

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056079	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025
NAME OF PROVIDER OR SUPPLIER Glendora Grand, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 805 W. Arrow Hwy. Glendora, CA 91740	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34273</p> <p>Based on interview and record review, the facility failed to notify one of eight sampled residents' (Resident 4's) physician(s) and responsible party according to the facility's policies and procedures (P&P) titled, Notification of Changes, and Change in a Resident's Condition or Status by failing to ensure:</p> <ol style="list-style-type: none"> 1. Licensed Nurses (all licensed nurses that assigned to care for Resident 4) notified Resident 4's physician(s) and Resident 4's family and/or responsible party (RP) when Resident 4 repeatedly refused to be treated by the podiatrist (medical doctor who specializes in the treatment of disorders of the foot, ankle, and the lower leg), for the year of 2024. 2. Licensed Nurses notified Resident 4's physician regarding the condition of Resident 4's toenails. <p>These failures resulted in Resident 4 to be transferred and admitted to the General Acute Care Hospital (GACH) 1, on 2/13/25, for intravenous (IV, given directly into the blood stream through the vein) antibiotic (medications used to treat infections) to treat right toe osteomyelitis (inflammation of bone or bone marrow, usually due to infection).</p> <p>Cross reference: F687, F656, and F684</p> <p>Findings:</p> <p>During a review of Resident 4's Admission Record (AR), the AR indicated Resident 4 was originally admitted to the facility on [DATE] with diagnoses that included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 4's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 12/10/24, the H&P indicated Resident 4 could make needs known but could not make medical decisions.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 4's CP titled, Care Plan Report. dated 12/10/24, the CP indicated Resident 4 was at risk for clinical or social decline due to Resident 4's refusal to shower, refusal of assistance with Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily), and refusal of treatment and medications. The CP's goal indicated for Resident 4's family members and/or staff to assist in making decisions for health and personal care and to inform Resident 4 of risks and consequences of the choices Resident 4 made daily. The CP's interventions included for staff (in general) to monitor Resident 4 for episodes of noncompliance and to notify the physician for possible treatment, and to refer Resident 4 for psychological (related to the mental and emotional state of a person) and/or psychiatric (relating to mental illness or its treatment) consultation as ordered by the primary physician.</p> <p>During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 1/26/25, the MDS indicated Resident 4's cognition (ability to remember and process information) was moderately impaired. The MDS indicated Resident 4 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating, oral (having to do with the mouth or speaking) hygiene, toileting hygiene, lower body dressing, and personal hygiene. The MDS indicated Resident 4 required partial/moderate assistance (helper does less than half the effort) with showering/bathing, upper body dressing, and with putting on/taking off footwear.</p> <p>During a review of Resident 4's Nursing Weekly Assessment (NWA), dated 1/14/25, 1/22/25, 1/28/25, and 2/5/25, the NWA indicated Resident 4 had mycotic (infection or disease caused by fungus [a type of organism that feeds from decaying material or other living things], hypertrophic (a nail disorder that causes fingernails or toenails to grow abnormally thick) toenails. The NWA indicated no treatment was provided to Resident 4 on 1/14/25, 1/22/25, 1/28/25, and 2/5/25 due to Resident 4's refusal of podiatric treatment.</p> <p>During a review of Resident 4's Nursing Progress Notes (NPN), dated 2/10/25, timed at 7:15 pm, the NPN indicated Certified Nursing Assistant (CNA) 8 reported to Licensed Vocational Nurse (LVN) 9 Resident 4 had mycotic toenails. LVN 9 notified Nurse Practitioner (NP- a registered nurse with advanced training who can diagnose and treat patients) 1 regarding Resident 4's mycotic toenails, and NP 1 recommended for Resident 4 to be seen by the podiatrist and to have an X-ray (imaging study that takes pictures of bones and soft tissues) of both feet.</p> <p>During a review of Resident 4's X-ray report, dated 2/11/25, the X-ray report indicated Resident 4 had suspicious osteomyelitis on the right second (the long toe) distal phalanx (the bone at the tip of the toes) and right fourth (the second-to-last toe on the foot, located between the third [middle] and fifth [pinky] toes) distal phalanx.</p> <p>During a review of Resident 4's Podiatric Consultation Notes (PCN), dated 2/12/25, the PCN indicated Resident 4 refused and had a history of refusing toenail debridement.</p> <p>During a review of Resident 4's SBAR (Situation, Background, Assessment, Recommendation- a communication tool used by healthcare workers when there is a change of condition among the residents), dated 2/13/25, the SBAR indicated Resident 4 had a change of condition. The SBAR indicated Resident 4's right foot X-ray showed possible osteomyelitis. The SBAR indicated NP 1 was informed of Resident 4's X-ray results on 2/13/25 at 9 am and recommended to send Resident 4 to GACH 1 for evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 4's GACH 1's H&P, dated 2/13/25, the H&P indicated Resident 4's assessment indicated osteomyelitis of the right foot and a plan to give Resident 4 intravenous Rocephin (medication used to treat infections) and Vancomycin (medication used to treat infections) and pain medication as needed (specific pain medication was not indicated).</p> <p>During a concurrent interview and record review, on 2/25/25 at 2:34 pm, with the SDDR, Resident 4's PCNs, dated 1/16/24, 3/18/24, 5/29/24, 8/8/24, 10/21/24, 12/26/24, and 2/12/25, were reviewed. Resident 4's PCNs dated 1/16/24, 3/18/24, 5/29/24, 8/8/24, 10/21/24, 12/26/24, and 2/12/25 indicated all of Resident 4's toenails on both feet were discolored, elongated, incurvated (ingrown toenail- a toenail that has grown curved with corners that have grown into the skin), dystrophic (deformed, thickened or discolored), hypertrophic, and painful (unrated) with subungual debris (buildup of skin cells and dead tissue under the nail caused by a fungal infection). The PCNs indicated Resident 4 refused toenail debridement (medical procedure that removes damaged or infected nail tissue) on both feet. The SDDR stated Resident 4 refused podiatry care for the whole year of 2024. The SDDR stated whenever the SDDR became aware a resident had refused treatment three times, the SDDR would inform the licensed nurses (licensed nurses that assigned to take care Resident 4) and asked the licensed nurses what else can be done for Resident 4. The SDDR stated the SDDR did not inform the licensed nurses when Resident 4 continued to refuse podiatry care for more than one year.</p> <p>During a concurrent interview and record review, on 2/25/25 at 2:52 pm, with the Director of Nursing (DON), Resident 4's PCNs dated 1/16/24, 3/18/24, 5/29/24, 8/8/24, 10/21/24, 12/26/24, and 2/12/25 were reviewed. Resident 4's PCNs dated 1/16/24, 3/18/24, 5/29/24, 8/8/24, 10/21/24, 12/26/24, and 2/12/25 indicated Resident 4 refused toenail debridement on both feet. The DON stated the DON was unaware Resident 4 had refused podiatry care for the whole year of 2024. The DON stated the SDDR and/or Social Services Designee (SSD) must notify licensed nurses whenever a resident refused podiatry care so the nursing department could try other interventions like having a staff that had a good rapport (a harmonious relationship between people, characterized by mutual understanding, trust, and agreement) with the resident be present during treatment. The DON stated, the licensed nurses (in general) could also notify the primary physician, the psychiatrist (a medical doctor who specializes in the diagnosis and treatment of mental illness) and/or the psychologist (a person who specializes in the study of mind and behavior or treatment of mental, emotional, and behavioral disorders), and the family or responsible party to coordinate care and for diagnostic studies.</p> <p>During a telephone interview on 2/25/25 at 4:20 pm with CNA 8, CNA 8 stated when CNA 8 showered Resident 4 on 2/10/25, Resident 4's toenails were thick and long (unable to specify size/measurement), and the big toenail on Resident 4's right foot was curving up. CNA 8 stated CNA 8 informed LVN 9 regarding Resident 4's long toenails because Resident 4's toenails were not supposed to be that long.</p> <p>During a telephone interview on 2/25/25 at 4:34 pm with LVN 9, LVN 9 stated after CNA 8 reported to LVN 9 about Resident 4's toenails on 2/10/25, LVN 9 assessed Resident 4's toenails. LVN 9 stated Resident 4's toenails were long, thick, and were dark yellowish green in color. LVN 9 stated Resident 4's toenails did not look normal so LVN 9 called NP 1 on 2/10/2025. NP 1 ordered a podiatry consultation and an X-ray of Resident 4's feet on 2/10/2025. LVN 9 stated long nails could cause residents discomfort and pain and put residents at risk for nail infections.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent record review and interview, on 2/26/25 at 3:41 pm, with the DON, the DON could not recall if Resident 4's family was informed of Resident 4's repeated refusals for podiatry care. Resident 4's last 4 Interdisciplinary Team (IDT, CP conferences, a team of health care professions who work together to establish plans of care for residents) were reviewed with the DON, the DON was unable to find documentation indicating Resident 4's family was informed of Resident 4's repeated refusal for podiatry care. The DON stated after a resident refused treatment three times, the primary physician, the psychologist/psychiatrist, and the family must be informed. The DON stated licensed nurses were not aware Resident 4 was refusing podiatry care and, probably did not inform (Resident 4's) physicians.</p> <p>During a review of the facility's P&P titled, Notification of Changes, undated, the P&P indicated, The facility must inform the resident, consults with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring notification. The P&P indicated, Circumstances requiring notification include . Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status . Circumstances that require a need to alter treatment.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, undated, the P&P indicated, The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been .refusal of treatment or medications .A significant change of condition is a decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, impacts more than one area of the resident's health status, requires interdisciplinary review and/or revision to the care plan and ultimately is based on the judgment of the clinical staff .Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident's family or representative when .there is a significant change in the resident's physical, mental, or psychosocial status .</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34273</p> <p>Based on interview and record review, the facility failed to implement the care plan for one of eight sampled residents (Resident 4) when licensed nurses did not notify Resident 4's physician regarding Resident 4's repeated refusals to be treated by the podiatrist as indicated in Resident 4's care plan (CP) titled, Care Plan Report.</p> <p>This failure had the potential for Resident 4 to not receive the necessary care and treatment for Resident 4's foot and result in discomfort, injury, and/or infections.</p> <p>Cross Reference F687, F580, and F684</p> <p>Findings:</p> <p>During a review of Resident 4's Admission Record (AR), the AR indicated Resident 4 was originally admitted to the facility on [DATE] with diagnoses that included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 4's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 12/10/24, the H&P indicated Resident 4 could make needs known but could not make medical decisions.</p> <p>During a review of Resident 4's CP titled, Care Plan Report. dated 12/10/24, the CP indicated Resident 4 was at risk for clinical or social decline due to Resident 4's refusal to shower, refusal of assistance with Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily), and refusal of treatment and medications. The CP's goal indicated for Resident 4's family members and/or staff to assist in making decisions for health and personal care and to inform Resident 4 of risks and consequences of the choices Resident 4 made daily. The CP's interventions included for staff (in general) to monitor Resident 4 for episodes of noncompliance and to notify the physician for possible treatment, and to refer Resident 4 for psychological (related to the mental and emotional state of a person) and/or psychiatric (relating to mental illness or its treatment) consultation as ordered by the primary physician.</p> <p>During a review of Resident 4's Nursing Weekly Assessment (NWA), dated 1/14/25, 1/22/25, 1/28/25, and 2/5/25, the NWA indicated Resident 4 had mycotic (infection or disease caused by fungus [a type of organism that feeds from decaying material or other living things], hypertrophic (a nail disorder that causes fingernails or toenails to grow abnormally thick) toenails. The NWA indicated no treatment was provided to Resident 4 on 1/14/25, 1/22/25, 1/28/25, and 2/5/25 due to Resident 4's refusal of podiatric treatment.</p> <p>During a review of Resident 4's Podiatric Consultation Notes (PCN), dated 2/12/25, the PCN indicated Resident 4 refused and had a history of refusing toenail debridement.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/25/25 at 1:59 pm with the Social Service Director (SSDR), the SSDR stated all residents in the facility were seen by a podiatrist every two months or as needed. The SSDR could not remember when Resident 4 was last seen by the podiatrist. The SSDR stated in general when a resident refused podiatry care, the podiatrist would ask for staff assistance, and if the resident continued to refuse, the podiatrist would document the refusal on the PCN. The SSDR stated it was Resident 4's right to refuse podiatry care, but the facility could not let Resident 4 refuse for too long because it could cause residents to sustain harm and or injury.</p> <p>During a concurrent interview and record review, on 2/25/25 at 2:34 pm, with the SSDR, Resident 4's PCNs, dated 1/16/24, 3/18/24, 5/29/24, 8/8/24, 10/21/24, 12/26/24, and 2/12/25, were reviewed. Resident 4's PCNs dated 1/16/24, 3/18/24, 5/29/24, 8/8/24, 10/21/24, 12/26/24, and 2/12/25 indicated all of Resident 4's toenails on both feet were discolored, elongated, incurvated (ingrown toenail- a toenail that has grown curved with corners that have grown into the skin), dystrophic (deformed, thickened or discolored), hypertrophic , and painful (unrated) with subungual debris (buildup of skin cells and dead tissue under the nail caused by a fungal infection). The PCNs indicated Resident 4 refused toenail debridement (medical procedure that removes damaged or infected nail tissue) on both feet. The SSDR stated Resident 4 refused podiatry care for the whole year of 2024. The SSDR stated whenever the SSDR became aware a resident had refused treatment three times, the SSDR would inform the licensed nurses (licensed nurses that assigned to take care Resident 4) and asked the licensed nurses what else can be done for Resident 4. The SSDR stated the SSDR did not inform the licensed nurses when Resident 4 continued to refuse podiatry care for more than one year.</p> <p>During a concurrent interview and record review, on 2/25/25 at 2:52 pm, with the Director of Nursing (DON), Resident 4's PCNs dated 1/16/24, 3/18/24, 5/29/24, 8/8/24, 10/21/24, 12/26/24, and 2/12/25 were reviewed. Resident 4's PCNs dated 1/16/24, 3/18/24, 5/29/24, 8/8/24, 10/21/24, 12/26/24, and 2/12/25 indicated Resident 4 refused toenail debridement on both feet. The DON stated the DON was unaware Resident 4 had refused podiatry care for the whole year of 2024. The DON stated the SSDR and/or Social Services Designee (SSD) must notify licensed nurses whenever a resident refused podiatry care so the nursing department could try other interventions like having a staff that had a good rapport (a harmonious relationship between people, characterized by mutual understanding, trust, and agreement) with the resident be present during treatment. The DON stated, the licensed nurses (in general) could also notify the primary physician, the psychiatrist (a medical doctor who specializes in the diagnosis and treatment of mental illness) and/or the psychologist (a person who specializes in the study of mind and behavior or treatment of mental, emotional, and behavioral disorders), and the family or responsible party to coordinate care and for diagnostic studies. The DON stated the licensed nurses must also check the resident's fingernails and toenails during the weekly nursing assessment of the resident and notify the resident's physician(s) once they found any change in the resident's condition.</p> <p>During an interview on 2/26/25 at 3:41 pm, with the DON, the DON stated after a resident refused treatment three times, the primary physician, the psychologist/psychiatrist, and the family must be informed. The DON stated licensed nurses were not aware Resident 4 was refusing podiatry care and, probably did not inform (Resident 4's) physicians.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Comprehensive Care Plans, undated, the P&P indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The P&P indicated, The physician, other practitioner; or professional will inform the resident and/or resident representative of the risks and benefits of proposed care, of treatment, and treatment alternatives/options. The P&P indicated, The facility will attempt alternative methods of refusal of treatment and services and document such attempts in the clinical record, including discussions with the resident and/or resident representative.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34273</p> <p>Based on interview and record review, the facility failed to provide necessary care and services to one of eight sampled residents (Resident 4) and failed to implement its policies and procedures (P&P) titled, Change in a Resident's Condition or Status, and Comprehensive Care Plans, when:</p> <ol style="list-style-type: none"> 1. Resident 4's repeated refusal to be treated by the podiatrist (medical doctor who specializes in the treatment of disorders of the foot, ankle, and the lower leg) was not communicated to Resident 4's physician(s) and to Resident 4's family and/or responsible party (RP). 2. Resident 4's care plan regarding refusal of care and treatment was not implemented. 3. Licensed Nurses did not inform Resident 4's physician regarding the condition of Resident 4's toenails during weekly nursing assessment (a comprehensive evaluation of a resident's health status conducted by a nurse on a weekly basis) of Resident 4. <p>These failures resulted in Resident 4 to be transferred and admitted to the General Acute Care Hospital (GACH) 1, on 2/13/25, for intravenous (given directly into the blood stream through the vein) antibiotic (medications used to treat infections) to treat right toe osteomyelitis (inflammation of bone or bone marrow, usually due to infection).</p> <p>Cross reference F687, F580, and F656</p> <p>Findings:</p> <p>During a review of Resident 4's Admission Record (AR), the AR indicated Resident 4 was originally admitted to the facility on [DATE] with diagnoses that included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 4's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 12/10/24, the H&P indicated Resident 4 could make needs known but cannot make medical decisions.</p> <p>During a review of Resident 4's CP titled, Care Plan Report. dated 12/10/24, the CP indicated Resident 4 was at risk for clinical or social decline due to Resident 4's refusal to shower, refusal of assistance with Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily), and refusal of treatment and medications. The CP's goal indicated for Resident 4's family members and/or staff to assist in making decisions for health and personal care and to inform Resident 4 of risks and consequences of the choices Resident 4 made daily. The CP's interventions included for staff (in general) to monitor Resident 4 for episodes of noncompliance and to notify the physician for possible treatment, and to refer Resident 4 for psychological (related to the mental and emotional state of a person) and/or psychiatric (relating to mental illness or its treatment) consultation as ordered by the primary physician.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 1/26/25, the MDS indicated Resident 4's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired. The MDS indicated Resident 4 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating, oral hygiene, toileting hygiene, lower body dressing, and personal hygiene. The MDS also indicated Resident 4 required partial/moderate assistance (helper does less than half the effort) with showering/bathing, upper body dressing, and with putting on/taking off footwear.</p> <p>During a review of Resident 4's Podiatric Consultation Notes (PCN), dated 1/16/24, 3/18/24, 5/29/24, 8/8/24, 10/21/24, and 12/26/24, the PCN indicated all of Resident 4's toenails on both feet were discolored, elongated, incurvated (ingrown toenail- a toenail that has grown curved with corners that have grown into the skin), dystrophic (deformed, thickened or discolored), hypertrophic (thickened, overgrown toenails), and painful with subungual debris (buildup of skin cells and dead tissue under the nail caused by a fungal infection). The PCNs indicated Resident 4 refused toenail debridement (medical procedure that removes damaged or infected nail tissue) on both feet.</p> <p>During a review of Resident 4's Nursing Weekly Assessment (NWA), dated 1/14/25, 1/22/25, 1/28/25, and 2/5/25, the NWA indicated Resident 4 had mycotic (infection or disease caused by fungus [a type of organism that feeds from decaying material or other living things]), hypertrophic toenails. The NWA indicated no documentation Resident 4's physician was informed of the condition of Resident 4's toenails on 1/14/25, 1/22/25, 1/28/25, and 2/5/25.</p> <p>During a review of Resident 4's Nursing Progress Notes (NPN), dated 2/10/25 and timed 7:15 pm, the NPN indicated Certified Nursing Assistant (CNA) 8 reported to Licensed Vocational Nurse (LVN) 9 Resident 4 had mycotic toenails. LVN 9 notified Nurse Practitioner (NP- a registered nurse with advanced training who can diagnose and treat patients) 1 regarding Resident 4's mycotic toenails, and NP 1 recommended for Resident 4 to be seen by the podiatrist and to have an X-ray (picture of the inside of the body) of both feet.</p> <p>During a review of Resident 4's X-ray report, dated 2/11/25, the X-ray report indicated Resident 4 had possible osteomyelitis on multiple toes of both feet.</p> <p>During a review of Resident 4's PCN, dated 2/12/25, the PCN did not indicate the condition of Resident 4's toenails. The PCN indicated Resident 4 refused and had a history of refusing toenail debridement.</p> <p>During a review of Resident 4's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 2/13/25, the SBAR indicated Resident 4 had a change of condition. The SBAR indicated Resident 4's right foot X-ray showed possible osteomyelitis. The SBAR also indicated NP 1 was informed of Resident 4's X-ray results on 2/13/25 at 9 am and recommended to send Resident 4 to GACH 1 for evaluation.</p> <p>During a review of Resident 4's GACH 1 H&P, dated 2/13/25, the H&P indicated Resident 4's assessment indicated osteomyelitis of the right foot and a plan to give Resident 4 antibiotics and pain medication.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056079	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025
NAME OF PROVIDER OR SUPPLIER Glendora Grand, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 805 W. Arrow Hwy. Glendora, CA 91740	
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/25/25 at 1:59 pm with the Social Service Director (SSDR), the SSDR stated all residents were seen by a podiatrist every two months and as needed. The SSDR could not remember when Resident 4 was last seen by the podiatrist. The SSDR stated when residents refused podiatry care, the podiatrist would ask staff to assist, and if residents continued to refuse, the podiatrist would document it on the PCN. The SSDR stated it was the resident's right to refuse podiatry care, but the facility could not let residents refuse for too long because it could cause residents to sustain an injury.</p> <p>During a concurrent interview and record review on 2/25/25 at 2:34 pm with the SSDR, Resident 4's PCN, dated 1/16/24, 3/18/24, 5/29/24, 8/8/24, 10/21/24, 12/26/24, and 2/12/25 were reviewed. The SSDR stated Resident 4 refused podiatry care for the whole year of 2024. The SSDR stated whenever the SSDR became aware a resident had refused treatment three times, the SSDR would inform the licensed nurses and ask the licensed nurses what else can be done for the resident. The SSDR stated the SSDR did not inform the licensed nurses of Resident 4's repeated refusal for podiatry care.</p> <p>During a concurrent interview and record review on 2/25/25 at 2:52 pm with the Director of Nursing (DON), Resident 4's PCN for 1/16/24, 3/18/24, 5/29/24, 8/8/24, 10/21/24, 12/26/24, and 2/12/25 were reviewed. The DON stated the DON was unaware Resident 4 had refused podiatry care for the whole year of 2024. The DON stated the SSDR and/or Social Services Designee (SSD) must notify licensed nurses whenever a resident refused podiatry care so the nursing department could try other interventions like having a staff with good rapport with the resident be present during treatment. The DON stated licensed nurses could also notify the primary physician, the psychiatrist and/or the psychologist, and the family or responsible party to coordinate care and for diagnostic studies. The DON stated licensed nurses must also check the resident's fingernails and toenails during the weekly nursing assessment of the resident and notify the resident's physician(s) once they find any change in the resident's condition.</p> <p>During a telephone interview on 2/25/25 at 4:20 pm with CNA 8, CNA 8 stated when CNA 8 showered Resident 4 on 2/10/25, Resident 4's toenails were thick and long, and the big toenails on Resident 4's right foot was curving up. CNA 8 stated CNA 8 informed LVN 9 regarding Resident 4's long toenails because Resident 4's toenails were not supposed to be that long.</p> <p>During a telephone interview on 2/25/25 at 4:34 pm with LVN 9, LVN 9 stated after CNA 8 told LVN 9 about Resident 4's toenails on 2/10/25, LVN 9 assessed Resident 4's toenails. LVN 9 stated Resident 4's toenails were long, thick, and dark yellowish green in color. LVN 9 stated Resident 4's toenails did not look normal so LVN 9 called NP 1. LVN 9 stated NP 1 ordered a podiatry consultation and an X-ray of Resident 4's feet on 2/10/25. LVN 9 stated LVN 9 should have done an SBAR for Resident 4's change of condition on 2/10/25. LVN 9 stated long nails could cause residents discomfort and pain and put residents at risk for infection.</p> <p>During an interview on 2/26/25 at 9:28 am with the DON, the DON stated an SBAR must be done every time a resident had a change of condition. The DON stated LVN 9 should have written an SBAR on 2/10/25 regarding Resident 4's toenails and not wait until 2/13/25 (3 days later).</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent record review and interview on 2/26/25 at 3:41 pm with the DON, the DON could not recall if Resident 4's family was informed of Resident 4's repeated refusal for podiatry care. The DON reviewed the last 4 care plan conferences for Resident 4 and was unable to find documentation Resident 4's family was informed regarding Resident 4's repeated refusal for podiatry care. The DON stated after a resident refused treatment three times, the primary physician, the psychologist/psychiatrist, and the family must be informed. The DON stated licensed nurses were not aware Resident 4 was refusing podiatry care and probably did not inform (Resident 4's) physicians.</p> <p>During a review of the facility's P&P titled, Change in a Resident's Condition or Status, undated, the P&P indicated, The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been .refusal of treatment or medications .A significant change of condition is a decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, impacts more than one area of the resident's health status, requires interdisciplinary review and/or revision to the care plan and ultimately is based on the judgment of the clinical staff .Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident's family or representative when .there is a significant change in the resident's physical, mental, or psychosocial status .</p> <p>During a review of the facility's P&P titled, Comprehensive Care Plans, undated, the P&P indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The P&P indicated, The facility will attempt alternative methods of refusal of treatment and services and document such attempts in the clinical record, including discussions with the resident and/or resident representative.</p>		

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<p>F 0687</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34273</p> <p>Based on interview and record review, the facility failed to provide foot care and treatment to one of eight sampled residents (Resident 4) according to Resident 4's Care Plan (CP) titled, Care Plan Report, and the facility's policies and procedures (P&P) titled, Podiatry Services, and Comprehensive Care Plans, by failing to ensure:</p> <ol style="list-style-type: none"> 1. Licensed Nurses (all licensed nurses that assigned to care for Resident 4) notified Resident 4's physician(s) and Resident 4's family and/or responsible party (RP) when Resident 4 repeatedly refused to be treated by the podiatrist (medical doctor who specializes in the treatment of disorders of the foot, ankle, and the lower leg), for the year of 2024. 2. Licensed Nurses implemented Resident 4's CP when Resident 4 refused to receive podiatrist care and treatment for multiple times in one year. 3. Licensed Nurses notified Resident 4's physician regarding the condition of Resident 4's toenails. <p>These failures resulted in Resident 4 to be transferred and admitted to the General Acute Care Hospital (GACH) 1, on 2/13/25, for intravenous (IV, given directly into the blood stream through the vein) antibiotic (medications used to treat infections) to treat right toe osteomyelitis (inflammation of bone or bone marrow, usually due to infection).</p> <p>Cross reference: F580, F656, and F684</p> <p>Findings:</p> <p>During a review of Resident 4's Admission Record (AR), the AR indicated Resident 4 was originally admitted to the facility on [DATE] with diagnoses that included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 4's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 12/10/24, the H&P indicated Resident 4 could make needs known but could not make medical decisions.</p> <p>During a review of Resident 4's CP titled, Care Plan Report. dated 12/10/24, the CP indicated Resident 4 was at risk for clinical or social decline due to Resident 4's refusal to shower, refusal of assistance with Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily), and refusal of treatment and medications. The CP's goal indicated for Resident 4's family members and/or staff to assist in making decisions for health and personal care and to inform Resident 4 of risks and consequences of the choices Resident 4 made daily. The CP's interventions included for staff (in general) to monitor Resident 4 for episodes of noncompliance and to notify the physician for possible treatment, and to refer Resident 4 for psychological (related to the mental and emotional state of a person) and/or psychiatric (relating to mental illness or its treatment) consultation as ordered by the primary physician.</p> <p>(continued on next page)</p>

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<p>F 0687</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 1/26/25, the MDS indicated Resident 4's cognition (ability to remember and process information) was moderately impaired. The MDS indicated Resident 4 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating, oral (having to do with the mouth or speaking) hygiene, toileting hygiene, lower body dressing, and personal hygiene. The MDS indicated Resident 4 required partial/moderate assistance (helper does less than half the effort) with showering/bathing, upper body dressing, and with putting on/taking off footwear.</p> <p>During a review of Resident 4's Nursing Weekly Assessment (NWA), dated 1/14/25, 1/22/25, 1/28/25, and 2/5/25, the NWA indicated Resident 4 had mycotic (infection or disease caused by fungus [a type of organism that feeds from decaying material or other living things]), hypertrophic (a nail disorder that causes fingernails or toenails to grow abnormally thick) toenails. The NWA indicated no treatment was provided to Resident 4 on 1/14/25, 1/22/25, 1/28/25, and 2/5/25 due to Resident 4's refusal of podiatric treatment.</p> <p>During a review of Resident 4's Nursing Progress Notes (NPN), dated 2/10/25, timed at 7:15 pm, the NPN indicated Certified Nursing Assistant (CNA) 8 reported to Licensed Vocational Nurse (LVN) 9 Resident 4 had mycotic toenails. LVN 9 notified Nurse Practitioner (NP- a registered nurse with advanced training who can diagnose and treat patients) 1 regarding Resident 4's mycotic toenails, and NP 1 recommended for Resident 4 to be seen by the podiatrist and to have an X-ray (imaging study that takes pictures of bones and soft tissues) of both feet.</p> <p>During a review of Resident 4's X-ray report, dated 2/11/25, the X-ray report indicated Resident 4 had suspicious osteomyelitis on the right second (the long toe) distal phalanx (the bone at the tip of the toes) and right fourth (the second-to-last toe on the foot, located between the third [middle] and fifth [pinkie] toes) distal phalanx.</p> <p>During a review of Resident 4's Podiatric Consultation Notes (PCN), dated 2/12/25, the PCN indicated Resident 4 refused and had a history of refusing toenail debridement.</p> <p>During a review of Resident 4's SBAR (Situation, Background, Assessment, Recommendation- a communication tool used by healthcare workers when there is a change of condition among the residents), dated 2/13/25, the SBAR indicated Resident 4 had a change of condition. The SBAR indicated Resident 4's right foot X-ray showed possible osteomyelitis. The SBAR indicated NP 1 was informed of Resident 4's X-ray results on 2/13/25 at 9 am and recommended to send Resident 4 to GACH 1 for evaluation.</p> <p>During a review of Resident 4's NPN, dated 2/13/25, timed at 9:34 am, the NPN indicated Resident 4 was picked up by the ambulance and was transported to GACH 1.</p> <p>During a review of Resident 4's GACH 1's H&P, dated 2/13/25, the H&P indicated Resident 4's assessment indicated osteomyelitis of the right foot and a plan to give Resident 4 intravenous Rocephin (medication used to treat infections) and Vancomycin (medication used to treat infections) and pain medication as needed (specific pain medication was not indicated).</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/25/25 at 1:59 pm with the Social Service Director (SSDR), the SSDR stated all residents in the facility were seen by a podiatrist every two months or as needed. The SSDR could not remember when Resident 4 was last seen by the podiatrist. The SSDR stated in general when a resident refused podiatry care, the podiatrist would ask for staff assistance, and if the resident continued to refuse, the podiatrist would document the refusal on the PCN. The SSDR stated it was Resident 4's right to refuse podiatry care, but the facility could not let Resident 4 refuse for too long because it could cause residents to sustain harm and or injury.</p> <p>During a concurrent interview and record review, on 2/25/25 at 2:34 pm, with the SSDR, Resident 4's PCNs, dated 1/16/24, 3/18/24, 5/29/24, 8/8/24, 10/21/24, 12/26/24, and 2/12/25, were reviewed. Resident 4's PCNs dated 1/16/24, 3/18/24, 5/29/24, 8/8/24, 10/21/24, 12/26/24, and 2/12/25 indicated all of Resident 4's toenails on both feet were discolored, elongated, incurvated (ingrown toenail- a toenail that has grown curved with corners that have grown into the skin), dystrophic (deformed, thickened or discolored), hypertrophic, and painful (unrated) with subungual debris (buildup of skin cells and dead tissue under the nail caused by a fungal infection). The PCNs indicated Resident 4 refused toenail debridement (medical procedure that removes damaged or infected nail tissue) on both feet. The SSDR stated Resident 4 refused podiatry care for the whole year of 2024. The SSDR stated whenever the SSDR became aware a resident had refused treatment three times, the SSDR would inform the licensed nurses (licensed nurses that assigned to take care Resident 4) and asked the licensed nurses what else can be done for Resident 4. The SSDR stated the SSDR did not inform the licensed nurses when Resident 4 continued to refuse podiatry care for more than one year.</p> <p>During a concurrent interview and record review, on 2/25/25 at 2:52 pm, with the Director of Nursing (DON), Resident 4's PCNs dated 1/16/24, 3/18/24, 5/29/24, 8/8/24, 10/21/24, 12/26/24, and 2/12/25 were reviewed. Resident 4's PCNs dated 1/16/24, 3/18/24, 5/29/24, 8/8/24, 10/21/24, 12/26/24, and 2/12/25 indicated Resident 4 refused toenail debridement on both feet. The DON stated the DON was unaware Resident 4 had refused podiatry care for the whole year of 2024. The DON stated the SSDR and/or Social Services Designee (SSD) must notify licensed nurses whenever a resident refused podiatry care so the nursing department could try other interventions like having a staff that had a good rapport (a harmonious relationship between people, characterized by mutual understanding, trust, and agreement) with the resident be present during treatment. The DON stated, the licensed nurses (in general) could also notify the primary physician, the psychiatrist (a medical doctor who specializes in the diagnosis and treatment of mental illness) and/or the psychologist (a person who specializes in the study of mind and behavior or treatment of mental, emotional, and behavioral disorders), and the family or responsible party to coordinate care and for diagnostic studies. The DON stated the licensed nurses must also check the resident's fingernails and toenails during the weekly nursing assessment of the resident and notify the resident's physician(s) once they found any change in the resident's condition.</p> <p>During a telephone interview on 2/25/25 at 4:20 pm with CNA 8, CNA 8 stated when CNA 8 showered Resident 4 on 2/10/25, Resident 4's toenails were thick and long (unable to specify size/measurement), and the big toenail on Resident 4's right foot was curving up. CNA 8 stated CNA 8 informed LVN 9 regarding Resident 4's long toenails because Resident 4's toenails were not supposed to be that long.</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 2/25/25 at 4:34 pm with LVN 9, LVN 9 stated after CNA 8 reported to LVN 9 about Resident 4's toenails on 2/10/25, LVN 9 assessed Resident 4's toenails. LVN 9 stated Resident 4's toenails were long, thick, and were dark yellowish green in color. LVN 9 stated Resident 4's toenails did not look normal so LVN 9 called NP 1 on 2/10/2025. NP 1 ordered a podiatry consultation and an X-ray of Resident 4's feet on 2/10/2025. LVN 9 stated LVN 9 should have done an SBAR for Resident 4's change of condition on 2/10/25 when CNA 8 first reported about Resident 4's toenails and not to wait until 2/13/25. LVN 9 stated long nails could cause residents discomfort and pain and put residents at risk for nails infections.</p> <p>During an interview on 2/26/25 at 9:28 am with the DON, the DON stated an SBAR must be completed on the same day when Resident 4 had a change of condition. The DON stated LVN 9 should have completed an SBAR on 2/10/25 regarding Resident 4's toenails and not wait until 2/13/25 (3 days later).</p> <p>During a concurrent record review and interview, on 2/26/25 at 3:41 pm, with the DON, the DON could not recall if Resident 4's family was informed of Resident 4's repeated refusals for podiatry care. Resident 4's last 4 Interdisciplinary Team (IDT, CP conferences, a team of health care professions who work together to establish plans of care for residents) were reviewed with the DON, the DON was unable to find documentation indicating Resident 4's family was informed of Resident 4's repeated refusal for podiatry care. The DON stated after a resident refused treatment three times, the primary physician, the psychologist/psychiatrist, and the family must be informed. The DON stated licensed nurses were not aware Resident 4 was refusing podiatry care and, probably did not inform (Resident 4's) physicians.</p> <p>During a review of the facility's P&P titled, Podiatry Services, undated, the P&P indicated, It is the policy of this facility to ensure residents receive proper treatment and care within professional standards of practice and state scope of practice, as applicable, to maintain mobility and good foot health. The P&P indicated, Employees should refer any identified need for foot care to the social worker or designee.</p> <p>During a review of the facility's P&P titled, Comprehensive Care Plans, undated, the P&P indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The P&P indicated, The facility will attempt alternative methods of refusal of treatment and services and document such attempts in the clinical record, including discussions with the resident and/or resident representative.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, undated, the P&P indicated, The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been .refusal of treatment or medications .A significant change of condition is a decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, impacts more than one area of the resident's health status, requires interdisciplinary review and/or revision to the care plan and ultimately is based on the judgment of the clinical staff .Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident's family or representative when .there is a significant change in the resident's physical, mental, or psychosocial status .</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34273</p> <p>Based on observation, interview, and record review, the facility failed to provide supervision to prevent elopement (when an individual leaves the healthcare facility unsupervised and/or undetected) for one of three sampled residents (Resident 1) assessed as at risk for elopement as indicated in the facility's policy and procedure titled, Elopements and Wandering Residents, by failing to ensure Resident 1 was readmitted to the facility's secured unit (any area in the facility designed and operated to ensure that all its entrances and exits are locked to prevent residents from leaving the facility without permission and/or supervision).</p> <p>As a result, on 2/19/25 at 8:45 pm, facility staff (general) were unable to locate Resident 1 and filed a missing person report with the local police department on 2/19/25 at 10:10 pm. As of 2/26/25 at 5:37 pm, Resident 1 had not been found.</p> <p>This failure had the potential to put Resident 1 at risk for serious injury, harm, and/or death due to not receiving psychotropic medication (medication that affects behavior, mood, thoughts, or perception), not having food and shelter, and being exposed to cold weather.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses which included schizophrenia (a serious mental illness that interferes with a person's ability to think clearly, manage emotions, make decisions, and relate to others) and anxiety disorder (feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).</p> <p>During a review of Resident 4's care plan, dated 9/15/24, the care plan indicated Resident 1 was at risk for wandering due to impaired cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and fluctuation in mental status and due to diagnosis of anxiety disorder and schizophrenia. The care plan goal indicated for Resident 4 to have no wandering behavior daily. The care plan interventions included always alerting all staff to whereabouts of Resident 4, distracting and/or redirecting Resident 4 away from facility doors, and placing Resident 4 in a secured unit if resident continued to wander out of the facility.</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/21/24, the MDS indicated Resident 1 verbalized Resident 1's needs. The MDS indicated Resident 1's cognition was moderately impaired. The MDS indicated Resident 1 required setup or clean-up assistance (helper sets up or cleans up, resident completes activity) with eating and oral hygiene and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with toileting hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 1 walked with supervision or touching assistance.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056079	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025
NAME OF PROVIDER OR SUPPLIER Glendora Grand, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 805 W. Arrow Hwy. Glendora, CA 91740	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Elopement Risk Evaluation (ERE), dated 2/7/25, the ERE indicated Resident 1 was at risk for elopement due to a 'history of elopement or an attempted elopement at home and due to wandering behavior.</p> <p>During a review of Resident 1's Order Summary Report, there were two different physician's orders, dated 2/7/25, which indicated which unit of the facility to admit Resident 1 to from the General Acute Care Hospital (GACH) 1. The first physician's order, dated 2/7/25, indicated to admit Resident 1 to the secured unit of the facility due to wandering behavior. The second physician's order, dated 2/7/25, indicated Resident 1 may transfer to Station 6 (an unsecured or open unit in the facility). The Order Summary Report also indicated Resident 1 had a physician's order dated 2/7/2025, to administer buspirone HCL (medication to treat anxiety) 10 milligrams (mg- unit of measure) two times a day and olanzapine (medication to treat schizophrenia) 15 mg two times a day.</p> <p>During a review of Resident 4's Nursing Progress Note (NPN), dated 2/7/25 and timed 2:52 pm, the NPN indicated Resident 4 was readmitted to the secured unit from GACH 1.</p> <p>During a review of Resident 4's NPN, dated 2/7/25 and timed 6:12 pm, the NPN indicated, (Resident 4)] was transferred to (an) open unit (Station 6).</p> <p>During a review of Resident 1's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 2/10/25, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 1's SBAR (Situation, Background, Assessment, Recommendation- a communication tool used by healthcare workers when there is a change of condition among the residents), dated 2/19/25, untimed, the SBAR indicated Resident 1 left the facility without notifying staff. The SBAR indicated the certified nursing assistant (CNA) assigned to care for Resident 1 (CNA 14) did not find the resident in Resident 1's room and bathroom on 2/19/25 at 8:45 pm. The SBAR indicated all the staff (in general) looked for Resident 1 in all the rooms and bathrooms, the facility grounds, neighboring parks, stores, gas stations, and smoke shops, and called hospitals, but was unable to find Resident 1.</p> <p>During a review of Resident 1's NPN, dated 2/19/25 and timed 8:45 pm, the NPN indicated the licensed vocational nurse (LVN) assigned to care for Resident 1 (LVN 4) saw Resident 1 walk past the nurses' station at 7:45 pm. The NPN indicated CNA 14 saw Resident 1 walking around the unit at 8:04 pm. At 8:45 pm, CNA 14 did not find Resident 1 in Resident 1's room and bathroom. The staff (in general) in the unit searched in all the rooms and bathrooms in the unit and did not find Resident 1. The facility emergency code for missing resident was called and all the staff in the facility searched all the rooms, all the bathrooms, the facility grounds, drove around the neighboring areas, and called hospitals around the area but unable to find Resident 1. The NPN indicated the local police department was called at 10:05 pm and the police visited the facility for investigation and report at 10:55 pm.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 2/21/25 at 2:28 pm with LVN 1 in Station 6, LVN 1 stated there were 4 exit doors in Station 6: the main door (in front of the nurses' station), the exit door at the end of East Hall, the exit door at the end of [NAME] Hall, and the exit door by the kitchen. LVN 1 stated the East, West, and kitchen exit doors were alarmed but not locked, and the main door was not alarmed and never locked. The East and [NAME] doors were visible when standing in the middle of the main hallway of Station 6, which was divided into the East Hall and the [NAME] Hall. The kitchen exit door was not visible from the main hallway of Station 6. During a tour of Station 6, LVN 1 opened the East, West, and kitchen exit doors and a loud alarm went off. LVN 1 had to use a key to silence the red alarm located on top of the East, West, and kitchen exit doors. LVN 1 stated LVN 1 was not very familiar with Resident 1 because Resident 1 had only been in Station 6 for two weeks. LVN 1 stated Resident 1 moved to Station 6 from the secured unit. LVN 1 stated Resident 1 paced back and forth in the hallways of Station 6 and liked using the vending machine in Station 6 to get snacks. The vending machine in Station 6 was located by the kitchen exit door, which was not visible from the East and [NAME] halls and was not visible from the nurses' station.</p> <p>During an interview on 2/21/25 at 2:57 pm with LVN 2, LVN 2 stated LVN 2 worked in Station 6 on 2/19/25, when Resident 1 went missing. LVN 2 stated LVN 2 worked in the [NAME] side and Resident 1 resided in the East side. LVN 2 stated on 2/19/25 at approximately 8 pm, CNA 14 told LVN 2 Resident 1 was not in Resident 1's room. LVN 2 told LVN 4 Resident 1 was missing, and LVN 2 and LVN 4 took turns searching for Resident 1. LVN 2 searched in Resident 1's room and searched outside facility, then LVN 2 continued with medication administration. LVN 4 and CNA 14 continued to search for Resident 1 along with other facility staff and the Registered Nurse (RN) Supervisor. LVN 2 stated all exit doors in Station 6 were kept locked except for the main door. LVN 2 stated the maintenance staff put up an alarm on the kitchen exit door after Resident 1 went missing. LVN 2 stated, Now (we are) required to lock and turn on the alarm there (kitchen exit door). LVN 2 stated Resident 1 paced a lot.</p> <p>During an interview on 2/24/25 at 11:47 am with the Director of Nursing (DON), the DON stated Resident 1's representative (RP) stated Resident 1 eloped from another facility where Resident 1 lived before.</p> <p>During a telephone interview on 2/24/25 at 12:40 pm with LVN 4, LVN 4 stated on 2/19/25 at 7:45 pm, LVN 4 saw Resident 1 walking in the hallway by the nurses' station. While LVN 4 was passing out medications, LVN 4 saw Resident 1 listening to the radio in Resident 1's room. LVN 4 stated CNA 14 saw Resident 1 at 8:04 pm walking in the hallway. At 8:45 pm, while LVN 4 was in another resident's room with the RN Supervisor, CNA 14 notified LVN 2 CNA 14 could not find Resident 1 in Resident 1's room. LVN 4 stated LVN 2 informed LVN 4 and all staff in Station 6 looked for resident 1 in all the rooms and bathrooms in Station 6. LVN 4 stated when Station 6 staff did not find Resident 1 in Station 6, the RN Supervisor called the facility emergency code for elopement and all the staff in all the other units of the facility started looking for Resident 1 in all the rooms and bathrooms in their units. LVN 4 stated some staff from the other units searched the outside grounds outside Station 6 and outside all units of the facility. Some staff drove around to neighboring parks, stores, gas stations, smoke shops and neighboring areas and the RN Supervisor called hospitals, but they did not find Resident 1. LVN 4 stated the local police department was called, and a police officer came to the facility for the investigation report. LVN 4 stated LVN 4 did not hear any door alarm go off that night. LVN 4 stated on 2/19/25, the East and [NAME] exit doors had an alarm, and the kitchen exit door and the main door did not have an alarm. LVN 4 stated the kitchen exit door was now alarmed and always kept closed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/24/25 at 3:01 pm with the Maintenance Supervisor (MNS), the MNS stated the MNS installed an alarm on the kitchen door in Station 6 on 2/20/25 because he was instructed by the Administrator (ADM) and the DON.</p> <p>During an interview on 2/24/25 at 4:45 pm with the DON, the DON stated, Back door by the kitchen where vending machines were could be where Resident 1 went out. The DON stated Station 6 staff (general) had seen Resident 1 use the vending machine before, that was why the DON, and the ADM had an alarm placed on the kitchen exit door in Station 6. The DON stated Resident 1 was originally admitted to Station 3 which was an open/unsecured unit in the facility. While Resident 1 was in Station 3, Resident 1 was found in the parking lot and Resident 1's physician had Resident 1 moved to the secured unit. The discharge plan for Resident 1 was to move to a Board and Care (a residential care home that provides room, meals, personal care, and basic support services to individuals who do not require care from licensed healthcare professional). The DON stated during the Interdisciplinary Team (IDT, a team of professionals from various disciplines who work in collaboration to address the resident's care) care conference in December 2024, Resident 1's representative (RP) wanted Resident 1 to be moved to an open unit so Resident 1's RP could move Resident 1 to an Assisted Living or a Board and Care facility. The DON stated that was why Resident 1 was moved to Station 6, which was an open unit, when Resident 1 came back from GACH 1 on 2/7/25.</p> <p>During a telephone interview on 2/26/25 at 12:35 pm with RN 2, RN 2 stated when Resident 1 was readmitted on [DATE], Resident 1 was supposed to be readmitted to Station 6, which was an open unit, and Resident 1's RP was aware of it.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Elopements and Wandering Residents, dated 2/2020, the P&P indicated, the facility ensured residents who exhibited wandering behavior and/or were at risk for elopement received adequate (sufficient/enough) supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The P&P indicated, the facility established and utilized a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. The P&P indicated, adequate supervision would be provided to help prevent accidents or elopement.</p>		