despite Resident 29's discomfort. During a concurrent interview and record review on 4/8/2026 at 11:45 AM, Resident 29's Weights and Vitals Summary (WVS) was reviewed with the Treatment Nurse (TN). The WVS indicated Resident 29's most recent weight dated 4/7/2026 was 84 lbs. The TN stated the APP was used for prevention of skin breakdown by redistributing pressure. The TN stated that the mattress setting should always (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be adjusted to the resident's comfort level. The TN stated when the setting was set too high or too low, it could result in the opposite [desired] effect, increased pressure rather than relieving it, and reduced the therapeutic effect of the mattress. The TN stated setting the mattress at 200 lbs. for Resident 29 who weighed 84 lbs. could result in ineffective pressure redistribution and placed Resident 29 at increased risk for skin breakdown due to Resident 29's frail condition. The TN stated adjusting the mattress based on the resident's comfort level and weight optimized the therapeutic effect and supported the purpose of the APP in preventing skin breakdown. During a review of the facility's policy and procedure (P&P) titled, Accommodation of Needs, revised 1/2020, the P&P indicates that it is the policy of this facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being. The P&P indicated the resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, shall be evaluated upon admission and reviewed on an ongoing basis. During a review of the undated Alternating Pressure Pump & Bubble Pad User Manual Proactive, the user manual indicated please use pressure adjustable knob to give maximum patient comfort. b. During a review of Resident 46's AR, the AR indicated the facility originally admitted Resident 46 on 4/1/2026 with diagnoses including PI of right upper back stage 1 (intact skin with a localized area of redness and/or changes in sensation, temperature, or firmness), PI of right upper back stage 4 (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), PI of left upper back unstageable (the base of the wound is covered by dead tissue), PI of the sacral region (tailbone) stage 4, pressure induced deep tissue damage of sacral (large triangular bone at the base of the spine) region (an injury at the tailbone caused by prolonged pressure), PI of left buttock stage 4, and PI of right heel stage 1. During a review of Resident 46's History and Physical (H&P), dated 4/2/2026, the H&P indicated Resident 46 did not have the capacity to understand and make decisions. During a review of Resident 46's Order Summary Report (OSR), dated active as of 4/8/2026, the OSR indicated Resident 46 had a physician's order, dated 4/1/2026, for a pressure redistribution mattress-low air loss setting per weight range for wound care. During a review of Resident 46's CP titled Pressure Ulcer Care Plan, initiated 4/3/2026, the CP indicated Resident 46 was at risk for further impairment to skin integrity and delayed or slow [wound] closure. The CP's interventions indicated, Specialty bed-low air loss mattress setting per weight range and/or comfort level check function [every] shift. During a review of Resident 46's Treatment Administration Record (TAR), dated 4/1/2026-4/30/2026, the TAR indicated Resident 46's LALM weight range setting was to be checked three times a day [day, evening, and night shifts]. During a review of Resident 46's WVS, dated 4/8/2026, the summary indicated Resident 46 weighed 100 lbs. on 4/7/2026. During an observation on 4/8/2026 at 9:11 AM, Resident 46 was observed lying on Resident 46's left side on a LALM. The LALM control unit indicated the pressure dial was set to 250 lbs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and observation on 4/8/2026 at 1:40 PM with Certified Nursing Assistant (CNA) 1, Resident 46 was observed lying on Resident 46's back on a LALM. The LALM pressure dial was observed to be set at 250 lbs. CNA 1 stated CNA 1 was unsure if this was the correct setting for Resident 46. During a concurrent interview and observation on 4/8/2026 at 1:46 PM with the TN, Resident 46's LALM pressure dial was observed to be set at 250 lbs. The TN stated Resident 46 weighed 100 lbs. and the LALM should be set to 100. The TN stated the importance of setting the LALM correctly was to ensure Resident 46's wounds did not get worse. During a review of the facility's P&P titled, Prevention of Pressure Ulcers/Injuries, revised July 2017, the P&P's purpose indicated, The purpose of this procedure is to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors. The P&P's preparation indicated, Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Additionally, the P&P indicated, Select appropriate support surfaces based [on] the resident's mobility, continence, skin moisture and perfusion, body size, weight, and overall risk factors. During a review of the facility's undated Med-Aire 8 Alternating Pressure Mattress Replacement System with Low Air Loss User Manual, the user manual indicated the LALM had a control unit with a pressure dial that was adjustable to the patient's weight and comfort. The user manual's operation indicated users could adjust the pressure level of the air mattress using the analog pressure dial to a desired firmness based on personal comfort or weight setting.

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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 ensure safe and sanitary food storage practices in one of one kitchen (Kitchen 1) when:a. An opened package of cheese in the walk-in refrigerator was unlabeled and not marked with the open date.b. One of two shelving racks in the walk-in refrigerator had amber discoloration, peeling paint, and was not smooth to touch.c. The walk-in freezer was observed with food and debris on the ground.These failures had the potential to result in pests, foodborne illnesses (an illness from eating contaminated food), and cross-contamination (transfer of harmful bacteria from one place to another) placing residents (in general) at risk and significantly impacting the resident's health.Findings:a. During a concurrent observation and interview on 4/7/2026 at 8:45 AM with the Director of Dietary Services (DDS), in Kitchen 1's walk-in refrigerator, there was an unlabeled opened package of cotija cheese, no open date was observed. The DDS stated the cotija cheese did not indicate when it was opened and the opened bag should be marked (labeled) with an open date.b. During a concurrent observation and interview on 4/7/2026 at 8:45 AM with the DDS, in Kitchen 1's walk-in refrigerator, one of two shelving racks was observed with amber discoloration, peeling blue paint, and was not smooth to touch. An unsealed box of lettuce located below the shelf was observed with peeling paint. The DDS stated the chipped paint from the shelving unit could fall onto the lettuce below.c. During a concurrent observation and interview on 4/7/2026 at 9 AM with the DDS in Kitchen 1's walk-in freezer, food and debris were observed on the ground. The DDS stated there was a breadstick on the floor, the DDS picked up the breadstick and threw it away in the trash. The DDS stated the walk-in freezer [should be clean] and was cleaned daily.During an interview on 4/9/2026 at 10:43 AM with the Registered Dietician (RD) 2, RD 2 stated it was concerning to have flaking shelves because the paint could contaminate open food. RD 2 stated it was important to keep the walk-in freezer floors clean to prevent pests and dangerous slipping hazards for employees. Additionally, RD 2 stated it was important for all open foods to be marked (labeled) with an open date to ensure the food was still useful to serve.During a review of the facility's undated Policy and Procedure (P&P) titled, Kitchen and Kitchen Equipment Policy, the P&P's general work areas indicated all shelves, drawers, and cabinets should be clean, in good repair, and not rusted. The P&P's cold storage indicated the freezer should be clean with no food on the floor. Additionally, the P&P indicated food should be covered, labeled, dated with received or use by dates and open dates.

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	555737	A. Building B. Wing	04/09/2026

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 implement infection (the invasion and growth of germs in the body) prevention and control practices when:a. Certified Nursing Assistants (CNA) 3 and CNA 5 failed to don (put on) proper PPE (personal protective equipment - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) while taking care for one of six sampled residents (Resident 5) who was on EBP (enhanced barrier precautions - an infection-control practice to prevent the spread of bacteria in nursing homes)b. One of one sampled staff (LA, Laundry Attendant) failed to store LA's personal belongings away from the clean area of the facility's laundry room.c. The Infection Preventionist (IP) failed to keep accurate Flu (influenza - a contagious infection of the nose, throat, and lungs) vaccination (immunization - a simple, safe, and effective way of protecting you against harmful diseases/infections) records for two of four sampled staff (MDS Nurse [MDSN] and CNA 6).These deficient practices had the potential to result in cross contamination (the process by which microorganisms are unintentionally transferred from one area/object to another with a harmful effect) and/or the development and transmission of disease (an illness or sickness) and infections to the residents residing at the facility including Resident 5.Findings:a. During a review of Resident 5's admission Record (AR), the AR indicated Resident 5 was admitted to the facility on [DATE] with multiple diagnoses including type 2 diabetes mellitus (DM II - adult-onset disorder characterized by difficulty in blood sugar control and poor wound healing) without complications, and pressure ulcer of sacral region, stage 4 (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone).During a review of Resident 5's History of Present Examination (H&P), dated 2/23/2026, the H&P indicated Resident 5 had the capacity to understand and make decisions.During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool), dated 2/27/2026, the MDS indicated Resident 5's cognitive skills for daily decision making were intact (decisions consistent/reasonable). The MDS indicated Resident 5 was dependent (helper does all of the effort) to requiring partial/moderate assistance (helper does less than half the effort) for activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and mobility including being dependent with chair/bed-to-chair transfer (the ability to transfer to and from a bed to a chair [or wheelchair]). The MDS indicated Resident 5 had one or more unhealed pressure ulcers/injuries and diabetic foot ulcer(s).During an observation on 4/7/2026 at 9:35 AM, there was an EBP signage and a sticker indicating 6 resident care activities posted outside by Resident 5's room door and a clear colored black trimmed 3-drawer PPE cart located at the entrance of Resident 5's room. During an observation on 4/7/2026 at 10:02 AM, CNA 3 was wearing a surgical mask entered Resident 5's room without donning a gown and started cleaning up Resident 5.During a concurrent interview and record review on 4/7/2026 at 10:17 AM with CNA 3, the EBP signage posted outside of Resident 5's door was reviewed. CNA 3 stated Resident 5 was on EBP due to the wound on his bottom. CNA 3 stated wearing gown and gloves when providing [direct resident] care to Resident 5 was important for the safety of not spreading the stuff, infection, for infection control.During a concurrent observation and interview on 4/7/2026 at 4:03 PM with the IP, inside Resident 5's room, CNA 5 was not wearing PPE and was assisting Resident 5 to get Resident 5 ready to be transferred to the wheelchair and to be showered. CNA 3 entered Resident 5's room wearing PPE and assisted CNA 5 with Resident 5's transfer. CNA 5 proceeded to transport Resident 5 to the shower room. The IP stated, Resident 5 had a wound on the left and right heel and was on EBP. The IP stated, donning PPE like gown and gloves was important to prevent transmission of MDROs (Multi-Drug Resistant Organisms - superbug or a germ [bacteria] that become resistant to certain antibiotics [medicine used to treat infections caused by bacteria]), for infection control.During a review of the facility's undated policy and procedure (P&P) titled, Enhanced Barrier Precautions, the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	P&P indicated EBP were utilized to prevent the spread and transmission of MDROs to residents in long-term care facilities. The P&P indicated gloves and gowns were applied prior to performing high contact resident activities that included: dressing a resident, transferring resident, changing linens and changing briefs or assisting with toileting. The P&P indicated EBPs were indicated for residents with unhealed wounds, pressure injuries, or diabetic ulcers.b. During a concurrent observation and interview on 4/9/2026 at 11:43 AM with the LA in the laundry room, an open shelving in the clean area of the laundry room there were packages of newly ordered bath towels, and a stack of laundered folded bath sheets open to air stored on the third (3rd) shelf. The second (2nd) shelf above the 3rd shelf had non- laundry items including multiple office supplies, a personal bag, a dark blue colored reusable tumbler, a make-up pouch, a Ziploc bag of condiments, a red colored plastic drinking cup with a lid, and an empty rectangular glass food storage container. The LA stated the nonlaundry items on the 3rd shelf belonged to the LA. The LA stated storing and separating staff personal items away from the clean laundry was important to prevent cross contamination and for infection control.During an interview on 4/9/2026 at 12:28 PM with the Assistant Infection Preventionist (AIP), the AIP stated staff personal belongings should be separated from the clean laundry to prevent cross contamination and for infection control.During a review of the facility's P&P titled, Departmental (Environmental Services) - Laundry and Linen, revised January 2014, the P&P indicated the purpose of the P&P was to provide a process for the safe and aseptic handling, washing, and storage of linen. The P&P indicated, clean linen would remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination.c. During a concurrent interview and record review on 4/9/2026 at 1:51 PM with the IP, in the presence of the AIP, the facility's undated vaccination CNA Tracking (CTK), Licensed Tracking (LTK), CNA 6 and MDSN's Influenza Vaccine - Staff Consent and Administration (IVC), were reviewed. The CTK and LTK indicated a R for the Flu vaccine for CNA 6 and the MDSN. The IP stated, the R indicated, the staff refused the vaccine. CNA 6's IVC, dated and signed 1/9/2025 was not complete. The MDSN's IVC, dated and signed 10/2/2025 indicated the MDSN already received this season's annual influenza vaccine. The IP stated, the MDSN never received the flu vaccine for this season's annual influenza.During a phone interview on 4/9/2026 at 2:05 PM with CNA 6, CNA 6 stated CNA 6 wanted the Flu vaccine but received the vaccine early this year (did not remember date), at CVS (the U.S. largest pharmacy chain that also sells a wide assortment of general merchandise) and not at the facility.During an interview on 4/9/2026 at 2:21 PM with the MDSN, the MDSN stated the MDSN did not get the Flu vaccine for this flu season. The MDSN stated, the MDSN got confused with the flu season dates but only received the flu vaccine for the previous flu season.During an interview on 4/9/2026 at 2:26 PM with the IP, the IP stated the IP checked CAIR (California Immunization Registry - a secure, confidential, statewide computerized system that stores immunization records for California residents) and CNA 6 did not receive the flu vaccine. The IP stated ensuring the staff's Flu vaccination record was accurate and the IP following through was important to lessen the infection rate of flu and for the protection of the residents (in general). During a review of the facility's P&P titled, Infection Prevention and Control Program, revised October 2018, the P&P indicated an infection prevention and control program (IPCP) was established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.During a review of the facility's P&P titled, Influenza Vaccine, revised March 2022, the P&P indicated all residents and employees who have no medical contraindications to the vaccine would be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. The P&P indicated if an employee refused the vaccine for reasons other than medical contraindication, this should be documented on the employee consent for influenza vaccine. The P&P indicated, the infection preventionist would maintain surveillance data on influenza vaccine coverage.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility's licensed staff failed to obtain and/or ensure an accurate informed consent for the administration of a psychotropic medication, (a drug that affects the brain and changes how an individual feels, thinks, or behaves) alprazolam (Xanax, a medication used to treat anxiety [intense, excessive, and persistent worry and fear about everyday situations] and panic disorders [treatable anxiety disorder characterized by recurrent, unexpected panic attacks - sudden episodes of intense fear accompanied by physical symptoms like a racing heart, dizziness, and shortness of breath] by calming the brain and nerves), was obtained prior to the medication's administration for one of one sampled resident (Resident 15).This deficient practice violated Resident 15's and/or Resident 15's representative right to be fully informed of the purpose, risks, and benefits of the medication and violated the right to make informed decisions about Resident 15's psychiatric treatment.Findings:During a review of Resident 15's admission Record (AR), the AR indicated the facility admitted Resident 15 on 2/16/2026, with diagnoses including, anxiety disorder, major depressive disorder (a mood disorder that causes a persistent feelings of sadness and loss of interest), and chronic kidney disease (when the kidneys are damaged and gradually lose the ability to filter waste and extra fluid from the blood over a long period, usually months or years).During a review of Resident 15's Psychotropic Consent (PC), dated 2/16/2026, the PC indicated an informed consent was obtained on 2/16/2026, for lorazepam (Ativan, a benzodiazepine [medication used to reduce anxiety and help a person feel calm and relaxed by slowing down activity in the brain]) 0.5 mg (mg-a unit used to measure amount) three times a day.During a review of Resident 15's Minimum Data Set (MDS- a resident assessment tool), dated 2/23/2026, the MDS indicated Resident 15's cognition (the ability to think and process information) was intact. The MDS indicated Resident 15 required substantial/maximal assistance (helper does more than half the effort) with activities of daily living (ADL-term used in healthcare that refers to self-care activities) and was dependent (helper does all of the effort) with mobility.During a review of Resident 15's Order Summary Report (OSR), dated active as of 4/8/2026, the OSR indicated a physician's order, dated 2/16/2026, for alprazolam 0.5 mg PO (oral), 1 tablet by mouth three times a day for anxiety manifested by verbalization of feeling anxious related to medical conditions. The order's start date indicated 2/17/2026.During a review of Resident 15's Medication Administration Records (MAR), dated 2/2026, 3/2026, and 4/2026, the MARs indicated the following: February 2026: Resident 15 was administered alprazolam 0.5 mg from 2/17/2026 through 2/28/2026. March 2026: Resident 15 was administered alprazolam 0.5 mg from 3/1/2026 through 3/31/2026. April 2026: Resident 15 was administered alprazolam 0.5 mg from 4/1/2026 through 4/8/2026.During an interview and concurrent record review on 4/8/2026 at 2:50 PM, Resident 15's PC, OSR, and MARs were reviewed with the Registered Nurse (RN). The RN stated based on Resident 15's OSR and MAR, Resident 15 was first administered alprazolam on 2/17/2026 upon Resident 15's admission. The RN stated the order for alprazolam remained active and Resident 15 continued to receive the medication at the time of review. The RN stated Resident 15's OSR did not indicate an order for lorazepam [Ativan] and the informed consent on file was completed for lorazepam instead of alprazolam. The RN confirmed that the psychotropic medication consent was not accurately completed, and a consent should have been obtained specifically for alprazolam prior to administration of the medication. The RN stated an informed consent must include the correct medication name, dosage, frequency, and indication to ensure the resident and/or responsible party (in general) are fully informed of the treatment, including risks, benefits, and alternatives. The RN stated failure to obtain accurate informed consents may result in the resident receiving medication without proper authorization and understanding, potentially impacting the resident's rights and ability to make informed decisions regarding care.During a review of the facility's policy and procedure (P&P) titled, Psychotherapeutic Medication Use, dated 3/2026, the P&P indicated that Informed consent will be obtained for new admissions, new psychotherapeutic drug orders, and dosage changes, and will be renewed at least every six months while the resident remains on the medication.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of two sampled residents' (Resident 27) assessment accurately reflected Resident 27's status in the Minimum Data Set (MDS - a resident assessment tool).This deficient practice could potentially result in compromised care to Resident 27 and the potential for Resident 27 not to receive the necessary care and services according to Resident 27's specific needs and due to improper care planning.Findings:During a review of Resident 27's admission Record (AR), the AR indicated Resident 27 was admitted to the facility on [DATE] with multiple diagnoses including acute (sudden) kidney failure and urinary tract infection (UTI - an infection [the invasion and growth of germs in the body] in the bladder/urinary tract), site not specified.During a review of Resident 27's admission Initial Eval (AIE), dated 1/5/2026, timed at 8:22 PM, the AIE indicated Resident 27 did not have an active infection and was not on antibiotic (a powerful medicine used to treat infections caused by bacteria) therapy. The AIE indicated, Resident 27 did not require a care plan (CP) for an infection or a UTI.During a review of Resident 27's MDS, dated [DATE], the MDS indicated Resident 27's cognitive skills (ability to think and process information) were intact (decisions consistent/reasonable). The MDS indicated Resident 27 was dependent (helper does all of the effort) requiring supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS's Section I-Active Diagnoses indicated Resident 27 had a UTI in the last thirty (30) days.During a review of Resident 27's History & Physical Examination (H&P), dated 2/1/2026, the H&P indicated, Resident 27 had the capacity to understand and make decisions.During an interview on 4/7/2026 at 9:56 AM with Resident 27, Resident 27 stated Resident 27 did not have a UTI and was not treated for UTI while at the facility.During a concurrent interview and record review on 4/8/2026 at 8:48 AM with the MDS Nurse (MDSN), Resident 27's MDS, dated [DATE] and 2/8/2026 were reviewed. The MDS indicated, Section I-Active Diagnoses included UTI in the last thirty (30) days. The MDSN stated, an MDS included the resident's (in general) data and assessments and was submitted to CMS (Centers for Medicare & Medicaid Services - U.S. federal agency that provides health coverage) [for review]. The MDSN stated the MDSN obtained a resident's data and assessment from the resident's medical records, admission paperwork, information [collected] from different disciplines (e.g. rehabilitation, dietary), and from visually assessing and interviewing the resident. The MDSN stated UTI was coded since UTI was a part of Resident 27's admitting diagnoses. The MDSN stated Resident 27's MDS dated [DATE] that was submitted to CMS on 3/2/2026 should not have been coded for UTI, that was an error, because Resident 27 no longer had an active UTI and was never treated for a UTI at the facility. The MDSN stated the facility continued to monitor Resident 27 for UTIs. The MDSN stated submitting an accurate MDS was important since the MDS, paints the picture of the patient [resident's assessment] to CMS.During an interview on 4/9/2026 at 8:06 AM with the Director of Nursing (DON), the DON stated, the MDS was an assessment for every resident that the facility was mandated to conduct and was the basis for the resident's plan of care. The DON stated, ensuring the MDS was accurate was important for CMS's way of tracking all sorts of information, about the resident.During a review of the facility's policy and procedure (P&P) titled, Resident Assessments, date revised November 2019, the P&P indicated the Resident Assessment Coordinator was responsible for ensuring that the Interdisciplinary Team (IDT - a group of healthcare professionals from various disciplines who collaborate, assess, coordinate, and manage each resident's comprehensive health care, including his or her medical, psychological, social, and functional needs) conducted timely and appropriate resident assessments. The P&P indicated all persons who have completed any portion of the MDS Resident Assessment Form must sign the document attesting to the accuracy of such information.