

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 06/26/2025
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** Based on interview, and record review, the facility failed to develop care plans (CPs) for two (2) of three (3) sampled residents (Resident 4 and Resident 6) in accordance with care and services to be provided to the residents according to the physician ' s order.</p> <p>Resident 4 ' s and Resident 6 ' s Diabetes Mellitus (DM, a disorder characterized by difficulty in blood glucose [sugar] control and poor wound healing) care plans (CPs) included a goal to maintain blood sugar levels between 70 milligrams per deciliter (mg/dl, a unit of measure) and 150 mg/dl. Resident 4 and Resident 6 did not have a physician ' s order for routine bedside blood sugar monitoring.</p> <p>These failure had the potential for Resident 4 and Resident 6 to receive inappropriate DM care and services.</p> <p>Findings:</p> <p>1. During a review of Resident 4 ' s admission Record (AR), the AR indicated the facility admitted Resident 4 on 4/21/2025 and readmitted Resident 4 on 5/16/2025 with diagnoses that included DM.</p> <p>During a review of Resident 4 ' s Minimum Data Set (MDS, a resident assessment tool), dated 4/30/2025, the MDS indicated Resident 4 ' s cognition (ability to understand and process information) was intact. The MDS indicated Resident 4 required supervision (helper provides verbal or touch cues as resident completes activity) when performing activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily), and Resident 4 was independent with mobility.</p> <p>During a review of Resident 4 ' s care plan (CP) titled Diabetes Mellitus 2, revised on 4/24/2025, the care plan ' s goal indicated to maintain Resident 4 ' s blood sugar between 70 (mg/dl) and 150 (mg/dl). The care plan ' s interventions included monitoring blood glucose level, to be alert for signs of hypoglycemia (low blood glucose level) or hyperglycemia (high blood glucose level).</p> <p>During a review of Resident 4 ' s History and Physical (H&P), dated 5/17/2025, the H&P indicated Resident 4 had fluctuating capacity to understand and make decisions. The H&P indicated Resident 4 was diagnosed with DM 2 with diabetic polyneuropathy (nerve damage caused by diabetes).</p> <p>During a review of Resident 4 ' s Order Summary Report (OSR), with active physician ' s orders as of 6/25/2025, the OSR indicated Resident 4 did not have a physician ' s order for routine bedside blood sugar monitoring.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 6/25/2025 at 2:20 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 reviewed Resident 4 ' s Diabetes Mellitus (DM) CP, dated 4/24/2025. LVN 1 stated, the DM CP ' s goal was to maintain Resident 4 ' s blood sugar between 70 (mg/dl) and 150 (mg/dl).</p> <p>During a concurrent interview and record review on 6/25/2026 at 3:45 PM with LVN 6, LVN 6 reviewed Resident 4 ' s DM CP, dated 4/24/2025. LVN 6 stated that the DM CP ' s goal was to maintain Resident 4 ' s blood sugar between 70 (mg/dl) and 150 (mg/dl).</p> <p>2. During a review of Resident 6 ' s AR, the AR indicated the facility admitted Resident 6 on 8/13/2021 and readmitted Resident 6 on 1/16/2025 with diagnoses that included DM.</p> <p>During a review of Resident 6 ' s DM CP, dated 1/24/2025, the CP ' s goal indicated to maintain Resident 6 ' s blood glucose level between 70 (mg/dl) and to prevent problems from inadequate control of blood glucose levels resulting in hypoglycemia (low blood sugar level) or hyperglycemia (high blood sugar level). The CP ' s interventions included monitoring blood glucose levels and monitoring for signs and symptoms of hypoglycemia and hyperglycemia.</p> <p>During a review of Resident 6 ' s MDS, dated [DATE], the MDS indicated Resident 6 ' s cognitive skills were severely impaired. The MDS indicated Resident 6 required moderate (helper does less than half the effort) assistance with most ADLs. The MDS indicated Resident 6 required supervision when ambulating and transferring from the bed to the chair or the chair to the bed.</p> <p>During a review of Resident 6 ' s OSR, with active orders as of 6/25/2025, the OSR indicated Resident 6 did not have a physician ' s order for routine bedside blood sugar monitoring or to monitor Resident 6 for signs and symptoms of hypoglycemia or hyperglycemia.</p> <p>During a concurrent interview and record review on 6/25/2025 at 2:15 PM with LVN 1, LVN 1 reviewed Resident 6 ' s CP titled Diabetes Mellitus, dated 1/24/2025. LVN 1 stated, the CP goal indicated to maintain Resident 6 ' s blood sugar between 70 (mg/dl) and 150 (mg/dl) and the care plan ' s interventions included monitoring Resident 6 ' s blood glucose levels and monitoring for signs and symptoms of hypoglycemia or hyperglycemia.</p> <p>During a concurrent interview and record review on 6/25/2025 at 3:50 PM with LVN 6, LVN 6 reviewed Resident 6 ' s CP titled Diabetes Mellitus, dated 1/24/2025. LVN 6 stated, the CP goal indicated to maintain Resident 6 ' s blood sugar between 70 (mg/dl) and 150 (mg/dl) and the care plan ' s interventions included monitoring Resident 6 ' s blood glucose levels and monitoring for signs and symptoms of hypoglycemia or hyperglycemia.</p> <p>During an interview on 6/25/2025 at 4:45 PM with the Director of Nursing (DON), the DON stated CPs were important because CPs directed nursing staff on how to provide resident centered care for the residents. The DON stated the CP provided guidelines and directions for how the nursing staff should care for the residents ' diagnoses and medical conditions.</p> <p>During an interview on 6/25/2026 at 4:55 PM with the DON, the DON stated, it was important to monitor a diabetic resident ' s blood glucose level because a diabetic resident was at a higher risk for experiencing hypoglycemic or hyperglycemic signs and symptoms such as altered mental status or change in level of consciousness which may lead to hospitalization.</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 - Some</p>	<p>During a review of the facility ' s policy and procedure (P&P) titled, Comprehensive Care Plans, undated, the P&P indicated the comprehensive care plan will describe . the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being. The P&P indicated the comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to the attending physician .</p>

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<p>F 0689</p> <p>Level of Harm - 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>Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 1) received one-on-one supervision (1:1, one staff supervising 1 resident) to prevent fall (move downward, typically rapidly and freely without control, from a higher to a lower level) as indicated in Resident 1's Interdisciplinary Team (IDT, a group of healthcare professionals who collaborate to provide comprehensive care for Resident 1) Meeting/Care Conference, dated 5/1/2023.</p> <p>On 6/16/2025 at approximately 5:35 pm, Activity Assistant (AA) 1 left Resident 1 unsupervised in Resident 1's wheelchair inside Resident 1's room.</p> <p>Resident 1 fell from Resident 1's wheelchair and sustained a laceration (a tear or cut in the skin) measured 2 centimeters (cm unit of measurement) in length by (x) 1 cm in width x 0.5 cm in depth on Resident 1's left eyebrow and an abrasion (a surface or superficial wound where the skin was scraped off) to Resident 1's left elbow (size was not indicated) and multiple abrasions on Resident 1's left forearm (sizes were not indicated). On 6/16/2025 at 5:45 pm, the paramedic (a person trained to give emergency medical care to people who are injured or ill, typically in a setting outside of a hospital) transferred Resident 1 to General Acute Care Hospital (GACH) 1 for further evaluation.</p> <p>Findings:</p> <p>During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 6/24/2019 and readmitted Resident 1 on 12/2/2024 with diagnoses including intellectual disabilities (a condition characterized by significant limitations in both intellectual functioning and adaptive behavior), autistic disorder (a neurological and developmental disorder that affects how people interact with others, communicate, learn, and behave), and schizoaffective disorder (a mental health condition including schizophrenia [a disorder that affects a person's ability to think, feel, and behave clearly] and mood disorder symptoms).</p> <p>During a review of Resident 1's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 12/5/2024, 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 Minimum Data Set (MDS, a resident assessment tool), dated 4/16/2025, the MDS indicated Resident 1's cognitive skills (ability to make daily decisions) was severely impaired. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) from staff for personal hygiene and walking.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Progress Notes (PN), dated 6/16/2025 and timed at 7:02 pm, the PN indicated on 6/16/2025, at approximately 5:35 pm, Resident 1) was found by helper (AA 1) lying on the floor, on Resident 1's left side with profusely bleeding on Resident 1's left eyebrow. The PN indicated Resident 1 was noted with a laceration on Resident 1's left eyebrow, measured 2 cm in length x 1 cm in width x 0.5 cm in depth. The PN indicated Resident 1 had an abrasion to left elbow (size was not indicated) and multiple abrasions to Resident 1's left forearm (sizes were not indicated). The PN indicated (on 6/16/2025) at 5:40 pm, facility's staff (unidentified) called 911 (phone number used to contact the emergency services). The PN indicated (on 6/16/2025) at 5:45 pm, the paramedic arrived and transferred Resident 1 to GACH 1 for further evaluation and (wounds) management.</p> <p>During a review of Resident 1's Emergency Department (ED)Note Physician (EDNP, the documentation created by a physician or other qualified healthcare provider in the ED), dated 6/16/2025 and timed at 6:27 pm, the EDNP indicated Resident 1 was brought into GACH 1 by Emergency Medical Services (EMS, a comprehensive system providing urgent pre-hospital medical care and transportation to individuals experiencing illness or injury). The EDNP indicated Resident 1 had a fall at a Skilled Nursing Facility (SNF). The EDNP indicated Resident 1 had a laceration on Resident 1's forehead and wound care was provided to Resident 1's forehead laceration with Steri-Strips (thin, adhesive bandages used to close and support small cuts, wounds, and incisions).</p> <p>During an observation of Resident 1 inside the facility's activity room, on 6/25/2025 at 11 am, Resident 1 was sitting in a chair with Helper 1 providing 1:1 supervision to Resident 1. Resident 1 was noted to have a scab (a dry, rough protective crust that forms over a cut or wound during healing), measured 2 cm in length x 1 cm in width, over Resident 1's left eyebrow. Resident 1 was noted to have a bruise, the size of a nickel, under Resident 1's left eye.</p> <p>During a telephone interview on 6/25/2025 at 1:09 pm with Licensed Vocational Nurse (LVN) 3, LVN 3 stated LVN 3 was Resident 1's assigned nurse during the evening shift (from 3pm to 11 pm) on 6/16/2025. LVN 3 stated, on 6/16/2025, at 5:35 pm, Resident 1 fell on the floor in Resident 1's room. LVN 3 stated AA 1 was supposed to be watching/supervising Resident 1 when Resident 1 fell (on 6/16/2025, at 5:35 pm). LVN 3 stated an assigned staff (AA 1) needed to always watch/supervise Resident 1 due to Resident 1 was impulsive (acting without forethought) and would also throw tantrums (having an uncontrolled outburst of anger, often involving loud crying, screaming, or other physical displays) when Resident 1 became upset. LVN 1 stated Resident 1 would bang Resident 1's head against things (objects, material things that can be seen and touched) when Resident 1 became upset.</p> <p>During a telephone interview on 6/25/2025 at 2 pm with AA 1, AA 1 stated, on 6/16/2025, before Resident 1 fell (unable to recall exact time), LVN 4 had instructed AA 1 to watch/supervise Resident 1 while AA 1 was also supervising other residents (unidentified) in the smoking patio next to the activity room. AA 1 stated Resident 1 was watching television in the activity room when Resident 1 told AA 1 that Resident 1 was going back to Resident 1's room. AA 1 stated Resident 1's room was next to the activity room. AA 1 stated Resident 1 wheeled Resident 1 (in the wheelchair) from the activity room to Resident 1's room and closed Resident 1's room door behind Resident 1. AA 1 stated, after 30 seconds, AA 1 opened Resident 1's room door, went into Resident 1's room and found Resident 1 lying on the floor next to Resident 1's bed. AA 1 stated Resident 1 was bleeding over Resident 1's eyes and there was blood on the floor in Resident 1's room.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/25/2025 at 2:35 pm with LVN 1, LVN 1 stated Resident 1 required 1:1 supervision from facility's staff (in general). LVN 1 stated assigned staff (staff assigned to provide 1:1 supervision) needed to be with Resident 1 to supervise Resident 1 because Resident 1 had behaviors of throwing tantrums when Resident 1 got upset.</p> <p>During an interview on 6/25/2025 at 3:02 pm with Registered Nurse (RN) 1, RN 1 stated Resident 1 needed 1:1 supervision from staff (facility's staff). RN 1 stated Resident 1 should not have been in Resident 1's room alone and unsupervised when Resident 1 fell on 6/16/2024 (at 5:35 pm). RN 1 stated, It was not safe for Resident 1 to be left unattended by AA 1.</p> <p>During a concurrent interview and record review on 6/26/2025 at 11:40 am with the Director of Nursing (DON), Resident 1's IDT Meeting/Care Conference, dated 5/1/2023, was reviewed. The IDT notes indicated, Due to resident's (Resident 1) impaired cognition and medications, resident (Resident 1) will be closely monitored for falls. The IDT notes indicated effective 5/9/2023, the IDT team and the Regional Center's (a private, non-profit corporation that provided services for individual with developmental delay or disability) staff (RCS) determined that Resident 1 would be provided with helpers to perform 1:1 supervision for Resident 1 daily, for 10 hours a day (time frame was not indicated). The DON stated on 6/16/2025, Resident 1 should have been provided with 1:1 supervision from staff until 7:00 pm (from 9 am to 7 pm). The DON stated after dinner (around 7 pm), Resident 1 would calm down, go to bed and would not need a 1:1 supervision. The DON stated Resident 1 required 1:1 supervision from staff for 10 hours daily since 5/9/2023.</p> <p>During a telephone interview on 6/26/2025 at 12:05 pm with LVN 4, LVN 4 stated LVN 4 was responsible to make the staffing assignment for the evening shift (3 pm to 11 pm) on 6/16/2025. LVN 4 stated LVN 4 had instructed/assigned AA 1 to supervise Resident 1 on 6/16/2025 (from 3 pm to 11 pm). LVN 4 stated AA 1 was supposed to keep an eye on Resident 1 at all times.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents, undated, the P&P indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The P&P indicated, The interdisciplinary care team shall target interventions to reduce the potential for accidents. The P&P indicated Implementing interventions to reduce accident risks and hazards shall include the following: a. communicating specific interventions to all relevant staff; b. assigning responsibility for carrying out interventions; c. providing training, as necessary; d. ensuring that interventions are implemented; and e. documenting interventions.</p>		