STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056079	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendora Grand, Inc	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)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0627 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 interview and record review, the facility failed to provide and document sufficient preparation and orientation to ensure a safe and orderly discharge for one of two sampled residents (Resident 1) when:a. The facility failed to arrange for Resident 1's formula for enteral feeding (a method of providing nutrition directly into the gastrointestinal [GI] tract through a tube) to be readily available upon Resident 1's return home.b. The facility failed to assess Resident 1's Caregiver's (RP 1) ability to safely transfer (move from one surface to another) and care for Resident 1.These failures had the potential for Resident 1 to experience an unsafe discharge and had the potential for Resident 1 to be hospitalized .(Cross reference F688 and F842)Findings:During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 1/6/2025 and readmitted Resident 1 on 7/1/2025 with diagnoses including cerebral infarction (also called ischemic stroke, occurs as a result of disrupted blood flow to the brain), difficulty in walking, and personal history of traumatic brain disorder (damage to the brain caused by an external force, such as a blow, bump, hit, or jolt to the head).During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 8/28/2025, the MDS indicated Resident 1 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 supervision or touch assistance from staff for dressing, bathing, and toileting, oral, and personal hygiene.During a review of Resident 1's Order Summary Report (OSR) dated 10/16/2025, the OSR indicated Resident 1 had a physician order: Enteral feeding order every 8 hours bolus (a method of delivering nutrition through a tube directly into the stomach or small intestine) feeding Jevity 1.2 (a high-protein medical nutritional supplement for tube feeding).During a telephone interview on 10/16/2026 at 12:49 pm with Registered Nurse (RN) 1, RN 1 stated RN 1 worked for the home health agency (provides medical and therapeutic services to patients in their homes) assigned to provide services for Resident 1 following Resident 1's discharge from the facility. RN 1 stated Resident 1 was discharged home on [DATE]. RN 1 stated RN 1 was NPO (nothing by mouth, resident not to eat or drink anything) and received nutrition via a gastrostomy tube (G-tube, a tube inserted through the abdomen that delivers nutrition directly to the stomach). RN 1 stated the facility only provided a two-day supply of G-tube formula to Resident 1's caregiver when Resident 1 was discharged home. RN 1 stated RN 1 had to arrange to get more G-tube formula for Resident 1 from a medical supply company (as of 10/16/2025, Resident 1 was still waiting to get the G-tube formula). RN 1 stated the facility should have already arranged for Resident 1's caregiver to receive Resident 1's G-tube formula prior to Resident 1 being discharged home. During an interview on 10/16/2025 at 2:10 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated LVN 1 was responsible for giving discharge instructions to RP 1 when Resident 1 was discharged on 10/7/2025. LVN 1 stated LVN 1 gave RP 1 enough G-tube formula to feed Resident 1 for 24 hours. LVN 1 stated LVN 1 did not know who was responsible for arranging for Resident 1 to receive G-tube formula after discharging home. LVN 1 stated Resident 1 needed assistance because Resident 1 was incontinent (lack of voluntary control over urination or defecation) and unsteady to transfer himself. LVN 1 stated RP 1 was not trained on how to safely transfer Resident 1. LVN 1 stated LVN 1 did not assess if RP 1 was able to safely transfer and care for Resident 1. LVN 1 stated LVN 1 did not know if RP 1 had ever cared for Resident 1 in the past. During a telephone interview on 10/20/2025 at 9:24 AM with RP 1, RP 1 stated RP 1 was not aware Resident 1 could not get out of bed without assistance. RP 1 stated RP 1 did not receive any training from the facility on how to safely transfer Resident 1 from the bed. RP 1 stated the facility only sent a 1-day supply of G-tube formula upon Resident 1's discharge home. RP 1 stated the facility did not send any incontinence supplies upon Resident 1's discharge home. RP 1 stated the facility should have provided incontinence supplies.During an interview on 10/20/2025 at 10:01 AM with the Social Service Designee (SSD), The SSD stated Resident 1 discharged home from the facility on 10/7/2025. The SSD stated for Resident 1 to experience a safe discharge, Resident 1 required a caregiver who was properly trained on how to transfer Resident 1 safely. The SSD stated the SSD did not assess or verify if RP 1 knew how to transfer Resident 1 safely.During a review of the facility's P&P titled, Transfer and Discharge, dated 2025, the P&P indicated, Orientation for transfer or discharge will be provided and documented to ensure safe and orderly transfer or discharge from the facility, in a form and manner that the resident can understand. Depending on the circumstances, this orientation may be provided by various members of the interdisciplinary team.Facility will assist with transportation arrangements to the new facility and any other arrangements as needed

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1), received appropriate treatment to prevent further decrease in Resident 1's mobility (ability to move) when the facility failed to implement the physician order to have Resident 1 walk five times a week.This failure resulted in Resident 1 experiencing a decrease in the ability to walk. (Cross reference F627 and F842)Findings:During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 1/6/2025 and readmitted Resident 1 on 7/1/2025 with diagnoses including cerebral infarction (also called ischemic stroke, occurs as a result of disrupted blood flow to the brain), difficulty in walking, and personal history of traumatic brain disorder (damage to the brain caused by an external force, such as a blow, bump, hit, or jolt to the head).During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 8/28/2025, the MDS indicated Resident 1 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 supervision or touch assistance from staff for dressing, bathing, and toileting, oral, and personal hygiene.During a review of Resident 1's Order Summary Report (OSR) dated 10/16/2025, the OSR indicated Resident 1 had a physician order for Restorative Nursing Assistant (RNA) to ambulate (walk) Resident 1 five times a week with a front wheel walker (FWW). The physician order was dated 8/28/2025.During a concurrent interview and record review on 10/16/2025 at 1:26 PM with the Director of Rehabilitation (DOR), Resident 1's PT Discharge Summary (DS), dated 8/28/2025, was reviewed. The DS indicated, Patient (Resident 1) is currently able to walk in corridor, and walk in room.patient (Resident 1) will be able to walk in corridor with assist of one, and balance will require the physical support of one, by performing the following Restorative Nursing interventions: provide assistance of one, use gait belt, use walker, encourage participation and allow patient to take his or her time. The DOR stated Resident 1 was discharged from rehab services on 8/28/2025. The DOR stated Resident 1 needed RNA services to include an RNA would walk with Resident 1 in the hallway 5 days out of each week. During a concurrent interview and record review on 10/16/2025 at 2:04 PM with RNA 1, Resident 1's Restorative Nursing Orders (RNO) for August, September, and October 2025, were reviewed. The RNO failed to indicate Resident 1 received the treatment order of ambulating in the hallway 5 times a week. RNA 1 confirmed RNA 1 did not ambulate with Resident 1, 5 times a week. During a review of the facility's policy and procedure (P&P) titled, Restorative Nursing Programs, dated 2024, the P&P indicated, It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain a complete and accurate medical record for one of two sampled residents (Resident 1) when Certified Nursing Assistant (CNA) 1 and Licensed Vocational Nurse (LVN) 1 documented inaccurate information in Resident 1's medical record, regarding the level of assistance Resident 1 needed from a caregiver for bed mobility (the ability to move around in bed, including rolling over, scooting, and moving from a lying to a sitting position) and transfers (move from one surface to another).This failure resulted in Resident 1's medical record containing incomplete information.(Cross reference F627 and F688)Findings:During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 1/6/2025 and readmitted Resident 1 on 7/1/2025 with diagnoses including cerebral infarction (also called ischemic stroke, occurs as a result of disrupted blood flow to the brain), difficulty in walking, and personal history of traumatic brain disorder (damage to the brain caused by an external force, such as a blow, bump, hit, or jolt to the head).During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 8/28/2025, the MDS indicated Resident 1 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 supervision or touch assistance from staff for dressing, bathing, and toileting, oral, and personal hygiene.During a concurrent interview and record review on 10/20/2025 at 1:44 PM with CNA 1, Resident 1's Nurse Assistant Notes - A.M. Shift ([NAME]), dated 10/2025 was reviewed. The [NAME] indicated CNA 1 had documented on 10/2, 10/3, and 10/5/2025 that Resident 1 was dependent on staff for transfers, mobility, up in chair, and ambulation. CNA 1 stated CNA 1 had documented inacuratly and that Resident 1 was not dependent on staff for transfers, mobility, up in chair, and ambulation. CNA 1 stated Resident 1 required limited assistant from staff for transfers, mobility, up in chair, and ambulation.During a concurrent interview and record review on 10/20/2025 at 2:10PM with LVN 1, Resident 1's Discharge Summary/Comprehensive Assessment, (DS) dated 10/6/2025 was reviewed. The DS indicated Resident 1 was dependent on staff for transfers and bed mobility. LVN 1 stated LVN 1 had documented inacuratly and that Resident 1 was not dependent on staff for bed mobility and transfers.During a review of the facility's Policy and Procedure (P&P) titled, Accuracy of Medical Records, dated 2024, the P&P indicated, This facility will ensure that all medical records are complete, accurate, and updated to reflect the care and services provided to each resident.