POC Accepted 03/08/2023 HFEN 37897

PRINTED: 02/14/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	PLE CONSTRI		COMPLETED		
		055247	B. WING				C 02/14/2023
	ROVIDER OR SUPPLIER			215 W PEA	ODRESS, CITY, STATE, ZIP CODE ARL ST A, CA 91768	<u> </u>	02/14/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3	F 0	00			
	complaint investigation	nt of Public Health during a					
	Complaint Intake Nur Representing the De	partment: HFEN # 37897					
		mited to the specific d and does not represent nspection of the facility.					
	Five deficiencies wer complaint CA008185	e issued as a result of the 00.					
F 677 SS=D		or Dependent Residents	F6	77			
	out activities of daily services to maintain of and personal and ora This REQUIREMENT by: Based on observation review, the facility fail	lent who is unable to carry living receives the necessary good nutrition, grooming, al hygiene; is not met as evidenced on, interview, and record led to provide mouth hygiene three sampled residents					
	in periodontal disease that damages the gui	e had the potential to result e (a serious gum infection ms and can destroy the d to tooth loss) to Resident					
	Findings:						
APODATODY	DIDE TORS OF PROMISED!	SLIPPIONER REPRESENTATIVE'S SIGNATUR			TITI F		(X6) DATE

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.

DON

3/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
	055247	B. WING			C 02/14/2023		
NAME OF PROVIDER OR SUPPLIER COUNTRY OAKS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 W PEARL ST POMONA, CA 91768		02/14/2023		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
8/26/2022, indicated Reimpaired cognition (abil process information). Rependent, required phenomenation was between surface turns side to side and pendent, and required exterperson for dressing. A review of Resident 1' Hospital 1's (GACH 1) Instructions, dated 9/2/2 1 should have his teeth A review of Resident 1' Room Case Request Of Maxilla and Mandible, copen fracture (complete the left and right mandibone in the human skul teeth in place, helps with lower jawline) body, an space in the bones around the preoperative diagnine.	is Admission Record mitted the resident on a medical diagnosis (x) of the right and left and fracture of the left are that runs from the blade to the elbow). Is Minimum Data Set and screening tool), dated resident 1 had moderate lity to understand and resident 1 was totally assistance from a series (how resident resident from lying position, resitions body while in rensive assistance from one as General Acute Care Plastic Surgery 2022, indicated Resident brushed twice per day. Is GACH 1's Operating refers Removal, Deep related 9/2/2022, indicated refers or partial bone break) of bular (mandible, largest lithat holds the lower the chewing, and forms the diamaillary sinus (hollow and the nose) fracture. To sees included hardware in per jaw, forms part of the	F 6	77				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		055247	B. WING			02/	14/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, 215 W PEARL ST POMONA, CA 9	, CITY, STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTIO H CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 677	8/20/2022, indicated health problems due right and left mandil required assistance mouth cleaning with measure) of Chlorhe wash) solution 0.12' infection, pain, or bl Resident 1 to complidaily. The interventiarrangements for deas needed. Monitor, needed any signs a problems needing a gums, toothache or collection of pus), debroken down) in the bleeding, and inflamalso included provide Activity of Daily Livin healthcare that reference personal hygiene. During an observation 2/1/2023, at 11:3 Nurse 2 (LVN 2) state Assistants (CNA) we resident's teeth and CNAs were doing it. staff should be help with oral hygiene, rie	t 1's Care Plan, initiated on a Resident 1 had oral/dental to wiring of the mouth and ole fracture. Resident 1 with oral care and required 15 milliliters (mL, unit of exidine gluconate (mouth of exi	F	577				
	During an observati	on and concurrent interview						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SUR COMPLETE	
		055247	B. WING			C 02/14/ 2	2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 W PEARL ST POMONA, CA 91768	<u> </u>	02/14/2	2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	-	(X5) DMPLETION DATE
F 677	automatically every needed mouth wash his gums. LVN 1 starensure the CNAs we teeth and now felt the because Resident 1. During an observation and concurrent interfam. CNA 1 stated Reswollen, and "infected whitish buildup on his stated Resident 1.'s I stated she had cared and the resident has with whitish stuff. CN resident's native lang Resident 1 yesterdar Resident 1's teeth with afternoon. Resid was not true, CNA 1 teeth all day yesterd rinse or brush Resid yesterday because so During an interview of Dentist (D) 1 stated at the first time on 12/1 1 has a lot of buildup buildup was caused Resident 1 needed to least two time a day not able to do it by h for him. D 1 stated the first time on 1 stated the first time of the stated the first two time and the stated the st	1 pm., LVN 1 stated is teeth should be cleaned day. LVN 1 stated Resident 1 to prevent an infection on teed she had not checked to be re brushing Resident 1's e need to check up on them is teeth had buildup on them. In at Resident 1's bedside wiew on 2/1/2023, at 10:05 resident 1's gums looked red, and." CNA 1 stated, there is a sist teeth and gums. CNA 1 represented for Resident 1 occasionally had dry lips and his teeth lated (in Spanish, the guage) she was assigned to by, 1/31/23, and had rinsed rith mouth wash two times in the lates of the l	F 6	77			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							c
		055247	B. WING _			02/	14/2023
	OAKS CARE CENTER			21	TREET ADDRESS, CITY, STATE, ZIP CODE I5 W PEARL ST OMONA, CA 91768		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	During an interview or Director of Nursing (Doutcomes of Resident assistance with teeth bleeding gums, cavitic that causes swelling of mouth and jaw. A review of the facilitic titled, Activities of Dai healthcare that refers revised on 9/2/2022, i based on the resident assessment and consineeds and choices, e in ADLs do not deteriounavoidable. Care and the following activities dressing, grooming and is unable to carry out receive the necessary nutrition, grooming, and hygiene. The facility were assistance of Nursing and the facility were assistance of the property of	D 1 stated there could be area clean. In 2/3/2023, at 8:06 am., the area clean. It's not receiving staff In brushing could result in area, ginglivitis (gum disease of the gums), infection in his area policy and procedures are policy and procedures are policy and procedures are sident's abilities area are area cleant's abilities area are area consist of a services may consist of a services may consist of a services may consist of a services area cleant who activities of daily living will are services to maintain good and personal and oral	F	677			
F 688 SS=D		rease in ROM/Mobility	F (888			
	resident who enters the	ility must ensure that a ne facility without limited not experience reduction in					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		055247	B. WING		C 02/14/2023		
	ROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W PEARL ST POMONA, CA 91768	02/14/2023		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 688	range of motion unle condition demonstration for motion is unavoidated. §483.25(c)(2) A residemotion receives appropriate approvent further decreives appropriate assistance to maintathe maximum practice reduction in mobility unavoidable. This REQUIREMENT by: Based on interview a failed to provide Phytreatment used to resuch as standing, was parts) and Occupation aimed to increase or capability of participal activities) services for residents (Resident of This deficient practice in muscle wasting, motion contractures (shorter muscles, tendons, or to deformity and tight develop after prolong	tes that a reduction in range able; and dent with limited range of ropriate treatment and range of motion and/or to ease in range of motion. dent with limited mobility services, equipment, and in or improve mobility with eable independence unless a is demonstrably T is not met as evidenced and record review, the facility sical Therapy (PT- medical store functional movements alking, moving different body onal Therapy (OT, profession maintain a person's ating in everyday life or one of three sampled	F 688				
	Findings:						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		055247	B. WING				14/2023	
	ROVIDER OR SUPPLIER OAKS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP 215 W PEARL ST POMONA, CA 91768	CODE	1 02/	14/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD B		(X5) COMPLETION DATE	
F 688	indicated the facility a 8/19/2022. Resident of included fracture (bre mandible (jawbone), farm-humerus (long by shoulder and shoulder related health so an in-patient (stay over the need for skilled not a continuing basis. A review of Resident Hospital 1 (GACH 1) 8/19/2022, indicated shoulded physical their therapy (OT)OT Evaluated by theraper A review of the facility Evaluation and Plant (8/22/2022, indicated I musculoskeletal (relationes together) system impaired strength of the knees, and ankles). Reassistance with bed in resident from one flational walking. These were	1 's Admission Record dmitted the resident on 1 's medical diagnosis ak) of the right and left fracture of the left one that runs from the ar blade to the elbow). 1 's Physician 's order, cated Resident 1 's ty and Resident 1 required (SNF- a nursing facility with ent to give skilled nursing mabilitation services and ervices) services given on ernight) basis because of arsing or rehabilitation care 1 's General Acute Care Surgical Services, dated SNF Supplemental Orders rapy (PT) and occupational aution orders to be by evaluation. 1 's Physical Therapy-PT of Treatment, dated Resident 1 's ting to the muscles and the em assessment included the right and left legs (hips, desident 1 required mobility, transfers (moving a surface to another), and	F	688				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		055247	B. WING			1	C 14/2023	
	ROVIDER OR SUPPLIER OAKS CARE CENTER			21	REET ADDRESS, CITY, STATE, ZIP CODE 5 W PEARL ST DMONA, CA 91768	<u>1 02/</u>	14/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 688	due to no insurance of summary indicate no recommended for Resident (MDS- an assessment 8/26/2022, indicated from the impaired cognition (altographics information). It is dependent, required process information). It is dependent, required process information (MOM and required experson for dressing. Trange of motion (ROM a joint) indicated Resion his upper extremition wrists, hands) and hare extremities (hips, knew (GACH 1) Orthopedic focuses on the care of ligaments, tendons, and 10/18/2022, indicated physical therapy to reper week and to be sereason or urgency for to Resident 1's left his specific scheduling in aggressive range of in potential of a joint) of stretching, heat mass	overage. The assessment skilled PT was sident 1. 1's Minimum Data Set t and screening tool), dated Resident 1 had moderate bility to understand and Resident 1 was totally obysical assistance from ansfers (how resident ces from lying position, positions body while in tensive assistance from one the functional limitation of the function of the fu	F	588				

	CORRECTION	IDENTIFICATION NUMBER:			ISTRUCTION	COMP	PLETED
		055047	D WING			1	С
	ROVIDER OR SUPPLIER	055247	B. WING _		ET ADDRESS, CITY, STATE, ZIP CODE	02/	14/2023
COUNTRY	OAKS CARE CENTER			РОМ	ONA, CA 91768		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	Continued From page	e 8	F	688			
	Resident 1 's Respo Resident 1 's Medica coverage for low-inco expired, and the resid different insurance. T frustrated because th PT exercises to Resid was informed by the Services (SSD, social not qualify for PT becover rehabilitation so Resident 1 received therapy stopped whe to the facility. During an interview of the SSD stated that F not cover PT services During an interview of Resident 1 stated the someone strong to he he was afraid the fem Resident 1 stated the not get out of bed. Re in bed and the facility Resident 1 stated PT hospital, and he had since he was admitte stated it was important exercises because he able to walk and go he without the exercises Resident 1 stated he	en 12/27/2022, at 4:54 pm, efacility did not have elp him get out of bed and hale nurses would drop him. It was the reason why he did esident 1 stated he just laid ef did not give him PT. It was provided at the not received the services d to the facility. Resident 1					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		055247	B. WING	-			C 14/2023	
NAME OF P	ROVIDER OR SUPPLIER	000247	2	S	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	14/2023	
	OAKS CARE CENTER			2	15 W PEARL ST POMONA, CA 91768			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 688	Continued From page	e 9	F	688				
	the Admission Director was admitted to the factoric (services that can be who are neither skilled personnel) and non-horganization (HMO, transurance. AD stated physical therapy and facility because he wastated residents that under HMO insurance services and Resident cover such services. During an interview or Doctor of Medicine 1 resident is admitted to hospital, he continued MD 1 stated most resupon admission and transurance did not cover services and residents to of function and to rever Resident 1 was weak admission and was or stated when residents insurance did not cover doesn't matter." MD written the order for Focustodial care. During a concurrent in	Resident 1 did not get occupational therapy at the as in custodial care. AD were admitted to the facility e did receive therapy at 1 's insurance did not 'n 1/12/23, at 4:11 pm, (MD 1) stated when a to the facility from the did hospital discharge orders. Sidents received PT and OT the benefits of receiving PT return to their baseline level erse deficits. MD 1 stated at on one side upon in custodial care. MD 1 him aware PT and OT were admission orders. MD 1 swere on custodial care, the ter PT, "even though, that a stated he would have PT even though he was on onterview and record review						
		pm, Physical Therapist 1 experts who improve quality						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		055247	B. WING			1	C 14/2023
	ROVIDER OR SUPPLIER OAKS CARE CENTER			STREET ADDRESS 215 W PEARL ST POMONA, CA S		1 02/	14/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD B S-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	of life through prescrit care, and patient educimportance of an initial establish a baseline of safety, ability to perform (ADL, term used in he self-care activities), of up in bed, balance trained to establish a result that the evaluation would streatment plan of care evaluation would inclused follow commands and brain could communicated that Resident 1 8/22/22, did not specime recommended. PT 1 states that if Resident 1 could have PT services. PT 1 states that if Resident 1 had for an extended periodication of the services. PT 1 states are the evaluation was to determine the services of the services and the potential to the services are services and the potential that if Resident 1 (OT 1) states are services and the potential that if the services are services as the services are services.	cation) stated the cation is cation) stated the cation cation) stated the cation cation is cation in stated the cation cat	F	688			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING				(X3) DATE SURVEY COMPLETED	
						(c
		055247	B. WING_			02/	14/2023
	OAKS CARE CENTER			215	EET ADDRESS, CITY, STATE, ZIP CODE W PEARL ST MONA, CA 91768		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 688	services. OT 1 stated reasons to have a bas future services provid A review of the facility titled, "Specialized Rerevised 9/2/2022, indiprovide or obtain serv resource for specializ required by the reside assessment and care attain, maintain or respracticable level of physycho-social well-be rehabilitative services	it was important to indicate seline that could be used for ed. 's policy and procedure chabilitative Services," cated the facility shall rices from an outside ed rehabilitative services if ent's comprehensive plan to assist them to store their highest pysical mental functional and ing. Specialized included but were not g: Physical therapy and	F	588			
F 690 SS=E	§483.25(e) Incontiner §483.25(e)(1) The factoresident who is continuous admission receives semaintain continence to condition is or become not possible to maintain \$483.25(e)(2) For a reincontinence, based of comprehensive assessensure that— (i) A resident who entrindwelling catheter is	inence, Catheter, UTI (3) nce. cility must ensure that the ent of bladder and bowel on ervices and assistance to unless his or her clinical es such that continence is ain.	F	690			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		055247	B. WING			C)2/14/2023		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 W PEARL ST POMONA, CA 91768	<u>`</u>	721 1 4 12020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
indwelling cathete		necessary; nters the facility with an or subsequently receives one	F 69	0				
	as possible unless t demonstrates that c and	oval of the catheter as soon he resident's clinical condition atheterization is necessary; s incontinent of bladder						
	(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.							
	ensure that a reside receives appropriate restore as much non possible. This REQUIREMEN							
	review, the facility facindwelling catheter (the bladder into a back and services for one (Resident 1) who had infections (an infections (an infections), blathrough which the utilife-threatening con	on, interview, and record hiled to provide adequate tube that drains urine from ag outside of the body) care to of three sampled residents and a history of urinary tract on in any part of the urinary hadder, or urethra [tube rine leaves the body]), sepsis hplication of an infection), and						
	2) failed to properly nephrostomy cathet	ed Vocational Nurse 2 (LVN assess Resident 1 's er (tube, a small and flexible ed through the skin of the						

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		055247	B. WING			C 2/14/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 215 W PEARL ST POMONA, CA 91768		2/1-1/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 690	small bag connected (matter that settles in 2.On 2/3/2023, Treat not perform a clean to washing, maintaining preparing a clean fiel sterile instruments ar contamination of sup site dressing change used in patient care to microorganisms and as free from microorgetechnique during the Resident 1's nephrotindicated by the facilititled, "Nephrostomy and Maintenance." This deficient practicular in a urinary tract infector of the urinary system urethra [tube through body]) and sepsis (lift of an infection) to Refindings: A review of Resident indicated the facility at 8/19/2022. Resident included fracture (bremandible (jawbone), arm-humerus (long both)	idney and urine drains into a to the tube) for sediments iside the catheter tubing). ment Nurse 1 (TXN 1) did echnique (involves hand a clean environment by dusing clean gloves and indepreventing direct plies) during a nephrostomy nor a sterile (strategies to reduce exposure to maintain objects and areas ganisms as possible) irrigation (flushing) of instomy tube and as ty's policy and procedure and Cystostomy Tube Care the had the potential to result ection (an infection in any part is kidneys, bladder, or in which the urine leaves the e-threatening complication	F 69	90			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	(X3) DATE SURVEY COMPLETED				
		055247	B. WING		C 02/14/2023
				215 W PEARL ST	02/14/2023
PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES	D BE COMPLETION
F 690	A review of Resident Hospital (GACH) 1, 3 an inpatient treatment featuring licensed nuprofessionals) supple 8/19/2022 indicated procedure or methodorgans or other tissuredle-puncture of the small and flexible tube the skin of the lower urine drains into a small and flexible tube the skin of the lower urine drains into a small and flexible tube the skin of the lower urine drains into a small and flexible tube the skin of the lower urine drains into a small and flexible tube the skin of the lower urine drains into a small and flexible tube the skin of the lower urine drains into a small and flexible tube the skin of the lower urine drains into a small and flexible tube the skin of the lower urine drains information) dependent, required two persons during the person for dressing. A review of Resident 8/24/22 and revised 1 had a right nephrogoals included Resident symptoms of a uninterventions included record, and report to symptoms for urinary blood-tinged urine, coincreased pulse, incident inciden	1's General Acute Care Skilled Nursing Facility (SNF- nt and rehabilitation center arses and other medical emental orders dated right percutaneous (medical I where access to inner e is done via	F 690		

	A. BUILDING	DATE SURVEY COMPLETED				
		055247	B. WING			C
				215 W PEARL ST	I	02/14/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	HOULD BE	(X5) COMPLETION DATE
F 690	urine, fever, chills, al in behavior, and chain behavior and	tered mental status, change inge in eating patterns. y 's Progress Notes dated in, indicated Resident 1 was soft flexible tube placed in the hand or arm and in medicine or fluids) medication) for a urinary 's Progress Plan, dated 9/9/2022, sis and complicated urinary 1's Facility Progress Notes 8:42 pm, indicated the sted from the GACH 2 with flexible tube placed inside ver medicine or fluids) and pyelonephritis (kidney 1's Progress Notes dated om, indicated Resident 1 dition that included, elevated d heart rate, and episodes of esident 1's vital signs e 103-degrees Fahrenheit ween 97 to 99 degrees te/beat 140 (normal range is minute). The resident 's d with new orders that	F 69			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		055247	B. WING				C 1 14/2023
	ROVIDER OR SUPPLIER		,	215 W	PEARL ST DNA, CA 91768		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		BE	(X5) COMPLETION DATE
F 690	date 10/30/2022, ind impression/recomme severe sepsis. The e sepsis causes an infl body, if left untreated severe sepsis. Sever more of your body 's this inflammatory res affected, the heart, the and/or liver. A review of Resident 11/5/2022, at 10:53 at 1 was readmitted to the pyelonephritis. 1. During an observate bedside and concurred 10:05 am., Resident cloudy urine and paled Certified Nursing Assendent 1's urine was sediments inside the During an observation and concurrent intervent, LVN 1 stated the Resident 1's nephrosediments in the uring an infection. During an interview of LVN 2 stated she was nephrostomy tube, ""	s Progress Notes, admit icated the indation for Resident 1 was ducation materials indicated, ammatory response in the I, sepsis can progress to be sepsis occurs when one or a organs is damaged from ponse. Any organ can be ne brain, the kidneys, lungs, 1's Progress Notes dated am, indicated that Resident the facility with a UTI and tion at Resident 1's pent interview on 2/1/2023, at 1's nephrostomy tube had be-yellow chunks inside.	F	690			

	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER: A. BUILDING O55247 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 215 W PEARL ST POMONA, CA 91768 SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION) A. BUILDING O2/ O2/ STREET ADDRESS, CITY, STATE, ZIP CODE 215 W PEARL ST POMONA, CA 91768 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ILATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	DATE SURVEY COMPLETED			
		055247	B WING			C
	ROVIDER OR SUPPLIER	033241		215 W PEARL ST	I	02/14/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETION DATE
F 690	tubing. LVN 2 stated Resident 1 's assess 2. During an observation out of the treatment Resident 1 's room. Her pants pocket, curdressing, and cut the disinfecting the sciss During an observation Border (sterile dress 11/7/2026, indicated During a concurrent 8:55 am, TXN 1 put Resident 1 's room, and opened the private the supplies to change Resident 1 's bedsic disinfect the top of the control, raised, and for same pair of gloves. Covering the nephros TXN 1 from one correct dressing had a dark middle of the gauze. Temoved the soiled good clean gloves, took a syringe, and flushed tube. TXN 1 did not control to create a sterile fit tubing.	she did not document sment. Ation on 2/3/2023, at 8:50 At 1 (TXN 1) pulled supplies cart located outside of TXN 1 pulled scissors out of topen a packet of sterile asterile dressing without ors. An of the Comfort Foam ing pack), expiration date of the dressing was sterile. At on clean gloves outside of entered the room, touched acy curtains. TXN 1 placed ge the dressing on top of the table. TXN 1 did not able. TXN 1 grabbed the bed lattened the bed wearing the Resident 1's dressing, stomy tube, was lifted by the prown substance in the	F 69			
		esident 1 's dressing was a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		055247	B. WING _			C 2/14/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 215 W PEARL ST POMONA, CA 91768			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 690	should have been ch Resident 1's dressir and the tape holding not look clean or sec stated the nephrostor flushing were to be d supplies. TNX 1 state taking care of a resid tube. During a record revie on 2/3/2023, at 9:40 (DON) stated it was in nephrostomy site we nurses would assess blood and notify the prindicate something g stated it was not norrophrostomy site. The nephrostomy tubing and the nurses had to side table first and the they needed. The DO not follow the facility during dressing channephrostomy tubing, infection to the patier. During a review of the procedures, titled "Net Tube Care and Maint 9/2/2022, indicated the nephrostomy or cyster flexible tube surgically."	like it had dry blood, and it anged. TXN 1 stated ang was peeling on one side the dressing in place did ure. At 9:15 am, TNX 1 my dressing change and one with non-sterile and this was her first-time ent that had a nephrostomy and concurrent interview am, the Director of Nursing mportant to clean the ll and she expected her the nephrostomy site for dry physician because this might of pulled out. The DON mal to have dry blood on the le DON stated flushing of ang was a sterile procedure to sanitize the equipment DN stated if the nurses did 's policy and procedure ges and flushing of the they might introduce an int. The facility 's policy and ephrostomy and Cystostomy tenance," revised on that residents with postomy tubes (a small y inserted into the bladder to urethra) will receive care	F 6	90			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_			
		055247	B. WING			02/	14/2023
	ROVIDER OR SUPPLIER OAKS CARE CENTER			21	TREET ADDRESS, CITY, STATE, ZIP CODE 15 W PEARL ST OMONA, CA 91768		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 745 SS=D	the physician 's order the type and frequency Procedure for changing up a clean field on the touch technique to recontainer. Perform had clean gloves. Remove remove gloves, pulling dressing. Discard into Perform hand hygiene The procedure for irriguisetting up a sterile fiesusing a no touch technygiene and apply ste Provision of Medically CFR(s): 483.40(d) §483.40(d) The facility medically-related social maintain the highest pand psychosocial well This REQUIREMENT by: Based on interview a failed to ensure medicing provided for one of the (Resident 1) and as in Social Services policy. Resident 1 did not recomedical treatment use movements such as a different body parts) services.	d maintenance of the nall be in accordance with res. The orders shall specify by of dressing changes. In go a dressing include: to set a overbed table. Use no move supplies from and hygiene and put on a the old dressing carefully, go inside out over the appropriate receptacle. It is and put on clean gloves. It is and put on clean gloves. It is and put on clean gloves. It is referred to a the overbed table and nique, perform hand arile gloves. It is referred to a train or oracticable physical, mentally being of each resident. It is not met as evidenced and record review, the facility cally related services were ree sampled residents and procedure. The provide the facility is and procedure.		745			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		NSTRUCTION	(X3) DATE COMP	SURVEY LETED
		055247	B. WING			l	C 14/2023
	ROVIDER OR SUPPLIER OAKS CARE CENTER			215 V	ET ADDRESS, CITY, STATE, ZIP CODE V PEARL ST ONA, CA 91768	<u> 021</u>	14/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 745	Continued From page 20		F7	745			
	This deficient practice in a decline in physica well-being for Resider						
	Finding: A review of Resident 1's Admission Record indicated the facility admitted the resident on 8/19/2022. Resident 1's medical diagnosis included fracture (break) of the right and left mandible (jawbone), fracture of the left arm-humerus (long bone that runs from the shoulder and shoulder blade to the elbow), and nephrostomy catheter (a small and flexible tube -catheter- placed through the skin of the lower back into the kidney and urine drains into a small bag connected to the tube).						
	8/19/2022, indicated Inursing facility (SNF- staff and equipment to and/or skilled rehability related health service in-patient (stay overnity)	1's Physician's order, dated Resident 1 required skilled a nursing facility with the progress of the services and other so services given on an any or rehabilitation care on a					
	A review of the GACH's Surgical Services- Skilled Nursing Facility Supplemental Orders, dated 8/19/2022, indicated a follow up outpatient visit to the Urologist.						
	(MDS- an assessmen	1's Minimum Data Set t and screening tool), dated Resident 1 had moderate					

AND PLAN OF CORRECTION DENTIFICATION NUMBER: A. BUILDING	(X3) DATE SUF COMPLET						
		055247	P WINC			С	
NAME OF D	DOVIDED OD SUDDI IED	055247	B. WING _	CTDEET ADDDESS CITY STATE 71	D CODE	02/14/	2023
NAIVIE OF PI	ROVIDER OR SUPPLIER				PCODE		
COUNTRY	OAKS CARE CENTER						
PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE A CROSS-REFERENCED T	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
F 745 Continued From page		e 21	F 7	745			
1 743	impaired cognition (a process information) dependent, required two persons during to moves between surfaturns side to side and bed), and required experson for dressing. A review of the Gene (GACH 1) Orthopedia focuses on the care of ligaments, tendons, a 10/18/2022, indicated physical therapy to reper week and to be sreason or urgency for to Resident 1's left his scheduling instruction range of motion (RO a joint) of the elbow a heat massage, and represent the lower back into the	chility to understand and a Resident 1 was totally physical assistance from ransfers (how resident aces from lying position, d positions body while in extensive assistance from one aral Acute Care Hospital 1's c (a branch of medicine that		45			
	_	on 12/27/2022, at 2:30 pm, sible Party (RP) stated					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		055247	B. WING			02/	14/2023
	ROVIDER OR SUPPLIER OAKS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 215 W PEARL ST POMONA, CA 91768		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 745	General Acute Care Is several surgeries and appointments with the stated Resident 1 recomedical treatment use movements such as significant body parts) a received PT at the facilitis insurance did not had to change insurance overed. The RP states the Director of Social worker) and SSD informely with insurance is contact the case man she contacted the CN could not help her with contact the Admission stated the AC informed a managed care plan benefits or consequent insurance plan. The Isplan took effect Nove almost the end of the not received PT service another concern was be seen at GACH 1 for appointments (urolog located on a different the new insurance plan GACH 1. The RP stated feel resident already had appointments at GAC	tted to the facility from the Hospital (GACH) after having I required follow up a GACH surgeons. The RP serived Physical Therapy (PT-led to restore functional standing, walking, moving at the GACH and had not cility. The RP stated when ity informed her Resident cover PT services and she ince plans for PT to be led she requested help from Services (SSD, social formed the RP she did not issues, and she had to larger (CM). The RP stated if and was informed the CM in the insurance concern to in Coordinator (AC). The RP led her that she could select but was not explained the inces of selecting such it was month and Resident 1 had ces. The RP stated that that Resident 1 could not for follow up medical ity) because GACH 1 was county than the facility and an was not accepted by ing frustrated because the missed follow up	F	745			

NAME OF PROVIDER OR SUPPLIER COUNTRY OAKS CARE CENTER (X4) ID SUMMARY STATE (EACH DEFICIENCY M REGULATORY OR LSC) F 745 Continued From page 2 facility. The RP stated for Resident 1's well-being not knowing what to do. not receiving support from concerned because she happen with Resident 1 facility was not providing on how to address this is	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED			
		055247	B. WING			C 02/14/2023	
				STREET ADDRESS, CITY, STATE, ZIP C 215 W PEARL ST POMONA, CA 91768	CODE	02/14/2023	
PRÉFIX	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECTIVE ACT CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ION
F 745	facility. The RP state Resident 1's well-bei not knowing what to not receiving suppor concerned because happen with Resider facility was not provi on how to address th help me. I don't know During an interview of SSD stated being averpresentative (RP) questions regarding follow up appointment contacted the facility admission coordinate RP. The SSD stated Resident 1 with trans helped with the sche appointments. The SE Resident 1 to receive insurance did not constated that the first ti today and prior to the During an interview of the Case Manager (of worked with Resider insurance was mana (services that can be who are neither skille personnel). The CM residents who were a (services provided by	and feeling very concerned for ing and was worried about do. The RP stated she was at from the facility and felt she did not know what would not 1. The RP stated the ding her with any information his issue, "Please, please what to do." On 12/27/22, at 3:20 pm, the ware that the resident's had insurance concerns and scheduling GACH 1 urology ints. The SSD stated she is case manager and the for so that they could help the she had only helped sportation, and she had not induling of outside in SSD stated the RP wanted in PT, but the resident's ever the services. The SSD in the she talked to the RP was as interview. On 12/27/2022, at 4:08 pm, CM) stated he had not in 1 because the resident's inged care-custodial care are given safely by individuals and nor licensed medical stated he only worked with approved for skilled services by a licensed professional for ooting, maintaining, or	F 7	745			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE S	ETED
		055247	B. WING		02/4	
NAME OF PROVIDER OR SUPPLIER COUNTRY OAKS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 215 W PEARL ST POMONA, CA 91768	02/1	14/2023
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD) BE	(X5) COMPLETION DATE
F 745	minimize the effects of disability). The CM standitted to the facilit now on a Health Main (HMO, type of health limits coverage to car or contract with the Happlied to request for Resident 1 and state Resident 1 with sche appointments to GAC insurance. The CM standing an interview of Coordinator was protext with selection of an in During an interview of Resident 1 stated he of care was, "No one laying here, and I do here." Resident 1 stated he of care was, "No one laying here, and I do here." Resident 1 stated he facility did not giv PT was provided at the facility. Resident him to get PT exercises the facility. Resident him to get PT exercises the facility. Resident 1 stated he appointments with the stated he did not known appointments again. Very concerned for his titled "Social Services indicated the social widesignee, will pursue at the facility titled "Social Services indicated the social widesignee, will pursue at the facility titled social services indicated the social widesignee, will pursue at the facility titled social services indicated the social widesignee, will pursue at the facility titled social services indicated the social widesignee, will pursue at the facility titled social services indicated the social widesignee, will pursue at the facility titled social services indicated the social widesignee, will pursue at the facility titled social services indicated the social services indicated the social widesignee, will pursue at the facility titled social services indicated the social services in	of injury, illness, or sated that Resident 1 was an on custodial care and was intenance Organization insurance plan that usually refrom doctors who work for IMO). The CM stated he reskill nursing services for death had not helped duling follow up urology CH 1 or with selection of an an otated the Admission bably helping Resident 1 insurance plan. In 12/27/2022, at 4:54 pm, adid not know what his plan tells me anything, I'm just in the known how long I will be ted he just laid in bed and the hospital, and he had not is since he was admitted to a stated it was important for the see because he wanted to to walk and go home. The had missed follow up the Urologist at GACH 1 and the when he would get those Resident 1 stated he was is health. In y's Policy and Procedure, so," revised on 9/22/2022 worker, or social service	F 745			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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		055247	B. WING _			02/	14/2023
NAME OF PROVIDER OR SUPPLIER COUNTRY OAKS CARE CENTER			21	TREET ADDRESS, CITY, STATE, ZIP CODE 15 W PEARL ST OMONA, CA 91768			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 745	needs of the resident appropriate discipline residents' needs may with the facility to represent goals, dischart encouragement to particular encouragement to particular family, and or recare options and their referrals and obtaining outside entities. Assist and legal matters the service designee, will	nt and attempts to meet the will be handled by the . Services to meet the include maintaining contact ort on changes in health, age planning, and rticipate in care planning. In and educating residents, presentatives about health armifications. Making gneeded services from string residents with financial social worker, or social monitor the residence physical, mental, ending.	F	745			
F 791 SS=D	Routine/Emergency ECFR(s): 483.55(b)(1)- §483.55 Dental Service The facility must assist routine and 24-hour expectations §483.55(b) Nursing Foundation The facility- §483.55(b)(1) Must proutside resource, in a control of this part, the follow the needs of each resource (i) Routine dental service under the State plan) (ii) Emergency dental	Dental Srvcs in NFs c(5) ces st residents in obtaining mergency dental care. acilities. rovide or obtain from an accordance with §483.70(g) ing dental services to meet sident: vices (to the extent covered	F	791			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		055247	B. WING		C 02/14/2023	
NAME OF PROVIDER OR SUPPLIER COUNTRY OAKS CARE CENTER			ST 21	TREET ADDRESS, CITY, STATE, ZIP CODE 5 W PEARL ST DMONA, CA 91768	02/14/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO		BE COMPLETION	
F 791	substitute of the substitute o	tments; and transportation to and from the tions; promptly, within 3 days, refer r damaged dentures for referral does not occur within nust provide documentation of ure the resident could still eat y while awaiting dental enuating circumstances that the application of the loss or damage of the ty's responsibility and may not for the loss or damage of the din accordance with facility ity's responsibility; and the assist residents who are participate to apply for ental services as an incurred der the State plan. This not met as evidenced on, interview, and recordalled to ensure necessary ded for one of three sampled	F 791			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		055247	B. WING			C	
NAME OF PROVIDER OR SUPPLIER COUNTRY OAKS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODI 215 W PEARL ST POMONA, CA 91768	<u>l</u>	02/14/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		DATE		
F 791	Continued From pag	e 27	F 7	91			
	1	mouth) surgeon (a surgical e restoration, reconstruction, uman body) since					
	discomfort, and teeth particles) to Residen result in periodontal infection that damag	e resulted in pain, gum n buildup (food and saliva t 1 and had the potential to disease (a serious gum es the gums and can and can lead to tooth loss.)					
	Findings:						
	indicated the facility 8/19/2022. Resident included fracture (bromandible (jawbone), arm-humerus (long b	admitted the resident on 1's medical diagnosis eak) of the right and left and fracture of the left one that runs from the er blade to the elbow).					
	8/20/2022, indicated health problems due right and left mandib required assistance mouth cleaning with measure) of Chlorhe wash) solution 0.12% infection, pain, or ble Resident 1 to comply daily. The intervention arrangements for de as needed. Monitor, needed any signs ar	Resident 1 had oral/dental to wiring of the mouth and le fracture. Resident 1 with oral care and required 15 milliliters (mL, unit of xidine gluconate (mouth 6. The goals included: free of reding in the oral cavity and y with mouth care at least ons included to coordinate intal care with transportation document, and report as and symptoms of oral, dental tention, such as pain of the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		055247	B. WING		C 02/14/2023
NAME OF PROVIDER OR SUPPLIER COUNTRY OAKS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 215 W PEARL ST POMONA, CA 91768	02/14/2023
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 791	Continued From pag		F 79	ı	
	collection of pus), de broken down) in the bleeding, and inflame also included providi Activity of Daily Livin healthcare that refers personal hygiene.	palate, abscess (painful obris (remains of something mouth, cracked lips or ed tongue. The interventions ng mouth care as part of g (ADL, term used in s to self-care activities)			
	(MDS- an assessme 8/26/2022, indicated impaired cognition (a process information) dependent, required two persons during t moves between surfaturns side to side and	nt and screening tool), dated Resident 1 had moderate ability to understand and Resident 1 was totally physical assistance from ransfers (how resident aces from lying position, d positions body while in xtensive assistance from one			
	Room Case Reques Maxilla and Mandible open fracture (complete left and right mandone in the human set teeth in place, helps lower jawline) body, space in the bones and The preoperative dia	t 1's GACH 1's Operating t Order: Removal, Deep e, dated 9/2/2022, indicated lete or partial bone break) of indibular (mandible, largest kull that holds the lower with chewing, and forms the and maxillary sinus (hollow around the nose) fracture. In upper jaw, forms part of the ethal and mandible.			
		Plastic Surgery Instructions, 11:40 am, indicated a follow urgery. Wound care			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		055247	B. WING			00/		
NAME OF PROVIDER OR SUPPLIER COUNTRY OAKS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COE 215 W PEARL ST POMONA, CA 91768)E	<u> UZ</u>	14/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI E APPROPRIA		(X5) COMPLETION DATE	
F 791	activity included ope possible a few times During an interview of Resident 1 stated he needed to be remove an appointment wou removal. Resident 1 due to the wires, "The blisters on my mouth wires, it's painful, son Resident 1 stated he 9/26/2022 the doctor appointment needed wires had to be removed. During an observation and concurrent intervam, Licensed Vocation, Licensed Vocation, Resident 1's lips wer irritation on the inner (painful sore) on his metal wire rubbing. During an interview of Dentist (D) 1 stated is the first time on 12/1 1 had a lot of buildup possible outcomes of were pain, periodont infections and inflam bone that surround a infection. D 1 stated out of her scope of pindividual health care	teeth twice daily and the ning mouth as much as per hour. on 12/27/2022, at 4:54 pm, a had wires on his jaw that he didn't know when lid be scheduled for the stated he could not chew hey hurt my mouth, I have a and lips because of these metimes my mouth bleeds." The had a GACH 1 visit on to to be scheduled because all	F 7	91				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
	055247		B. WING			C 02/14/2023	
NAME OF PROVIDER OR SUPPLIER COUNTRY OAKS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 215 W PEARL ST POMONA, CA 91768		02/14/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTIO		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 791	During an interview on Director of Nursing (Doutcomes of Residem assistance with teeth bleeding gums, cavition that causes swelling of mouth and jaw. During an interview on Resident 1 stated he his teeth because he wires. A review of the facilition titled, "Dental Service indicated the dental noidentified through the MDS assessment profine each resident's pladenture care shall be	Illow up referral to an oral In 2/3/2023, at 8:05 am., the pool of the possible at 1's not receiving staff brushing could result in the pes, gingivitis (gum disease of the gums), infection in his in 2/3/2023, at 11:20 am, was required help brushing was afraid of pulling out the pulling out the policy and procedures s," revised 9/22/2022 to eds of each resident are physical assessment and coesses and are addressed an of care. Oral care and provided in accordance and as specified in the plan	F 7	91			