STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055299	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loma Linda Post Acute	25383 Cole Street Loma Linda, CA 92354

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review, the facility failed to post the results of the facility's most recent recertification survey when it was discovered the survey results were not posted anywhere in the facility.This failure resulted in residents and visitors inability to read the survey results and assess facility's compliance with regulations which directly impacts their well-being and quality of life within the skilled nursing facility.Findings:During an observation on July 3, 2025, at 10:40 AM, a binder titled, Survey Results Binder 2022, 2023, 2024 was observed to be posted on the wall in one of the main hallways of the facility. Upon review of the contents of the binder, there was no survey information in the binder for the facility's recertification survey in 2024.During a concurrent observation and interview on July 3, 2025, at 10:43 AM, with the Administrator (ADMIN), the ADMIN stated the facility's previous recertification survey results were supposed to be in the survey binder. The ADMIN reviewed the survey binder and stated he did not know why the most recent survey results from 2024 were not in the binder. The ADMIN further reviewed the binder and stated he did not realize only complaints were in the binder. The ADMIN stated the facility did not post the survey results anywhere else in the facility and the only place it was supposed to be posted was in the survey binder. During a review of the facility's policy and procedure (P&P) titled, Examination of Survey Results, revised April 2017, the P&P indicated, Survey reports and plans of correction are readily accessible to the resident, family members, resident representatives and to the public .2. A copy of the most recent survey report and any plans of correction are kept in a binder in the residents' day room .

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to update Resident 30's Pre-admission Screening and Resident Review (PASARR - a federally mandated program that requires all individuals seeking admission to a Medicaid-certified nursing facility to be screened to ensure individuals who are identified to have a significant mental illness [SMI], intellectual or developmental disability [I/DD] are not inappropriately placed in skilled nursing facilities for long term care) when Resident 30 did not have his diagnoses of major depressive disorder, and anxiety disorder included in the PASARR assessment used to admit Resident 30 into the skilled nursing facility.This failure had the potential to result in Resident 30 being not accurately assessed regarding the need for supplemental treatment and services to better suite the needs of Resident 30. Findings:During a review of Resident 30's admission Record (contains medical and demographic information), the admission Record, indicated Resident 30 was admitted to the facility on [DATE], with diagnosis which included major depressive disorder (a mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and a diminished ability to function in daily life), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and Post Traumatic Stress Disorder (PTSD - a mental health condition triggered by experiencing or witnessing a terrifying, shocking, or dangerous event).During a review of Resident 30's Social History Assessment, signed February 12, 2025, the assessment indicated Resident 30 had been taking the medication buspirone (medication commonly used to treat anxiety) oral tablet 15 milligrams (mg - unit of measure) by mouth two times a day to treat anxiety since January 9, 2025. Further review indicated Resident 30 had been taking the medication Fluoxetine (medication commonly used to treat depression) oral tablet 20 mg one time a day to treat depression.During an interview on July 3, 2025, at 8:43 AM, with the Administrator (ADMIN), the ADMIN stated Minimum Data Set Nurse 1 (MDS 1) was responsible for reviewing completion and accuracy of PASARR assessments when residents were admitted into the facility.During a review of Resident 30's PASARR assessment dated [DATE] (PASARR assessment used to admit the resident into the facility), the PASARR indicated NO to the question 9, Diagnosed Serious Mental Illness [SMI]. Does the individual have a serious diagnosed mental disorder such as depressive disorder, anxiety disorder .During a concurrent interview and record review on July 3, 2025, at 9:00 AM, with MDS 1, MDS 1 stated it was her responsibility to review PASARR assessments for all newly admitted residents. Resident 30's PASARR assessment, dated January 9, 2025, was reviewed. The MDS 1 acknowledged the PASARR assessment did not accurately indicate Resident 30 had major depressive disorder, and anxiety disorder. MDS 1 stated it should have been identified that the PASARR did not include Resident 30's diagnoses for depression and anxiety and a revision to the PASARR should have been done, but was not. During a review of the facility's policy and procedure (P&P) titled, admission Criteria, revised March 2019, the policy indicated, .9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID), or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process. A. The facility conducts a Level 1 PASARR screen for all potential admissions .to determine if the individual meets the criteria for a MD, ID or RD. B. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process 1. The skilled nursing facility admitted the patient and never identified the PASARR discrepancy or revised/updated the PASARR assessment.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to notify the State Mental Health authority or the State Intellectual Disability authority of a resident's new mental illness diagnosis, when on December 3, 2024, Resident 31 was newly diagnosed with Paranoid Schizophrenia (a mental disorder that affects a person's ability to think, feel, and behave clearly).This failure had the potential to prevent Resident 31 to receive specialized care and services.Findings:A review of the face sheet (contains demographic information) reveals that Resident 31 was admitted to the facility on [DATE], with diagnoses which include bipolar disorder (a mental health condition characterized by significant and persistent shifts in mood, energy, and activity levels), unspecified dementia (a group of conditions that cause a progressive decline in cognitive abilities, such as memory, thinking, reasoning, and judgment) with other behavioral disturbance, and post-traumatic stress disorder (a mental health condition that develops after experiencing or witnessing a traumatic event).During a review of Resident 31's clinical record, the clinical record indicated on December 3, 2024, Resident 31 was diagnose with Paranoid Schizophrenia and Schizophreniform Disorder (a mental health condition where individuals experience psychotic symptoms like hallucinations, delusions, and disorganized speech). During a further review of Resident 31's clinical record, there is no documented evidence a PASSAR was completed upon receiving the newly diagnosis and the California Department of Health Services and the State Mental Health Department were not notified. During an interview with the Director of Nurses (DON) on July 2, 2025, at 10:56 AM, the DON stated that the MDS Coordinator is responsible for making the referral to the appropriate state-designated authority when a resident is identified as having an evident or possible Mental Disorder or related condition. During an interview with the MDS Coordinator on July 3, 2025, at 1:33 PM, the MDS Coordinator acknowledged that when there is a new diagnosis of Schizophrenia or a significant change in status was identified in a resident with a mental disorder or intellectual disability, the appropriate state mental health or intellectual disability authority must be promptly notified. The MDS Coordinator stated she can't explain the reason as of why the California Department of Health Services and the State Mental Health Department were not notified regarding Resident 31's new mental diagnosis and a new PASARR was not completed. During a concurrent interview, and record review with the DON on July 3, 2025, at 1:49 PM, the Policy and Procedure (P&P) titled, Psychotropic/Anti-Psychotropic Medication Use/PASSRR last revised on December 2016, was reviewed. The P&P indicated, Residents who are admitted from the community or transferred from a hospital and who are already receiving antipsychotic or psychotropic medications will be evaluated for the appropriateness and indications of use. The interdisciplinary team will (a) Complete PASRR screening (preadmission screening for mentally ill individuals), and facility will see the State program requirements for specific procedures on the completion of PASRR. The DON acknowledged that the facility's P&P was not followed. The DON stated, The facility must notify the state-designated mental health or intellectual disability authority promptly when a resident with MD or ID experiences a significant change in mental or physical status.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview, and record review, the facility failed to ensure physical therapy services were provided to one of two residents (Resident 35) sampled for rehabilitative and restorative services when Resident 35 did not receive physical therapy four times a week as ordered by the physician.This failure had the potential to contribute to a delay in Resident 35's ability to reach his highest level of physical functioning. Findings:During a concurrent observation and interview on June 30, 2025, at 1:08 PM, Resident 35 was lying in bed. When asked how his physical therapy was going, Resident 35 stated he did not think he was receiving physical therapy as often as he was supposed to.During a review of Resident 35's Physical Therapy Medicare PT [physical therapy] Evaluation & Plan of Treatment (outlines resident current level of functioning, diagnoses, goals and physical therapy treatment plan), dated May 19, 2025, the plan indicated Resident 35's start of care date was May 19, 2025, and Resident 35 had diagnoses which included end stage renal disease (the final, irreversible stage of chronic kidney disease (CKD). It occurs when the kidneys are no longer able to filter waste and excess fluid from the blood at a level sufficient to sustain life. At this point, individuals require dialysis or a kidney transplant), encephalopathy (A broad term for any brain disease that alters brain function or structure). Further review of the plan indicated Resident 35 was to have physical therapy four times a week for four weeks.During a review of Resident 35's care plan (an individualized plan of care for the medical treatment of a resident) titled, ADL [activities of daily living]/mobility, dated March 11, 2025, the care plan indicated, Resident has actual ADL/mobility decline and requires assistance related to encephalopathy .respiratory failure, wounds, ESRD [end stage renal disease] .legally blind . goals for this care plan included, .will have no significant declines in ADLs or mobility .physical therapy referral and treatment as indicated .During a review of Resident 35's physician's orders, an order dated May 19, 2025, indicated, PT [physical therapy 4x/week [four times a week] for 4 weeks.During a review of Resident 35's Service Log Matrix (document which outlines treatment services provided in a calendar layout), the log indicated Resident 35 only received three physical therapy visit sessions on the week of May 26, 2025 (instead of four as ordered by the physician).During a review of Resident 35's Physical Therapy Treatment Encounter Note(s) (notes documented from each physical therapy session), dated May 19, 2025 (start of care), through May 31, 2025, the notes indicated Resident 35 only received three physical therapy visit sessions on the week of May 26, 2025. The resident had a PT visit session on May 26, 28, and 29, of 2025. During a concurrent interview and record review on June 2, 2025, at 12:50 PM, with the Regional Rehab Resource (RRR), Resident 35's clinical record was reviewed. The RRR stated residents were supposed to receive physical therapy services in the frequency as ordered by the physician. The RRR further stated Resident 35 only had three physical therapy sessions during the week of May 26, 2025, and there was a missed visit on May 27, 2025. The RRR stated she was unable to find documentation regarding why the resident only had three physical therapy sessions that week or why the appointment on May 27, 2025 was missed. The RRR stated facility staff were expected to input documentation in the residents clinical record regarding missed visits, but they did not.During a review of the facility's policy and procedure (P&P) titled, Specialized Rehabilitative Services, revised December 2009, the P&P indicated, .2. Specialized rehabilitative services include the following: a. Physical Therapy .3. Therapeutic Services are provided only upon the written order of the resident's Attending Physician .During a review of the facility document titled, Best Practices: Daily Notes, (undated), the document indicated, Required daily for all patients when treatment was rendered or attempted .contains the reason why plan of care was discontinued or modified .include missed or refused treatments .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff provided nutritional services to one of one sampled residents (Resident 49) reviewed for dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys no longer function) when Resident 49 was not provided a sack lunch on multiple days in May 2025, and June 2025.This failure had the potential for Resident 49 to experience undesirable weight loss.Findings:During a review of Resident 49's admission Record (contains medical and demographic information), the admission Record, indicated Resident 49 was admitted to the facility on [DATE], with diagnoses which included chronic kidney disease (a condition where the kidneys are damaged and can't filter blood as well as they should), dependence on renal dialysis (the state where an individual's kidneys have permanently failed and they require regular dialysis treatments to sustain life), anemia in chronic kidney disease (condition in which the body does not have enough healthy red blood cells to carry oxygen to the organs), and sepsis (a serious condition in which the body responds improperly to an infection).During a concurrent observation and interview on June 30, 2025, at 9:17 AM, Resident 49 was lying in bed and stated he underwent dialysis three times each week.During an interview on June 30, 2025, at 2:56 PM, Resident 49 stated last Saturday June 28, 2025, he had dialysis but he didn't receive a sack lunch to take with him. Resident 49 further stated sometimes staff is behind and don't prepare his lunch in time before he leaves for dialysis and he gets really hungry because he also sometimes doesn't have breakfast. Resident 49 was unable to remember specifically what dates he didn't receive a sack lunch but stated it occurred on multiple occasions. During a review of Resident 49's physician's orders, an order dated May 21, 2025, indicated Resident 49 was to have dialysis procedures three times a week on Tuesday, Thursday and Saturday at an outside facility.During a review of Resident 49's Hemodialysis Communication Observation/Assessment (a document used to record the assessment of a dialysis patient before dialysis, at the dialysis center, and after dialysis upon return to the facility), dated May 1, 2025, through June 25, 2025, the assessments dated May 8, 2025, May 24, 2025, May 29, 2025, May 31, 2025, June 19, 2025, and June 24, 2025, all indicated No to the question whether a sack meal was provided to the resident for his dialysis appointment.During a review of Resident 49's clinical record, the facility's Electronic Health Record (EHR) indicated Resident 49 dry post dialysis weight (resident's weight without excess fluid accumulated between dialysis treatments) on April 3, 2025, was 174 pounds and Resident 49's dry post dialysis weight on July 1, 2025, was 165 pounds (5.17% weight loss).During a review of Resident 49's physician's orders, an order dated May 28, 2025, indicated Resident 49 was on a Renal diet [eating plan designed specifically for people with kidney disease or those on dialysis], mechanical soft texture [foods that have been altered to be easily chewed and swallowed], thin liquids consistency. In addition, a physician's order dated May 28, 2025, indicated, [name of nutritional supplement drink] 8 oz [ounces] 1 [one] time a day for supplement.During an interview on July 3, 2025, at 9:34 AM, with the Director of Nursing (DON), the DON stated Resident 49 was supposed to receive a sack lunch to take with him every day he has dialysis. The DON further stated he was supposed to receive sack lunches for his dialysis since the time he was first admitted since he was on dialysis when he came to the facility. The DON stated it was the responsibility of the nurse who admitted him at the facility to ensure a physician's order for a sack lunch was obtained from the doctor. The DON stated that was never done for the resident, but should have been.During a review of the facility's policy and procedure (P&P) titled, Dialysis, Coordination of Care and Assessment, revised March 2024, the P&P indicated, .While at the skilled facility: this facility has direct responsibility for the care of the resident, including the customary standard care provided by the facility and the following: .6. Notification of dietary for need of sack lunch on dialysis days will be done .11. Providing and monitoring any special diets.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure nursing staff provide a complete pain assessment when a Licensed Vocational Nurse 3 (LVN 3) and a Registered Nurse Supervisor 1 (RNS 1) were observed not performing a complete pain assessment during an emergency for Resident 278 who was experiencing chest pain.This failure had the potential to cause Resident 278 to experience a decline in health status and function.Findings:A record review of Resident 278's Face Sheet (a document which contains basic information about the resident) indicated Resident 278 was admitted to the facility on [DATE], with diagnoses which included presence of prosthetic heart valve (an artificial valve implanted to replace a damaged or diseased heart valve), paroxysmal atrial fibrillation (a condition where the upper chambers of the heart beat irregularly and rapidly), and hypertension (high blood pressure).During an observation On July 2, 2025, at 5:28 AM, A certified nursing assistant informed licensed vocational Nurse 3 (LVN 3) Resident 278 was experiencing pain. Upon arriving at Resident 278's room, Resident 278 was found in bed, supine, on room air, and covered with a blanket up to the neck. LVN 3 asked Resident 278 about the pain's location and intensity on a 0-10 scale. Resident 278 stated, the pain is 10/10 in the middle. LVN 3 said, The doctor prescribed Norco for pain; I will give you Norco. There were no further pain assessment done concerning the chest pain. LVN 3 proceeded to check Resident 278's vital signs. Resident 278 vital signs were as follows: blood pressure 121/66, heart rate 82, and oxygenation was 90% on room air. Resident 278 was able to sit up, scoot to the bed's edge, and place both feet on the floor. During an observation on July 2, 2025, At 5:38 AM, Registered Nurse Supervisor 1 (RNS 1) arrived at the scene, RNS 1 asked Resident 278 about the pain's location and intensity, and Resident 278 reiterated it was 10/10 in his mid-chest. RNS 1 informed Resident 278 that she needed to call 911 and left the room. There was no further pain assessment by RNS 1. During an Interview with LVN 3 on July 2, 2025, at 6:45 AM, LNV 3 was asked to describe the facility's protocol, pain assessment, and interventions for chest pain. LVN 3 stated, I called the Registered nurse supervisor, and then she called 911 because the patient was having chest pain. There was no further explanation given concerning pain assessment procedures.A review of LVN 3's Performance Evaluation, dated June 24, 2024, in the Self-Evaluation section, completed by LVN 3 indicated, In what areas associated with your job would you like more training? LVN3 responded: Patient assessment.During a review of the LVN job description on July 2, 2025, at 10:41 AM, with the director of staff development (DSD), the LVN job description was reviewed. It indicated a LVN Must demonstrate knowledge and skills necessary to provide care appropriate to the age-related needs of the residents served. Must possess the ability to make independent decisions when circumstances warrant such actions . must be knowledgeable of nursing and medical practices and procedures, as well as laws regulations and guidelines that pertain to nursing care facilities . Must possess the ability to plan, organize, develop, implement, and interpret the programs, goals, objectives, policies and procedures, etc., that are necessary for providing quality care. LVN 3 actions did not follow the expectations detailed in the job description.During an interview with RNS 1 on July 2, 2025, at 7:04 AM, RNS 1 was asked to describe the facility's protocol, pain assessment, and interventions for chest pain. RNS 1 stated, we go in, look at the residents and make an assessment. When asked how she completes a chest pain assessment, the RNS 1 said that when a resident complains of chest pain, it is the facility's protocol to call 911. When questioned about the thoroughness of her pain assessment in relation to the residents' symptoms, RNS 1 did not provide a further explanation. RNS 1 was unable to explain how she completed a chest pain assessment and repeatedly said we call 911. There was no further explanation given concerning pain assessment procedures. During a review of RNS 1's Performance Evaluation, dated May 21, 2025, the Self-Evaluation section, completed by RNS 1, indicated, In what areas associated with your job would you like more training? RNS 1 responded: NADuring a review of the RN job description on July 2, 2025, at 10:41 AM with DSD, the RNS job description was reviewed. It indicated, .Perform skilled care assessments. Respond to and monitor care issues and changes in condition. Coordinate and respond to medical emergencies. Report significant findings or changes in condition and potential concerns to the director of nursing. Oversee direct care activities to ensure care delivery is consistent and follows policies and procedures. RNS 1 actions did not follow the expectations detailed in the job description.During an interview and record review with the Director of Nursing (DON) on July 3, 2025, at 8:12 AM, the facility's Policies and Procedure (P&P) titled, Staffing, Sufficient and Competent Nursing revised August 2022, was

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff provided assessment and monitoring for one of one sampled residents (Resident 49) reviewed for dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys no longer function) when there was no documented evidence staff assessed Resident 49's dialysis access site (the location where a dialysis machine is connected to a patient) after Resident 49 dialysis procedure on June 14, 2025, and June 17, 2025. This failure had the potential for a delay in the staff identification and subsequent treatment of possible dialysis associated complications such as symptoms of infection, bleeding or dislodgement of the dialysis access site for Resident 49. Findings:During a review of Resident 49's admission Record (contains medical and demographic information), the admission Record, indicated Resident 49 was admitted to the facility on [DATE], with diagnoses which included chronic kidney disease (a condition where the kidneys are damaged and can't filter blood as well as they should), dependence on renal dialysis (the state where an individual's kidneys have permanently failed and they require regular dialysis treatments to sustain life), anemia in chronic kidney disease (condition in which the body does not have enough healthy red blood cells to carry oxygen to the organs), and sepsis (a serious condition in which the body responds improperly to an infection). During a concurrent observation and interview on June 30, 2025, at 9:17 AM, Resident 49 was lying in bed and stated he underwent dialysis three times each week.During a review of Resident 49's physician's orders, an order dated May 21, 2025, indicated Resident 49 was to have dialysis procedures three times a week on Tuesday, Thursday and Saturday at an outside facility.During a review of Resident 49's care plan (a medical plan of care) titled, Dialysis, dated January 7, 2024. The care plan indicated, The resident needs hemodialysis r/t [related to] renal failure .Goal .The resident will have immediate intervention should any s/sx [sign and symptoms] of complications from dialysis occur . Interventions listed for this care plan indicated, . Monitor/document/report PRN [as needed] any s/sx of infection to access site: redness, swelling, warmth or drainage .Monitor/document/report PRN [as needed] s/sx of the following: bleeding, hemorrhage .During a review of Resident 49's Hemodialysis Communication Observation/Assessment (a document used to record the assessment of a dialysis patient before dialysis, at the dialysis center, and after dialysis upon return to the facility), dated June 14, 2025, the tool indicated for the section that was supposed to be completed by facility staff upon return to the facility post dialysis treatment to be completed by Licensed Nurse Post dialysis treatment, it was blank next to Access site: swelling, redness, drainage, pain, or no complications. In addition, the section for Resident General condition upon return to facility . was left blank, and the section for pain level and location was left blank.During a review of Resident 49's Hemodialysis Communication Observation/Assessment, dated June 17, 2025, the tool indicated for the section that was supposed to be completed by facility staff upon return to the facility post dialysis treatment to be completed by Licensed Nurse Post dialysis treatment, it was blank next to Access site: swelling, redness, drainage, pain, or no complications.During a concurrent interview and record review on July 3, 2025, at 9:34 AM, with the Director of Nursing (DON), Resident 49's Hemodialysis Communication Observation/Assessments, dated June 14, 2025, and June 15, 2025, were reviewed. The DON stated staff were supposed to assess the access site and status of dialysis residents upon their return to the facility post dialysis to ensure there was no complications or bleeding from the access site. The DON further stated it was important that residents were assessed immediately upon return to the facility because a lot can change quickly if there were complications. The DON stated staff should have done the assessment of the resident and documented it (their assessment) of the resident on the Hemodialysis Communication Observation/Assessment, notes dated June 14, 2025, and June 17, 2025, but they did not.During a review of the facility's policy and procedure (P&P) titled, Dialysis, Coordination of Care and Assessment, revised March 2024, the P&P indicated, .While at the skilled facility: this facility has direct responsibility for the care of the resident, including the customary standard care provided by the facility and the following: Assessment of the resident, including: .the condition of the resident's dialysis access site or device .a description of the resident's general condition .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055299	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loma Linda Post Acute	25383 Cole Street Loma Linda, CA 92354

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals stored in the facility were not expired when on July 2, 2025, three over-the-counter bottles of medications were found to be stored in the medication storage room past their expiration date. This failure had the potential for the expired medications to be accessed and administered to a vulnerable population of 77 residents, potentially resulting in altered effectiveness of the medication and worsening of the residents' symptoms, requiring medical intervention.Findings:On July 2, 2025, at 7:21 AM during the inspection of the medication storage room, three over the counter bottles of expired medications were found stored in a medication cabinet: Simethicone (a medication used for gas) expired January 2025, Vitamin A - expired June 2024, and Vitamin B complex - expired September 2024.During an interview with the Registered Nurse Supervisor (RNS) on July 2, 2025, at 7:25 AM, the RNS acknowledged that the Simethicone, Vitamin A, and Vitamin B complex medications were expired and stated, these should have been discarded since they're expired.During a concurrent interview and record review of the Policy and Procedure (P&P) titled, Medication Storage in the Facility dated June 2016, the P&P was reviewed with the Director of Nurses (DON) on July 2, 2025, at 9:03AM. The P&P indicated, All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner. The DON stated the medication should have been discarded and replaced.During a concurrent interview and record review, the P&P titled, Storage of Medications, revised April 2007, the P&P was review with the DON on July 2, 2025 at 9:03 AM. The P&P indicated, 4. The facility shall not use discontinued, expired, or deteriorated drugs and biologicals. The DON stated that the Simethicone - expiration date January 2025, Vitamin A - expiration date July 2024, and Vitamin B complex - expiration date September 2024 should have been discarded and replaced. The DON acknowledged that the facility's P&P were not followed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055299	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loma Linda Post Acute	25383 Cole Street Loma Linda, CA 92354

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 dishwashing equipment and food serving utensils were kept in a sanitary condition when:1. The dish drying racks were found to be unsanitary.2. Three scoops stored in a clean storage drawer were found to have dry food particles sticking on the inside part of the scoops.3. Four (4) bags of wheat tortilla were found in the refrigerator past expiration date of June 25, 2025.These failures had the potential to cause cross-contamination of food prepared in the kitchen which can cause severe illness and even be fatal for the 77 vulnerable residents who resided at the facility.Findings:1. During the dishwasher area inspection on July 1, 2025, at 9:42 AM, the dish drying racks (sanitized dishes are placed on these dish racks to air dry) were observed to have significant amount of black-colored substance build-up, scratches, cracks and corrosions in the interior and exterior walls and on the supporting pillars of the drying racks.During an interview with the Director of Kitchen 1 (DOK 1) on July 1, 2025, at 9:50 AM, the DOK 1 confirms the problem and recognizes the risk of food becoming cross contaminated due to the unsanitary drying racks. DOK 1 explained that she had been trying to order new drying racks for some time, but the supplier has been taking longer than expected to ship them. 2. During the inspection of kitchen drawers on July 1, 2025, at 10:03 AM, three scoops with dry food residue sticking on the inside of the scoops were found stored in a clean drawer among other clean scoops.During an interview with DOK 1 on July 1, 2025 at 10:03 AM, the DOK 1 confirmed three scoops with dry food residue sticking on the inside of the scoops were found stored in a clean drawer among other clean scoops. DOK 1 can't explain why these unsanitary scoops are stored in a clean drawer with other clean scoops.3. During an inspection of the walk-in refrigerator on June 30, 2025, at 7:56 AM, four (4) bags of wheat tortilla with an expiration date of June 25, 2025, were found on the shelf.During an interview with DOK 1 on June 30, 2025 at 7:56 AM, DOK 1 confirmed the expired tortilla bags found in the refrigerator. DOK 1 further stated they should have been discarded on June 25, 2025, rather than being kept on the shelf. During a concurrent interview and record review on July 2, 2025, at 10:52 AM with DOK 1, the facility's undated Policy and Procedure (P&P) titled, Sanitation was reviewed.The P&P indicated, 1. The Food and Nutrition Services Director (FNSD) is responsible for training employees in sanitation fundamentals and ensuring the use of proper techniques . 3. The FNSD is tasked with selecting and ordering all necessary equipment for the Food and Nutrition Service Department after consulting with the Administrator and Facility Registered Dietitian as needed . 11. All utensils, counters, shelves, and equipment must be clean, well-maintained, and free from breaks, corrosion, open seams, cracks, and chipped areas.DOK 1 stated the P&P were not followed.During a concurrent interview and record review on July 2, 2025, at 10:52 AM with DOK 1, the facility's undated P&P titled, Storage of Food and Supplies, was reviewed.The P&P indicated, No food will be kept longer than the expiration date on the product.The DOK 1 stated the P&P were not followed.During a record review of the FDA Federal Food Code, dated 2022, 4-601.11 indicated, (C) Non-FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. in addition, The objective of cleaning focuses on the need to remove organic matter from food-contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate and insects and rodents will not be attracted.