

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 08/08/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure call lights were within reach for four of four sampled residents (Residents 50, 117, 148, and 197) in accordance with the facility's policy titled Call Light. These failures had the potential for Residents 50, 117, 148, and 197 not to receive necessary care or receive delayed services, placing the residents at risk for falls or injury. Findings:</p> <p>a. During a review of Resident 50's admission Record (AR), the AR indicated Resident 50 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hyperlipidemia (high cholesterol) and depression (a feeling of severe sadness or hopelessness).</p> <p>During a review of Resident 50's undated Care Plan (CP) dated 11/26/2024, the CP indicated Resident 50 needed assistance with Activities of Daily Living (ADL). The CP intervention indicated for nursing staff to have Resident 50's call light within reach and to answer the call light promptly.</p> <p>During a review of Resident 50's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 7/20/2025, the MDS indicated Resident 50 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 50 needed supervision (helper sets up or cleans up) from staff for oral hygiene, toileting, shower, upper/lower body dressing and putting on/off footwear and personal hygiene.</p> <p>During a review of Resident 50's Fall Risk Evaluation (FRE- method of assessing a patient's likelihood of falling) dated 7/31/2025, the FRE indicated Resident 50 was assessed as high risk for falls due intermittent confusion, balance problem while standing and walking and change in gait (a person's manner of walking) pattern when walking through the doorway.</p> <p>During an observation on 8/5/2025 at 9:01 am, Resident 50 was sitting on her bed. Resident 50 stated "I couldn't reach it (pointing to the call light at the back of the headboard). In a concurrent observation, Registered Nurse 1 (RN 1) needed force to remove Resident 50's call light at the back of the resident's headboard.</p> <p>During an interview on 8/5/2025 at 9:03 am, with RN 1, RN 1 stated Resident 50's call light was stuck at the back of Resident 50's headboard. RN 1 stated the call light needed to be within reach of the resident all the time for the resident to alert staff if help was needed.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056079
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 8/7/2025 at 11:22 am with the facility's Director of Nursing (DON), the DON stated the resident's call light needed to be within reach at all times in case the resident needed help or assistance. The DON stated that even if the resident refused to use the call light, it should be placed within reach at all times for residents' safety.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Call Lights: Accessibility and Timely Response, revised on 2021, the P&P indicated all residents will be educated on how to call for help by using the resident call system. The P&P indicated with each interaction in the resident's room or bathroom, staff will ensure the call light is within reach of resident and secured, as needed.</p> <p>b. During a review of Resident 117's AR, the AR indicated Resident 117 was admitted on [DATE] and readmitted on [DATE] with diagnoses of hemiplegia (partial paralysis) and hemiparesis (weakness or inability to move on one side of the body) following a cerebrovascular (relating to the brain and its blood vessels) disease affecting the right dominant side.</p> <p>During a review of Resident 117's MDS dated [DATE], the MDS indicated Resident 117 had severely impaired cognition (ability to understand). The MDS indicated Resident 117 had limitations in range of motion of the upper and lower extremities, and Resident 117 was dependent on staff for ADLs (basic tasks that individuals perform to maintain their daily life), toileting, and eating.</p> <p>During a review of Resident 117's untitled CP dated 10/18/2024, the CP indicated for nursing staff to keep the resident's call light within reach to provide Resident 117's safety as a prevention from falling due to impaired mobility.</p> <p>During an observation on 8/5/2025 at 10:29 a.m., Resident 117's touch call light device was located on the upper left side of the bed, above Resident 117's left shoulder. Resident 117 was asked to call the staff with the touch call light device above Resident 117's left shoulder. Resident 117 held Resident 117's left hand forward and in front of Resident 117, then stated Resident 117 could not reach it.</p> <p>During an interview on 8/5/2025 at 2:02 p.m. with CNA 2, CNA 2 stated it was very important for Resident 117 to be able to reach the call light because the resident can't get up and it's a form of communication for the resident to the staff. CNA 2 stated residents should be able to reach their call light device.</p> <p>During an interview on 8/7/2025 at 2:10 p.m., with Licensed Vocational Nurse 8 (LVN 8), LVN 8 stated, the touch call light should be placed next to the resident, near the resident's dominant hand, and clipped to the fitted sheet. LVN 8 was presented with a picture of the touch call light for Resident 117 located on the upper left side of the bed, above Resident 117's shoulder. When asked if Resident 117 would be able to touch the call light, LVN 8 stated Resident 117 would not be able to reach the touch call light device from where it was located.</p> <p>(continued on next page)</p>		

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<p>F 0558</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 P&P titled Call Lights: Accessibility and Timely Response policy, dated 2021, the P&P indicated all staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light. In addition, each resident will be evaluated for unique needs and preferences to determine any special accommodation that may be needed for the resident to utilize the call system. Also, each resident will be evaluated for unique needs and preferences to determine any special accommodation that may be needed for the resident to utilize the call system. And finally, that special accommodations will be identified on the resident's person-centered plan of care and provided accordingly.</p> <p>c. During a review of Resident 148's AR, the AR indicated Resident 148 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), left hand contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion), and muscle weakness (lack of muscle strength).</p> <p>During a review of Resident 148's untitled CP dated 1/27/2025, the CP indicated Resident 148 needed assistance with activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The CP interventions included having a call light within reach and answering the call light promptly.</p> <p>During a review of Resident 148's MDS dated [DATE], the MDS indicated Resident 148 had severely impaired cognition. The MDS indicated Resident 148 was dependent (helper did all the effort, resident did none of the effort to complete the activity) with oral hygiene, toileting, shower, upper and lower body dressing and personal hygiene.</p> <p>During a review of Resident 148's FRE dated 7/1/2025, the FRE indicated Resident 148 was at risk for fall.</p> <p>During a concurrent observation inside Resident 148's room and interview on 8/5/2025 at 10:53 am with Certified Nurse Assistant 1 (CNA 1), Resident 148 was in bed on Resident 148's back with a call light on the left upper side of the bed above Resident 148's pillow. Resident 148's left hand was contracted. CNA 1 stated Resident 148 could not move Resident 148's left arm and hand and could not reach the call light. CNA 1 stated Resident 148 could move Resident 148's right arm and hand. CNA 1 stated the call light should be placed close or next to Resident 148's right arm and hand for Resident 148 to use when help was needed.</p> <p>During an interview on 8/8/2025 at 10:54 am with the DON, the DON stated call lights should be placed on the strong arm/hand of the resident for easy access to call for assistance and for the staff to address the residents' needs timely.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d. During a review of Resident 197's AR, the AR indicated Resident 197 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder (a serious mental health condition characterized by persistent feelings of sadness, loss of interest, and a reduced ability to function in daily life), overactive bladder (a condition characterized by the sudden, uncontrollable urge to urinate, often leading to frequent urination and, in some cases, leakage), generalized osteoarthritis (the cartilage [a firm, flexible connective tissue found throughout the body, providing support, cushioning, and reducing friction in joints] that lines the joints is worn down and the bones rub against each other) and bipolar disorder (a mental health condition that causes extreme mood swings).</p> <p>During a review of Resident 197's Health and History (H&P) dated 1/01/2025, the H&P indicated Resident 197 had the capacity to understand and make decisions. The H&P also indicated, Resident 197 was at risk for pressure ulcers (localized injuries to the skin and underlying tissue, usually caused by prolonged pressure on the skin) and falls.</p> <p>During a review of Resident 197's MDS dated [DATE], the MDS indicated Resident 197's cognition was moderately impaired and Resident 197 required partial/moderate assistance (helper does less than half the effort) from staff for personal hygiene, toileting hygiene, shower, upper and lower body dressing and putting on and taking off footwear. The MDS also indicated Resident 197 required partial/moderate assistance for toilet transfers.</p> <p>During a review of Resident 197's untitled CP initiated on 1/29/2025 and revised on 4/04/2025 indicated Resident 197 was at risk for fall and/or further falls secondary to impaired cognition, impaired mobility and transfer, poor impulse control, lack of safety awareness. The CP interventions indicated to assess environment for possible risk factors such as wet floors or items outside field of vision.</p> <p>During a review of Resident 197's untitled CP initiated on 1/29/2025 and revised on 4/04/2025 indicated Resident 197 required assistance with ADLs. The CP interventions indicated to have the call light within reach and answer the call light promptly.</p> <p>During an observation of Resident 197's room and interview on 8/5/2025 9:29 AM, Resident 197 was sitting in a wheelchair next to bed. Resident 197's call light was wedged (something placed into a very small or narrow space, so that it cannot move easily) behind Resident 197's bed, between the headboard and the wall. Resident 197's call light was not within Resident 197's reach. When the surveyor asked if Resident 197 could use the call light to request assistance, Resident 197 stated, the call light is way up there, as Resident 197 pointed with Resident 197's fingers towards the head of the bed. Resident 197 stated, I can't reach it. I can reach it when I'm in bed, but I can't reach it when I'm sitting up in my wheelchair. If I had to go to the bathroom, I would have to yell and hope for them (staff) to come quickly.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview with License Vocational Nurse 9 (LVN 9) on 8/5/2025 at 9:42 AM, LVN 9 walked over to the back of Resident 197's headboard and pulled out the call light from behind. LVN 9 stated Resident 197's call light was not within reach and that should be in Resident 197's hand. LVN 9 stated Resident 197 does use the call light to call for assistance and was semi ambulatory. LVN 9 stated it was important for Resident 197 to be able to reach the call light when Resident 197 was out of bed and sitting in wheelchair in case the resident needs to call staff for assistance. LVN 9 stated, all nurses know residents needed to always have their call light within reach and staff needed to answer the call light right away to prevent harm or injury to the resident. LVN 9 stated if the call light was not answered and Resident 197 called for assistance to the bathroom, and nobody came. Resident 197 would try to get up and suffer a fall and injury.</p> <p>During an interview with LVN 10 on 8/6/2025 at 9:39 AM, LVN 10 stated the residents' call light should always be within reach to prevent any delay of care and to assist the residents right away. LVN 10 stated not having the call light within reach could potentially cause fall, harm, or injury to the residents.</p> <p>During an interview with the facility's DON on 8/6/2025 at 10:56 AM, the DON stated the residents' call light should always be within reach for the resident's safety. The DON stated it was not acceptable for a resident's call light to be wedged in between the backboard and the wall. The DON stated, if a resident can't use the call light, it could potentially cause the resident harm by not alerting the staff that the resident needed help.</p> <p>During an interview with the facility's Infection Prevention Nurse (IPN2) on 8/6/25 at 11:11 AM, IPN2 stated residents' call lights must be within reach in case the residents need to call for help or assistance and prevent delay in care. IPN2 stated it was important to ensure the call light was within the residents' reach and for staff to answer the call light immediately.</p> <p>During a review of the facility's P&P titled "Call Light: Accessibility and Timely Response", revised 2021, the P&P indicated, "The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response.</p> <p>Policy Explanation and Compliance Guidelines:</p> <ol style="list-style-type: none"> 1. All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light. 3. Each resident will be evaluated for unique needs and preferences to determine any special accommodation that may be needed in order for the residents to utilize the call system. 		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>(continued on next page)</p>

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide Resident 197 food choices that accommodated Resident 179's food preferences. This deficient practice has the potential to alter Resident 179's nutritional status and decrease meal intake that can potentially lead to weight loss and malnutrition (not having enough to eat or not eating enough). Findings: During a review of Resident 197's admission Record (AR), the AR indicated Resident 197 was admitted to the facility on [DATE] with diagnoses that included but not limited to major depressive disorder (a serious mental health condition characterized by persistent feelings of sadness, loss of interest, and a reduced ability to function in daily life), type 2 diabetes (a chronic condition where the body either doesn't produce enough insulin or can't properly use the insulin it does produce, leading to high blood sugar levels), bipolar disorder (a mental health condition that causes extreme mood swings). During a review of Resident 197's Nutrition Dietary Note (NDN) dated 12/30/2024, the NDN indicated, Visited resident to update food preferences. Resident 197 stated she would like tuna and an egg salad sandwich as an alternative. Resident 197's dislikes included fish, Mexican food, pasta, vegetable. Liked hardboiled eggs, hamburgers, potato salad and corn on the cob when they are on menu. During a concurrent record review of NDN dated 8/06/2026, the NDN indicated, Visited Resident to update food preferences. Resident stated she would like a hamburger with either potato or macaroni salad. During a review of Resident 197's Health and History (H&P) dated 1/01/2025 indicated Resident 197 has the capacity to understand and make decisions. The H&P also indicated, Resident 197 is at risk for malnutrition, weight loss, pressure ulcers (localized injuries to the skin and underlying tissue, usually caused by prolonged pressure on the skin) and dehydration (condition that occurs when the body loses too much water and other fluids that it needs to work normally) and falls. During a review of Resident 197's Care Plan (CP) dated 1/29/2025, the CP indicated, Resident with regular diet, may deviate (change from the usual) therapeutic diet on special occasions and/or when resident so desires. Interventions indicated, offer substitutions for uneaten foods and refer to dietician to offer foods that resident likes within the limits of therapeutic diet. During a review of Resident 197's CP dated 1/29/2025, the CP indicated, Potential for malnutrition (lack of proper nutrition), compromised nutritional status, weight fluctuations and/or weight loss secondary to impaired cognition (decline in functions such as memory, attention, reasoning, language, decision-making, and problem-solving), physical function, limitations and multiple health conditions. During a review of Resident 197's Order Summary Report (OSR) dated 6/27/2025, the OSR indicated, Regular diet, regular texture, regular/thin consistency, with small portions at lunch and dinner and no-fat milk with meals. During a review of Resident 197's Minimum Data Set (MDS- a resident assessment tool), dated 6/28/2025, the MDS indicated Resident 197 needs partial/moderate assistance (helper does less than half the effort) from the staff for Activities of Daily Living (ADLs) such as personal hygiene, toileting hygiene, shower, upper and lower body dressing and putting on and taking off footwear. Resident 197 also requires partial/moderate assistance for toilet transfers. During a review of the facility's monthly menu for the month of August 2025 titled, Good for Your Health Menus, the menu indicated that once a month on 8/16/2025 the residents would be getting a hamburger on a bun with lettuce and tomato, potato salad and corn on the cob for lunch. During a review of the facility's non-dated food substitution request titled, Food Orders, there was no option for a hamburger, potato salad or corn on the cob. During a review of the non-dated facility's food alternative choices titled, Meal Service Alternative Choices the choices did not include a hamburger, potato salad or corn on the cob. During an interview while in the kitchen with the Kitchen Manager (KM) on 8/05/2025 at 8:11 AM, the KM stated We have substitution meal orders but the last order needs to be submitted by 10am. The resident completes the request form and the CNA drops it off at the kitchen, but still it depends on the resident's request to see if we can even provide it for them. During an initial observation and interview with Resident 197 on 8/05/2025 at 9:29 AM, Resident 197 was sitting at the bedside and stated she had breakfast. Resident 197 stated This morning the food was good, but I had to talk to the dietitian before. The food is not usually good. I would like to eat a hamburger, tuna fish and egg salad sandwiches. They don't provide it for me. I know I can request a substitution, but some of the substitution options I don't like. I want corn on the cob or potato salad. I don't order anything because I don't want to stir up trouble. I'm afraid they might retaliate against me. During a follow up interview with KM on 8/06/2025 at 11:51 AM KM stated that the only food substitutes for the day were a bean and cheese burrito, ham, cheese</p>		

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<p>F 0577</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>Based on interview and record review, the facility failed to ensure that ten of ten sampled residents, who attended the resident council meeting, were aware of the availability and location of the facility's latest survey results. This deficient practice had the potential for the residents not to be fully informed of the facility's deficient practices or how the facility corrected the deficient practices. Findings: During the resident council meeting on 8/7/2025 at 10:46 am with ten residents, ten residents stated they were unaware of the availability and location of the survey results and how the facility corrected the deficiencies that were identified during the past survey. The 10 residents stated they would like to know the facility's latest survey inspection results and the corrections that the facility put into place. During an interview on 8/8/2025 at 1:10 pm with the Director of Nursing (DON), the DON stated posting of the last survey results was the Administrator's (ADM) responsibility. During an interview on 8/8/2025 at 1:53 pm with the ADM, the ADM stated she was responsible for posting the survey results and was unaware the residents didn't know where the results were posted or how they could find the results. The ADM stated the survey results were discussed during resident council meetings. The ADM further stated, it was important for the residents to have knowledge of the survey results and know where the results were posted and be transparent with the residents because this allowed the residents to know the facility problem areas that were identified. The ADM stated it was the residents' right to know the survey results. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, undated, the P&P indicated, the residents had the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>(continued on next page)</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure its policies and procedures (P&P) were implemented for one of one sampled resident (Resident 11) by:1. Failing to obtain Resident 11's physician signature on the Acknowledgment of Receipt for Advance Directive (AD - a legal document indicating resident preference on end-of-life treatment decisions)/Medical Treatment Decisions (ARAD).2. Failing to maintain a full copy of the resident's POLST (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) in Resident 11's medical record with a physician signature.This failure resulted in incomplete medical treatment forms for a resident who was to receive comfort-focused treatment and had the potential to result in a violation of the residents' and/or the representatives' right to be fully informed of the option to formulate or provide their advance directives with the discussion of diagnoses and consequences of withdrawing or withholding life-sustaining treatment with the physician.Findings:During a review of Resident 11's admission Record (AR), the AR indicated Resident 11 was admitted to the facility on [DATE] with diagnoses that included cancer of the left breast, Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and dementia (a progressive state of decline in mental abilities).During a review of Resident 11's History & Physical (H&P), dated [DATE], the H&P indicated Resident 11 did not have the capacity to make decisions, but could make needs known.During a review of Resident 11's Minimum Data Set assessment (MDS - a federally mandated resident assessment tool), dated [DATE], the MDS indicated Resident 11 was rarely or never understood.During a concurrent interview and record review on [DATE] at 9:25 am with Social Services Designee 2 (SSD 2), Resident 11's ARAD form, dated [DATE] was reviewed. The ARAD Form was missing a physician signature and date, the form indicated Resident 11 had a DNR (do not resuscitate- a medical order written by a doctor to instruct health care providers NOT to do cardiopulmonary resuscitation (CPR) if breathing stops or the heart stops beating) status with comfort focus treatment. SSD 2 stated, the form should be signed by the physician acknowledging the condition of the resident and the services they should receive.During a concurrent interview and record review on [DATE] at 10:47 am with SSD 1, Resident 11's POLST form (obtained from Resident 11's medical record), dated [DATE] was reviewed. The POLST indicated, when signed it was a legally valid physician order, Resident 11's POLST was missing a physician signature, a date, and missing the back side of the form. SSD 1 stated Resident 11's POLST should be signed [and dated] by Resident 11's primary physician [and include both sides of the form]. SSD 1 stated, a completed form allowed the staff to know the physician confirmed the reason for the resident's code status and what treatment should be done for the resident.During an interview on [DATE] at 1:05 pm with the Director of Nursing (DON), the DON stated if the ARAD and POLST forms were not signed by the physician, they were incomplete. The DON stated the forms should have been completed to allow licensed staff to determine whether to perform life sustaining measures or start artificial nutrition in the case of an emergency. The DON stated the completion of these forms allowed nursing staff to implement Resident 11's wishes. During a review of the facility's policy and procedure (P&P) titled, Completeness and Accuracy of Documentation Policy, undated, the P&P indicated, the facility ensured all resident documentation was complete, accurate, timely, and reflected the care provided with all entries complying with federal and state regulations and be maintained in the resident's permanent medical record. The P&P indicated, the purpose was to maintain high-quality, truthful, and timely records that supported resident care, legal compliance, and continuity of services. The P&P indicated, all required forms must be fully completed, signed, dated, and include the title/role of the person making the entry.During a review of the facility's policy and procedure (P&P) titled, Advance Directives, undated, the P&P indicated, advance directives will be respected in accordance with state law and facility policy. The P&P indicated, the SSD would provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refused medical or surgical treatment, and the right to formulate an AD. The P&P indicated, information about whether or not the resident had executed an AD shall be displayed prominently in the medical record.During a review of the facility's P&P titled, POLST Policy & Procedure, undated, the P&P indicated the POLST was a physician order form that complements an AD by converting an individual's wishes regarding life-sustaining treatment and resuscitation into a legally sufficient and recognized physician order. The P&P indicated, the physician was responsible for discussing the efficacy or appropriateness of the</p>		

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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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide privacy for one of one sampled resident (Resident 5) when Registered Nurse 2 (RN 2) did not close the privacy curtain while checking Resident 5's foley catheter's (thin, sterile tube inserted into the bladder to drain urine into a bag outside the body) securement device. This deficient practice violated Resident 5's right to privacy and resulted in unnecessary exposure of Resident 5's lower extremities. This deficient practice had the potential to affect Resident 5's psychosocial (mental and emotional) well-being, self-esteem, and self-worth. Findings: During a review of Resident 5's admission Record (AR), the AR indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included chronic kidney disease (CKD, a progressive condition where the kidneys gradually lose their ability to filter waste and excess fluid from the blood) and benign prostatic hyperplasia (enlargement of the prostate gland). During a review of Resident 5's untitled Care Plan (CP) revised on 4/24/2025, the CP indicated Resident 5 was incontinent of bowel and bladder secondary to impaired cognition (mental action or process of acquiring knowledge and understanding). The CP intervention indicated for nursing staff to provide privacy during activities of daily living (ADL) care. During a review of Resident 5's Minimum Data Set (MDS-resident assessment tool) dated 7/12/2025, the MDS indicated Resident 5 had severely impaired cognition for daily decision making. The MDS indicated Resident 5 was dependent (helper did all the effort and lifted or held trunk or limbs) on staff for oral hygiene, toileting, showering/bathing self, lower body dressing, putting on/taking off footwear, and personal hygiene. During a concurrent observation and interview on 8/5/2025 at 10:17 am with Registered Nurse 2 (RN 2), in Resident 5's room. Resident 5 was awake, lying in bed. RN 2 pulled up Resident 5's gown and checked Resident 5's foley catheter securement device. RN 2 did not pull the privacy curtain to provide Resident 5 privacy, exposing Resident 5's upper legs to roommate and the hallway. RN 2 stated she pulled up Resident 5's gown to check Resident 5's foley catheter and was unable to close the privacy curtain and exposed Resident 5's body to the resident's roommate and passersby. RN 2 stated the privacy curtain needed to be closed prior to providing care and treatment to the residents to provide privacy. During a concurrent interview on 8/7/2025 at 11:24 am with the facility's Director of Nursing (DON), the DON stated the resident's privacy curtain needed to be closed prior to providing care and treatment to residents to provide privacy and dignity to the resident. The DON stated the residents' body should not be exposed during care and treatment. During a review of the facility's Policy and Procedure (P&P) titled, Quality of Life - Dignity, revised 2025, the P&P indicated the resident should be treated with dignity and respect at all times. The P&P indicated staff should promote, maintain and protect the resident's privacy, including bodily privacy during assistance with personal care and during treatment procedures.</p>		

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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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on interview and record review, the facility failed to screen one of four randomly selected employees (Registered Nurse 1 [RN 1]) with the Office of Inspector General (OIG - investigates alleged violations of criminal and civil laws) data base for convictions of fraud and abuse prior to hire. This deficient practice had the potential for applicants with a history of abuse to be hired, which could lead to possible harm and abuse of the residents. Findings:During a concurrent interview and record review of RN 1's employee file on 8/8/2025 at 9:33 am with the Director of Staff and Development (DSD), the DSD stated RN 1 was hired on 7/5/2025. The DSD stated that the facility did the background check after the employee got hired. The DSD stated, We hire applicants first and do the background check after. The previous DSD told me to hire the applicant and do the background check after hire. During a concurrent interview and record review of the facility's undated Policy and Procedure (P&P) titled Abuse, Neglect and Exploitation on 8/8/2025 at 10:43 am with the facility's Director of Nursing (DON), the DON stated the facility's process for screening potential employee was to do a background check after hiring the applicant. The facility DON stated, based on the facility's P&P, background check needed to be done prior to hire to determine if the potential applicant had history of abuse or criminal records and to not let these potential employees be hired to take care of the residents in the facility for the safety of the residents. During a concurrent interview and record review of the facility's undated P&P titled Abuse, Neglect and Exploitation on 8/8/2025 at 11:19 am with the facility's Administrator (ADM), the ADM stated, background check needed to be done prior to hiring of employees to check if they have criminal records. The ADM stated that a background check needed to be done to screen applicants for residents' safety. During a review of the facility's undated P&P titled, Abuse, Neglect and Exploitation, the P&P indicated, Screening potential employees will be screened for a history of abuse, neglect, exploitation or misappropriation of resident property. Background, reference and credential check shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers and consultants. Screening may be conducted by the facility itself, third party agency or academic institution.</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>(continued on next page)</p>

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete the Minimum Data Set (MDS, a resident assessment tool) comprehensive assessment within federal time frames per Center of Medicare and Medicaid Services (CMS, a federal agency that manages healthcare programs like Medicare and Medicaid) requirement for two of two sampled residents (Residents 137 and 172). These failures had the potential to affect Residents 137 and 172's care by not providing CMS specific resident information and assessment timely. Findings: a. During a review of Resident 137's admission Record (AR), the AR indicated Resident 137 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), schizophrenia (a mental illness characterized by disturbances in thought) and suicidal ideations (refers to thoughts, ideas, or contemplations about ending one's own life). During a review of Resident 137's Situation, Background, Appearance, Review and Notify (SBAR, a communication technique used in healthcare to structure and improve communication) Form, dated 5/7/2025, the SBAR indicated Resident 137 had behavioral symptoms that had gotten worse and had not occurred before. During a review of Resident 137's Progress Notes (PN) dated 5/7/2025, timed at 10:40 am, the PN indicated Resident 137 had increasing agitation, pacing the hallways, talking, mumbling and threatening staff. Resident 137 was placed on 1:1 monitoring (one-to-one observation). During a review of Resident 137's PN dated 5/7/2025, timed at 1:21 pm, the PN indicated Resident 137 was transferred to General Acute Care Hospital (GACH, a type of hospital that provides short-term, intensive medical care for acute illnesses and injuries) for psychiatric evaluation. During a review of Resident 137's PN, dated 5/16/2025, timed at 1:02 pm, the PN indicated Resident 137 was readmitted back to the facility. The PN indicated Resident 137 was placed on 5150 hold (an involuntary psychiatric detention) in GACH. During a review of Resident 137's MDS dated [DATE], the MDS did not indicate Resident 137 had a significant change of condition. During a concurrent interview and record review on 8/8/2025 at 9:22 am with MDS Coordinator (MDS C), Resident 137's SBAR dated 5/7/2025, PNs dated 5/7/2025 and 5/16/2025, and MDS dated [DATE] were reviewed. The MDS C stated Resident 137's condition was a change and decline from the residents' baseline and considered significant change of condition. b. During a review of Resident 172's AR, the AR indicated Resident 172 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia, schizophrenia and anxiety (intense, excessive and persistent worry and fear about everyday situations). During a review of Resident 172's SBAR Form dated 5/21/2025, the SBAR indicated Resident 172 had behavioral symptoms that had not occurred before. During a review of Resident 172's PN dated 5/21/2025, timed at 10:12 am, the PN indicated Resident 172 was observed putting self on the floor, noncompliant during care and exhibited verbal aggression with yelling towards staff. The PN indicated Resident 172 was transferred to GACH for psychiatric evaluation. During a review of Resident 172's PN dated 5/30/2025, timed at 1:21 pm, the PN indicated Resident 172 was readmitted back to the facility. The PN indicated Resident 172 was placed on 5150 involuntary hold in GACH due to danger to others (DTO, substantial risk that a person will cause serious physical harm to others). During a review of Resident 172's MDS dated [DATE], the MDS did not indicate Resident 172 had a significant change of condition. During a concurrent interview and record review on 8/8/2025 at 9:42 am with MDS C, Resident 172's SBAR dated 5/21/2025, PNs dated 5/21/2025 and 5/30/25, and MDS dated [DATE] were reviewed. The MDS C stated Resident 172's condition was a change and decline from the resident's baseline and considered a significant change of condition. The MDS C stated MDS comprehensive assessments for Residents 137 and 172 were not completed 14 days after the residents were readmitted back to the facility. The MDS C stated the MDS comprehensive assessments should have been completed for Residents 137 and 172 to identify the residents' overall health status and reported to CMS accurately and timely. During an interview on 8/8/2025 at 10:58 am with the Director of Nursing (DON), the DON stated the changes from the baseline mental behavior necessitate an MDS comprehensive assessment within 14 days after the residents had changes in condition to update the plan of care for each resident and for accuracy of information reported to CMS. During a review of the facility's undated Policy and Procedure (P&P) titled, Timely Completion of MDS Assessments, the P&P indicated, The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. Assessment completion dates must be no later than: Significant Change in Status - 14th calendar day after determination that significant change in</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 6) was kept clean on 8/5/2025. This failure had the potential to result in social decline, skin breakdown, and body odor to Resident 6. Findings: During a review of Resident 6's admission Record (AR), the AR indicated Resident 6 was admitted to the facility on [DATE] with diagnoses that included type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), schizophrenia (a mental illness that is characterized by disturbances in thought), and adult failure to thrive (a decline caused by chronic [persistent or long-lasting] diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 6's History & Physical (H&P), dated 4/2/2025, the H&P indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's Minimum Data Set assessment (MDS - a federally mandated resident assessment tool), dated 7/12/2025, the MDS indicated Resident 6 had severely impaired cognition (ability to understand and process information) and needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity with assistance throughout or intermittently) for showering and personal hygiene. During a review of Resident 6's Care Plan (CP), initiated on 10/24/2024, the CP indicated Resident 6 was at risk for clinical or social decline due to refusal of showers, Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) assistance, and refusing to wear socks. The CP's interventions indicated Resident 6 would be encouraged to wear socks, episodes of noncompliance would be monitored, and assistance would be offered to Resident 6 for ADLs that could not be completed by Resident 6. During a review of Resident 6's CP, revised on 4/10/2025, the CP indicated Resident 6 needed assistance with ADLs including personal hygiene and bathing. The CP's interventions indicated to encourage decision-making and participation and keeping Resident 6 clean and dry as much as possible. The CP's goals indicated for Resident 6 to minimize skin breakdown, body odor, and dress appropriately. During an observation on 8/5/2025 at 12:38 pm, Resident 6 was observed lying disheveled in bed with an oily, unkept messy ponytail, and the bottoms of both bare feet were covered with black dirt. During a concurrent observation and interview on 8/5/2025 at 12:44 pm with Certified Nurse Assistant 3 (CNA 3), Resident 6 was observed with unkept hair and both bare feet were covered with black dirt. CNA 3 stated, Resident 6 was a smoker, spent a lot of time outside, and had scheduled showers on Tuesdays and Fridays. During a concurrent observation and interview on 8/5/2025 at 12:50pm with Licensed Vocational Nurse 11 (LVN 11), Resident 6 was observed with unkept hair and both bare feet were covered with black dirt, Her feet are dirty, they're black. LVN 11 stated, Resident 6's feet were dirty and black in color and stated Resident 6's hair was oily. LVN 11 stated showers were given as scheduled and as needed. LVN 11 stated, residents should be clean and appear presentable to make them feel good. During an interview on 8/8/2025 at 12:54 pm with the Director of Nursing (DON), the DON stated it was inappropriate for Resident 6 to look disheveled or dirty. The DON stated, as part of ADLs nursing staff were supposed to provide hygiene to residents (in general) every shift. The DON stated, it was important for ADL's to be performed as they allowed the residents to have dignity and well-being. During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADLs), revised 2023, the P&P indicated, the facility will ensure a resident's abilities in ADLs, which included bathing, dressing, and grooming, did not deteriorate unless unavoidable. The P&P indicated a resident who was unable to carry out ADLs would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The P&P indicated, the facility would maintain individual objectives of the CP and periodic review and evaluation.</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>(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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the smoking policy and procedure (P&P) was implemented for one of two sampled residents (Resident 213) when Resident 213 was found with two cigarettes in Resident 213's possession. This failure had the potential to put the facility at risk of a fire hazard. Findings: During a review of Resident 213's admission Record (AR), the AR indicated Resident 213 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), schizophrenia (a mental illness characterized by disturbances in thought), and traumatic brain injury (TBI-a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head).During a review of Resident 213's History & Physical (H&P) dated 10/21/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 213's Minimum Data Set assessment (MDS - a federally mandated resident assessment tool) dated 6/8/2025, the MDS indicated Resident 213 had moderately impaired cognition (ability to think).During a review of Resident 213's Smoking Assessment Form (SAF) dated 6/14/2025, the SAF indicated Resident 213 utilized tobacco, was a danger to self or others while smoking, was unable to identify the designated smoking areas, and was an unsafe smoker that required supervision at all times when smoking. During a review of Resident 213's untitled Care Plan (CP) initiated on 10/21/2024, the CP indicated Resident 213 had a behavior problem of being socially inappropriate, aggressive, refusing care, and having sudden mood changes. The CP indicated a goal for Resident 213 to not harm self or others secondary to Resident 213's behavior.During a review of Resident 213's untitled Care Plan (CP) initiated on 3/12/2025, the CP indicated Resident 213 was at risk for self-injury related to smoking and Resident 213 preferred saving/hoarding cigarettes for later use. The CP goals indicated for Resident 213 to abide by house rules on safe smoking daily and minimal injuries to self and others. The CP interventions indicated for nursing staff to explain the facility's policy and procedures regarding smoking to Resident 213.During a concurrent observation and interview on 8/5/2025 at 9:36 am of Resident 213 in Resident 213's room, two tobacco cigarettes were in a cup on Resident 213's bedside table. Resident 213 stated, Resident 213 was a smoker. Resident 213 stated, Resident 213 asked for the cigarettes and received them the night prior from a facility staff member but was unable to recall from whom. During a concurrent observation and interview on 8/5/2025 at 9:54 am with Certified Nurse Assistant 4 (CNA 4), in Resident 213's room, two tobacco cigarettes were in a cup on Resident 213's bedside table in front of the resident. CNA 4 stated Resident 213 usually kept cigarettes in a cup, and cigarettes were provided by the licensed nurses. CNA 4 stated residents were not allowed to keep lighters, but they could keep cigarettes and were usually given one cigarette for the day. During an interview on 8/5/2025 at 9:57 am with Licensed Vocational Nurse 12 (LVN 12), LVN 12 stated Resident 213 was a smoker who liked to collect cigarettes to smoke later. LVN 12 stated residents were not allowed to keep cigarettes or lighters with them. LVN 12 stated cigarettes or lighters were kept by the nurses to prevent any untoward incidents from occurring.During an interview on 8/8/2025 at 12:54 pm with the Director of Nursing (DON), the DON stated Resident 213 was not allowed to keep cigarettes in Resident 213's possession. The DON stated the facility policy prohibited residents from keeping smoking paraphernalia (lighters, cigarettes, vapes). The DON stated the facility had residents with psychological issues and residents who use oxygen and since cigarettes were flammable, it posed a fire risk and was a safety issue. During a review of the facility's P&P titled, Resident Smoking Policy, revised 5/5/2023, the P&P indicated the facility will provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking with safety protections applying to smoking and non-smoking residents. The P&P indicated smoking materials of residents requiring supervision with smoking will be maintained by nursing staff.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents with indwelling catheter (also known as foley catheter, a thin flexible tube inserted into the body to drain urine or other fluids) were assessed and monitored for the presence of sediments (visible particles in the urine that may contain red or white blood cells, casts or bacteria) in the catheter tubing and bag consistent with the physician's order and the residents' care plan for two of two sampled residents (Residents 5 and 10). These failures had the potential for Residents 5 and 10 to receive delayed care and treatment to prevent urinary tract infection (UTI, an infection in the bladder or urinary tract).</p> <p>Findings:</p> <p>a. During a review of Resident 10's admission Record (AR), the AR indicated Resident 10 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included obstructive uropathy (a condition where the flow of urine is blocked or impaired at any point in the urinary tract, from the kidneys to the urethra), benign prostatic hyperplasia (BPH, enlarged prostate), and urinary tract infection (UTI, an infection in the bladder/urinary tract).</p> <p>During a review of Resident 10's untitled Care Plan (CP), dated 10/3/2024, the CP indicated Resident 10 had a Foley catheter (FC) related to urinary retention (unable to empty their bladder completely or adequately) and obstructive uropathy. The CP interventions included for staff to observe signs and symptoms of UTI.</p> <p>During a review of Resident 10's Order Summary Report (OSR), dated 6/24/2025, the OSR indicated Resident 10 had an order to monitor foley catheter tubing and bag for sediments, hematuria (blood in urine), and cloudy urine every shift.</p> <p>During a review of Resident 10's Minimum Data Set (MDS, a resident assessment tool), dated 7/13/2025, the MDS indicated Resident 10 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident was dependent (helper did all the effort, resident did none of the effort to complete the activity) with eating, oral hygiene, toileting, shower, upper and lower body dressing and personal hygiene. The MDS indicated Resident 10 had an indwelling catheter.</p> <p>During an observation inside Resident 10's room on 8/5/2025 at 10:51 am, Resident was in bed, lying on Resident 10's back with Foley catheter hanging on the right side of the bed.</p> <p>During a concurrent record review and interview on 8/7/2025 at 2:22 pm with Registered Nurse Supervisor 2 (RN 2), Resident 10's medical record (chart) and electronic medical record (EMR) were reviewed. RN 2 stated Resident 10 had an order to monitor foley catheter tubing and bag for sediment, hematuria and cloudy urine every shift. RN 2 stated there was no record documented in Resident 10's medical record indicating Resident 10's foley catheter tubing and bag was assessed and monitored. RN 2 stated Resident 10's FC tubing and bag should have been monitored and assessed every shift to prevent infection.</p> <p>(continued on next page)</p>		

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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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 8/8/2025 at 10:56 am with the Director of Nursing (DON), the DON stated all residents with indwelling catheter should be assessed and monitored for the presence of sediments, hematuria, and cloudiness in the urine as ordered by the physician to prevent infection.</p> <p>During a review of the facility's undated Policy and Procedure (P&P) titled, "Catheter Care, Urinary," the P&P indicated, "Observe the resident for complications associated with urinary catheters. Check the urine for unusual appearance. Character of urine such as color, clarity, and odor. Observe for other signs and symptoms of urinary tract infection or urinary retention. Report findings to the physician or supervisor immediately."</p> <p>b. During a review of Resident 5's AR, the AR indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included chronic kidney disease (CKD, a progressive condition where the kidneys gradually lose their ability to filter waste and excess fluid from the blood) and BPH (enlargement of the prostate gland).</p> <p>During a review of Resident 5's untitled CP dated 3/14/2025, the CP indicated Resident 5 had a foley catheter in place related to urinary retention. The CP intervention indicated for the nursing staff to observe Resident 5 for signs and symptoms of UTI.</p> <p>During a review of Resident 5's Order Summary Report (OSR) dated 5/13/2025, the OSR indicated for licensed staff to insert foley catheter French (a type of catheter) 18 (size of the catheter) per 10 milliliters (ml, unit of measurement) attached to bedside drainage bag due to CKD, BPH with urinary retention.</p> <p>During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5 had severely impaired cognition for daily decision making. The MDS indicated Resident 5 was dependent (helper did all the effort and lifted or held trunk or limbs) on staff for oral hygiene, toileting, showering/bathing self, lower body dressing, putting on/taking off footwear, and personal hygiene.</p> <p>During a concurrent observation in Resident 5's room and interview with Registered Nurse 2 (RN 2) on 8/5/2025 at 10:13 am, Resident 5 was awake, lying in bed. Resident 5 had foley catheter hanging on the right side of bed. Resident 5's foley catheter tubing had approximately one (1) feet (ft, unit of measurement) of white sediments. RN 2 stated the FC tubing had approximately 1 ft of white sediments inside. RN 2 stated white sediments in the tubing could indicate a sign of infection. RN 2 stated, signs of infection needed to be monitored every shift by License Nurses to prevent urinary tract infection (UTI- infection that affects part of the urinary tract). RN 2 stated, Resident 5's hospice (medical service designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life) nurse needed to be notified of the presence of white sediments in the foley catheter tubing.</p> <p>During an interview on 8/9/2025 at 11:27 am, with the facility's DON, the DON stated Resident 5's foley catheter needed to be monitored by licensed nurses every 8 hours for signs and symptoms of infection such as quality of urine, color of the urine, foul odor, and presence of sediments in the urine, to prevent UTI.</p> <p>(continued on next page)</p>		

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<p>F 0690</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 P&P titled, Catheter Care, Urinary, revised 2023, the P&P indicated, observe the resident for complications associated with the urinary catheters. Check the urine for unusual appearance (color, blood&hellip;), observe for other signs and symptoms of urinary tract infection or urinary retention. Report findings to the physician or supervisor immediately.</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, for two of two sampled residents, (Residents 304 and 18) the facility failed to:</p> <p>a. Ensure licensed nursing staff administered Resident 304's gastrostomy tube (GT- a tube inserted through the abdomen that delivers nutrition directly to the stomach) feeding as ordered by the physician and as indicated in the facility's Policy and Procedure (P&P) titled Enteral Nutrition.</p> <p>b. Ensure the Registered Dietitian's (RD) recommendation for Resident 18 to start multivitamins and minerals on 7/18/2025 was implemented/carried out and communicated to the physician. These deficient practices had the potential to result in adverse consequences for Residents 304 and 18. Findings:</p> <p>a. During a review of Resident 304's admission Record (AR), the AR indicated Resident 304 was initially admitted to the facility on [DATE] and re admitted on [DATE] with diagnoses that included Parkinson's disease (a progressive disorder of the nervous system that primarily affects movement), dysphagia (difficulty or pain in swallowing) and encounter for attention to gastrostomy (a surgically created opening in the stomach for feeding or medication administration).</p> <p>During a review of Resident 304's Health and History (H&P) dated 11/13/2024, the H&P indicated Resident 304 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 304's untitled Care Plan (CP) dated 11/14/2024, the CP indicated Resident 304 had a GT feeding. The CP interventions indicated G-Tube feeding as ordered. During a concurrent CP review dated 11/15/2025, the CP indicated potential for weight fluctuation. The CP interventions indicated to monitor tolerance in G-tube feeding and to administer as ordered.</p> <p>During a review of Resident 304's Order Summary Report (OSR) dated 11/22/2024, the OSR indicated for licensed staff to administer Enteral Feed continuous G-Tube feeding (a feeding tube inserted into the stomach through a small opening in the abdomen) of Fibersource (feeding formula) at 60 milliliter per hour (ml/hr.- measure of volume per hour) for 20 hours to provide 1200ml/1440cal in 24 hours via enteral feeding pump, on at 2pm and off at 10am or until dose completed.</p> <p>During a review of Resident 304's Minimum Data Set (MDS- a resident assessment tool), dated 5/27/2025, the MDS indicated Resident 304 was dependent (helper does all of the effort) on staff for all Activities of Daily Living (ADLs) such as oral and personal hygiene, toileting hygiene, shower, upper and lower body dressing and putting on and taking off footwear.</p> <p>During an observation of Resident 304 on 8/5/2025 at 11:07 AM in Resident 304's room, Resident 304 was resting in bed with an ongoing tube feeding at bedside. Resident 304's GT feeding was running at 65ml/hr. via feeding pump.</p> <p>During a concurrent observation and interview inside Resident 304's room with License Vocational Nurse 1 (LVN1) on 8/6/25, at 9:26 AM, LVN 1 stated Resident 304 should receive GT feeding at 60 mL/hr. as ordered and not 65 mL/hr. LVN 1 stated, it was important to follow physician's order so that the resident will get proper nutrition and weight management would be stable. LVN 1 stated the physicians order was not followed because the feeding administered was at 65 mL/hr.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the facility's Director of Nursing (DON) on 8/6/2025 at 10:56 AM, the DON stated it was important to administer the correct amount of GT feeding to the residents. The DON stated licensed nurses should follow the physician's order including the frequency or rate of tube feeding. The DON stated if the order was not followed and the resident received more than what was ordered, it could cause weight gain from excessive amount of calories and would be harmful to the resident by causing fluid overload (too much fluid in the body), abdominal distention (swelling in the stomach area) and/or aspiration in the lungs (the accidental inhalation of foreign material, such as food, liquid, or other substances, into the lungs). The DON stated it was the license nurse's responsibility to ensure the tube feeding was administered according to the physician's order to prevent any adverse effects on the residents.</p> <p>During an interview with the RD on 8/6/2025 at 3:30 PM, the RD stated Resident 304 had weight gain of eleven (11) lbs. in the last six (6) months and was triggered for gradual weight gain in the past 90 days. The RD stated that the tube feeding rate recommendations were given by the RD to the physician, and the physician placed the order. The RD stated that licensed nurses should follow the physicians' orders because if the orders were not followed, it could potentially cause the resident to have excess calorie intake leading to weight gain.</p> <p>During a review of the facility's undated Policy and Procedure (P&P), titled, "Enteral Nutrition," the P&P indicated adequate nutritional support through enteral feeding will be provided to the residents as ordered.</p> <p>4. Enteral nutrition will be ordered by the Physician based on the recommendations of the Dietitian.</p> <p>8. The nursing staff and Physician will monitor the resident of signs and symptoms of inadequate nutrition.</p> <p>b. During a review of Resident 18's AR, the AR indicated Resident 18 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included unspecified dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning) and severe with psychotic (serious mental disorder in which people interpret reality abnormally) disturbance.</p> <p>During a review of Resident 18's MDS dated [DATE], the MDS indicated Resident 18 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 18 was dependent (helper does all of the effort) on staff for toileting hygiene, shower, upper/lower body dressing and putting on/off footwear.</p> <p>During a review of Resident 18's Nutrition Screening dated 7/18/2025, the screening indicated to start multivitamins for Resident 18.</p> <p>During a review of the facility's Dietary Recommendations dated 7/23/2025, the Dietary Recommendations did not indicate starting multivitamins for Resident 18.</p> <p>During an observation on 8/5/2025 at 8:14 am while inside Resident 18's room, Resident 18 was awake lying in bed.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent record review of Resident 18's Nutrition Screening dated 7/18/2025 and interview on 8/6/2025 at 8:52 am with Registered Nurse 1 (RN 1), RN 1 stated the RD recommended to start multivitamins and minerals for Resident 18. RN 1 stated, Resident 18's primary physician was not notified of the RD recommendation. RN 1 stated, licensed nurses needed to check the RD Nutrition Screening to address RD's recommendations for residents. RN 1 stated if the RD recommendation was not communicated to the resident's primary physician, there could be potential significant weight/nutritional problems for the resident.</p> <p>During an interview on 8/6/2025 at 9:34 am with the facility's Director of Nursing (DON), the DON stated the RD recommendation for Resident 18 was not followed up and Resident 18's primary physician was not notified of the RD's recommendation to start multivitamins and minerals for Resident 18. The DON stated there was no clinical documentation that RD recommendation for Resident 18 was communicated to the physician. The DON stated Resident 18's nutritional needs would not be met and could lead to weight loss or weight gain if RD recommendations were not acted upon.</p> <p>During an interview on 8/6/2025 at 9:52 am with the facility's RD, the RD stated the RD had the dietary recommendations printed and gave it to the licensed nurse to notify the primary physician. The RD stated, within three (3) days, the facility needed to act upon the RD's recommendations. The RD stated, the RD missed to indicate Resident 18's RD recommendation on the form that the RD handed to the licensed nurse. The RD stated Resident 18 would not receive the intervention that was recommended, and the resident would not get adequate intervention that was recommended by the RD.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Dietary Recommendations, dated 7/2025 the P&P indicated, the dietitian may suggest changes such as supplements, diet texture, or calorie needs. These are written in the chart and shared with nursing. The P&P indicated all recommendations must be reviewed by the doctor. They will not be used unless the physician gives an order. The nurse will notify the doctor and document any order.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary care and services for residents receiving oxygen therapy (treatment that provides supplemental, or extra oxygen) in accordance with professional standards of practice for three of the three sampled residents (Residents 17, 52, and 238) by failing to: a. Ensure residents with pro re nata (PRN, as needed, when necessary) oxygen order had an oxygen concentrator machine (medical device used to deliver oxygen) stand by (ready or available) set up in the room for Resident 52 to use. b. Ensure Resident 17's nasal cannula tubing (flexible plastic tubing used to deliver oxygen through nostrils and the tubing is fitted over the patient's ears) was stored appropriately when not in use. c. Ensure Resident 238 had a physician's order for the use of oxygen at two and a half liters per minute through nasal cannula and a cautionary sign was posted on the resident's door indicating oxygen in use. These failures placed Residents 17, 52, and 238 at risk for complications related to the use of oxygen, shortness of breath and/or hypoxia (low levels of oxygen in the body tissues) and the risk of infection which could lead to respiratory complications. Findings:</p> <p>a. During a review of Resident 52's admission Record (AR), the AR indicated Resident 52 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), hypertensive heart disease heart conditions caused by long-term high blood pressure), and sleep apnea (sleep disorder where breathing repeatedly stops and starts during sleep).</p> <p>During a review of Resident 52's Minimum Data Set (MDS, a resident assessment tool), dated 7/4/2025, the MDS indicated Resident 52 had moderately impaired cognition (ability to understand and process information). The MDS indicated Resident 52 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity) with eating, oral hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 52 required partial/moderate assistance (helper did less than half the effort) with toileting, shower, and lower body dressing. The MDS indicated Resident 52 was on oxygen therapy.</p> <p>During a review of Resident 52's Order Summary Report (OSR), dated 8/2/2025, the OSR indicated Resident 52 had an order for PRN oxygen at 2 liters (L, unit of measuring volume of liquid or gas) via nasal cannula (NC, a thin, flexible tube used to deliver oxygen or other gases directly into the nostrils) for shortness of breath (SOB)/low oxygen saturation for COPD.</p> <p>During a concurrent observation inside Resident 52's room and interview on 8/5/2025 at 10:58 am with the Certified Nurse Assistant 1 (CNA 1), Resident 52 was in bed and on Resident 52's back. CNA 1 stated Resident 52 did not have an oxygen concentrator machine set up at bedside. CNA 1 stated Resident 52 was on oxygen therapy.</p> <p>During a concurrent record review and interview on 8/6/2025 at 11:49 am with Registered Nurse Supervisor 2 (RN 2), Resident 52's OSR, dated 8/2/2025, was reviewed. RN 2 stated Resident 52 had an order for as needed oxygen therapy. RN 2 stated all residents with continuous or as needed order for oxygen therapy should have an oxygen concentrator machine set-up in the room ready for the resident to use anytime the resident experienced shortness of breath.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 8/8/2025 at 10:55 am with the Director of Nursing (DON), the DON stated all residents with continuous or as needed order for oxygen should have an oxygen concentrator machine set-up in the room for use anytime the resident needed supplemental oxygen to prevent respiratory distress. The DON stated a &ldquo;cautionary sign&rdquo; should be posted outside the resident&rsquo;s room to alert staff, visitors and other residents on the presence of oxygen in the room for the safety of everyone in the facility.</p> <p>During a review of the facility&rsquo;s undated Policy and Procedure (P&P) titled, &ldquo;Oxygen Administration,&rdquo; the P&P indicated, &ldquo;Oxygen is administered under the orders of a physician, except in the case of an emergency. Oxygen warning signs must be placed on the door of the residents&rsquo; room where oxygen is in use.&rdquo;</p> <p>b. During a review of Resident 17&rsquo;s AR, the AR indicated Resident 17 was admitted to the facility on [DATE] with diagnoses that included personal history of pneumonia (an infection/inflammation in the lungs) and asthma (chronic lung disease that inflames and narrows the airways).</p> <p>During a review of Resident 17's Physician Order&rsquo;s (PO) dated 3/26/2025, the PO indicated for Resident 17 to receive oxygen at four (4) liters per minute (L/min) to maintain oxygen saturation above 92 percent (%) every four hours as needed (PRN) for oxygen saturation below 92 %.</p> <p>During a review of Resident 17&rsquo;s MDS dated [DATE], the MDS indicated Resident 17 had intact cognition for daily decision making. The MDS indicated Resident 17 needed supervision (helper sets up or cleans up) from staff for toileting, shower, upper/lower body dressing and putting on/off footwear and personal hygiene. During a concurrent observation and interview on 8/5/2025 at 10:43 am, together with Registered Nurse 1 (RN 1) Resident 17 was lying in bed with nasal cannula tubing hanging on the oxygen concentrator with nasal prongs touching the handle of the concentrator. RN 1 stated if oxygen was not in use, nasal cannula needed to be inside a bag for infection control.</p> <p>During an interview on 8/7/2025 at 11:26 am, with the facility&rsquo;s Director of Nurses (DON), the DON stated if oxygen was not in use, nasal cannula tubing needed to be stored in the plastic bag for infection control.</p> <p>During a review of the facility&rsquo;s undated P&P titled, &ldquo;Oxygen Administration,&rdquo; the P&P indicated to keep delivery devices covered in plastic bag when not in use.</p> <p>c. During a review of Resident 238&rsquo;s AR, the AR indicated Resident 238 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD- type of obstructive lung disease characterized by long-term poor airflow) and anemia (decrease in the total amount of red blood cells in the blood).</p> <p>During a review of Resident 238&rsquo;s MDS dated [DATE], the MDS indicated Resident 238 had moderately impaired cognition for daily decision making. The MDS indicated, Resident 238 needed moderate assistance (helper does less than half the effort) from staff for toileting, shower, upper/lower body dressing and putting on/off footwear and personal hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 8/5/2025 at 8:54 am, together with Registered Nurse 1 (RN 1) Resident 238 was lying in bed with ongoing oxygen at 2.5 liters per minute (LPM) via nasal cannula. RN 1 stated Resident 238 was receiving oxygen at 2.5 LPM via nasal cannula. RN 1 stated there was no sign posted outside Resident 238's door indicating oxygen was in use in the room or smoking was prohibited. RN 1 stated there should be an oxygen sign to remind staff and residents not to smoke inside the room to prevent fire and combustion (process of burning things).</p> <p>During a concurrent interview and record review on 8/5/2025 at 11:42 am with RN 1 of Resident 238's medical records (PointClickCare - PCC, a cloud-based software) RN 1 stated there was no physician's (doctors) order for Resident 238's oxygen administration. RN 1 stated, there should be a doctor's order for oxygen administration for Resident 238 to ensure Resident 238 received safe and accurate oxygen therapy.</p> <p>During a review of the facility's undated P&P titled, "Oxygen Administration," P&P indicated, oxygen is administered under orders of a physician, except in the case of an emergency. In such cases, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control. The P&P indicated warning signs must be placed on the door of the resident's room when oxygen is in use.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: A. Clarify a discrepancy between the physician's order for Resident 270's Olanzapine (treat mental disorders) and the prescription label prior to medication administration. B. Identify Resident 98 and Resident 270 prior to the administration of medication. C. Remove discontinued and inactive controlled medication ([CM]- medications which have a potential for abuse and may also lead to physical or psychological dependence) orders for Residents 47, 261, and 6. These failures increased the risk of medication errors for Residents 6, 47, 98, 261 and 270. Findings: A. During a review of Resident 270's admission record (AR, a document containing diagnostic and demographic information), the AR indicated Resident 270 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including paranoid schizophrenia (a chronic mental health disorder characterized by persistent delusions, false beliefs and hallucinations, hearing or seeing things not there). During a review of Resident 270's Minimum Data Set (MDS - a resident assessment tool), dated 6/19/2025, the MDS indicated Resident 270's cognition (ability to learn reason, remember, understand, and make decisions) was moderately impaired. During a review of Resident 270's Physician Order Summary, the Order Summary included an order dated 6/20/2025, to administer Zyprexa Zydis (Olanzapine) Oral Disintegrating Tablet (ODT) 10 milligrams (mg, unit of measure by weight), one tablet by mouth two times a day, for talking to self and unseen others related to paranoid schizophrenia. During a medication pass observation on 8/7/2025 at 8:41 AM with Licensed Vocational Nurse (LVN) 3, LVN 3 was observed preparing the following medications: 1. Cymbalta (used to treat depression and anxiety) 60 mg, one tablet 2. Olanzapine ODT 20 mg, one-half tablet 3. Metoprolol (treat high blood pressure) 25 mg, one tablet During a review of the Olanzapine prescription label for Resident 270, the label indicated to administer Olanzapine ODT 20 mg, half tablet (10 mg) by mouth twice a day for Paranoid Schizophrenia with an issue date of 6/20/2025. During a review of Resident 270's Medication Administration Record ([MAR] - a record of medications administered to residents), the MAR indicated Resident 270 was administered one tablet of Olanzapine 10 mg on 8/7/2025 scheduled for 9 AM administration, evident by nurse's initials. However, Resident 270 was observed during medication pass administration being administered Olanzapine 20 mg, one-half tablet for the 8/7/2025 scheduled 9 AM administration. During a concurrent interview and record review on 8/7/2025 at 2:52 PM with LVN 3, Resident 270's August 2025 Medication Administration Record [MAR] - a record of medications administered to residents), prescription label, and physician order for Olanzapine was reviewed. LVN 3 acknowledged Resident 270's Olanzapine order and medication label did not match, and the order was not clarified with the physician or pharmacy prior to administering the medication on 8/7/2025 for the 9 AM scheduled administration. During a concurrent interview and record review on 8/7/2025 at 3:21 p.m. with Registered Nurse (RN) 2, Resident 270's August 2025 MAR, prescription label, and physician order for Olanzapine were reviewed. RN 2 stated there was no sticker on the prescription label to indicate there was a change in direction from one tablet of Olanzapine 10 mg to one-half tablet of Olanzapine 20 mg, which could be confusing and may lead to medication errors. RN 2 stated Resident 270's Olanzapine order should have been clarified with the physician and/ or the facility's pharmacy. RN 2 stated the physician order, and the prescription label should match, the description of the tablet and dose is wrong. RN 2 stated, during the medication pass the licensed nurses are to compare the physician order with the prescription label. RN 2 stated if the order and label do not match the licensed nurse should obtain a clarification. RN 2 stated if the medication dosage form or direction is different the nurse should obtain a clarification and should document in the nursing progress note. During a concurrent interview and record review on 8/7/2025 at 3:37 PM with RN 2, Resident 270's nursing notes were reviewed from 6/20/2025 through 8/7/2025. RN 2 stated there was no documentation Resident 270's order for Olanzapine was clarified with the physician. During a review of the facility's Policy and Procedures (P&P) titled, Medication Administration - General Guidelines, dated 1/2024, the P&P indicated Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record. Compare the medication and dosage schedule on the resident's MAR with the medication label. If the label and MAR are different, and the container is not flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the prescriber's orders are checked for the correct dosage schedule. Since unscored tablets may not be accurately broken, their use is discouraged if a suitable alternative is available (such as liquid or half-strength</p>		

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record reviews, the facility failed to: A. Ensure Resident 5's inhalation medication DuoNeb (Ipratropium bromide and albuterol sulfate inhalation solution is a combination medication used to treat breathing problems associated with lung diseases like chronic obstructive pulmonary disease [COPD]) was stored appropriately in accordance with the manufacturer's specifications to maintain the medication's therapeutic effectiveness when needed. B. Remove non-controlled medications from the medication cart for a discharged resident, Resident 5C. Dispose of non-controlled medications in the presence of a witness in accordance with facility's policy titled, Disposal of Medications, Syringes and Needles - Disposal of Medications. These failures increased the risk of Resident 5 receiving an expired DuoNeb inhaler treatment that may result in the medication being less potent, ineffective, or contaminated which could lead to inadequate relief of respiratory symptoms, shortness of breath, hospitalization or harm, exposing residents on the Nursing Station to medication errors, potential inadvertent administration of discharged resident's (Resident 34) medications available for use inside the medication cart, and lack of accountability for disposal of non-controlled medications throughout the facility. Findings: A. During a review of Resident 5's admission record (AR, a document containing diagnostic and demographic information), the AR indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including acute (sudden) and chronic (long-term) respiratory failure (a serious condition that makes it difficult to breathe on your own). During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool), dated 6/19/2025 the MDS indicated Resident 5's cognition (ability to learn reason, remember, understand, and make decisions) was severely impaired. During a review of Resident 5's Physician Order Summary, the Order Summary included an order to administer albuterol 2.5 milligrams (mg, unit of measure by weight) - ipratropium 0.5 mg per 3 milliliters (ml, unit of measure by volume) inhalation solution 2.5-0.5 mg/3 ml, instructions indicated, 1 (one) unit inhale orally via nebulizer (a small machine that turns liquid medicine into a mist that can be easily inhaled) every 4 (four) hours as needed for shortness of breath, order dated 7/2/2025. During a review of Resident 5's Care Plan focus, the care plan indicated Resident at risk for SOB (shortness of breath) due to diagnosis of acute and chronic respiratory failure date initiated 10/12/2024. Resident 5's interventions included to administer albuterol-ipratropium as ordered with an initiation date of 7/2/2025. During a medication storage inspection on 8/6/2025 at 11:22 AM with a Licensed Vocational Nurse (LVN) 5 on Station 6 Westside Medication Cart, observed inside of the medication cart were vials of Albuterol-ipratropium Inhalation Solution 2.5-0.5 mg/3 ml labeled for Resident 5 stored in a clear plastic bag with a fill date of 7/2/2025. During a concurrent interview and review of the manufacturer specifications for albuterol-ipratropium inhalation solution 2.5-0.5 mg/3 ml on 8/6/2025 at 11:49 AM with LVN 6, LVN 6 stated that Resident 5's albuterol-ipratropium inhalation solution should be stored in a foil pouch and should be removed one vial at a time. LVN 6 stated Resident 5's albuterol-ipratropium inhalation solution was not stored in a foil pouch, and that the vials were stored in the medication cart in a clear plastic bag. LVN 6 stated the drug information reviewed indicated that Resident 5's inhalation solution expires seven days after removal from the foil pack. During a continued interview on 8/6/2025 at 11:55 AM with LVN 6, LVN 6 stated the fill date for Resident 5's albuterol-ipratropium inhalation Solution was 7/5/2025 and the medication was stored unprotected from light and outside of the foil pouch for over a month. LVN 6 stated the medication for Resident 5 was not good to use and he would have to notify his supervisor. During an interview on 8/7/2025 at 10:52 AM, with the Director of Nursing (DON), the DON stated she was made aware that Resident 5's albuterol-ipratropium inhalation solution was stored outside of the foil pouch for a month which would make the medication ineffective if Resident 5 needed a breathing treatment or experience shortness of breath. The DON stated if Resident 5 was given the expired inhalation solution the resident could experience respiratory issues that could lead to hospitalization, oxygen desaturation (a decrease in the oxygen saturation levels in the blood) and respiratory distress. During a review of Resident 5's Medication Administration Record ([MAR] - a record of medications administered to residents), the MAR for the months of 7/2025 and 8/2025 indicated Resident 5 was administered 15 doses of expired albuterol-ipratropium inhalation solution 2.5-0.5 mg/3 ml between 7/28/2025 through 8/6/2025 as follows on: 7/28/2025 two doses at 8:45 AM and 12:45 PM 7/29/2025 two doses at 8:15 AM and 12:45 PM 7/30/2025 two doses at 7:30 AM and 12:40 PM 7/31/2025 two doses at 7:20 AM and 11:50 AM 8/1/2025 two doses at 7:40 AM and 12:10 PM 8/5/2025 two doses at 7:35 AM and</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>Based on observation, interview, and record review, the facility failed to properly cover six of 10 large trash bins with lids as indicated in the facility's Policy and Procedure (P&P) on garbage disposal. This deficient practice had the potential to attract vermin (animals that are believed to be harmful, carry diseases such as rodents, parasitic worms, or insects) and pests (any living thing that has a negative effect on humans) that could potentially enter the facility, affect the resident care areas, and expose the residents and staff to diseases. Findings: During a facility tour and observation on 8/5/2025 at 8:44 AM, two large trash bins full of trash bags in the Lodge Building, three large trash bins in the Manor Building and one large trash bin in the Center Building area outside in the parking lot had open lids. During an interview with Kitchen Manager (KM) on 8/5/2025 at 8:49 AM, KM stated the trash bin lids should be kept closed at all times because it was unsanitary and to prevent cross contamination (transfer from one substance or object to another, with harmful effect). The KM stated the kitchen area in the Center Building had 2 large trash bins, but there wasn't enough space for the trash that needed to be placed inside daily. The KM stated if the trash bin lids were not kept closed there could be contamination or pest infestation. During an interview with the Maintenance Supervisor (MS) on 8/6/2025 8:41 AM, MS stated, if the trash bins were overfilled, the lids don't close and attract rodents/flies that could cause harm to the residents and staff. During an interview with the Director of Nursing (DON) on 8/6/2025 at 10:56 AM, the DON stated the trash bins should be covered with lids at all times for infection control. The DON stated keeping the trash lids closed prevent bad odors and rodents. The DON stated it was not sanitary to have trash lids open near the resident's room/activity room. During an interview with the facility's Infection Prevention Nurse (IPN2) on 8/6/2025 at 11:11 AM, IPN2 stated the trash bins needed to have a tight sealed lid to prevent the spread of infection and prevent rodents and other animals getting in the trash. IPN2 stated it was not sanitary and not acceptable for staff to leave the trash bin lids open. During a review of the facilities undated P&P titled, Disposal of Garbage and Refuse, the P&P indicated, The facility shall properly dispose of garbage and refuse. Garbage and refuse containers should be free from cracks and leaks and covered when not in use. 6. Refuse containers and dumpsters kept outside the facility should have tightly fitting lids and should be kept covered when not being loaded.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review the facility failed to ensure: A. Licensed Vocational Nurse (LVN) 1 performed hand hygiene (hand washing using soap and water, and cleaning hands with waterless or alcohol-based hand sanitizers) for one of five sampled resident (Resident 59) during medication administration observation. B. Resident 304's [NAME] valve (used to maintain a closed system, minimizing healthcare worker exposure to bodily fluids and reducing the risk of accidental contamination) used with a gastric or enteral feeding tube (GT or ENT, medical devices used to deliver nutrition, fluids, and medications directly into the stomach) was not observed crusty, dirty, or worn, and missing a coverage cap. These failures placed Resident 59 and Resident 304 at risk for the spread of infection between residents and staff and had the potential to result in cross contamination (physical movement or transfer of harmful bacteria from one person, object, or place to another).</p> <p>Findings:</p> <p>A. During a review of Resident 59's admission Record (AR, a document containing diagnostic and demographic information), the AR, indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that included dry eye syndrome (when the eyes do not produce enough tears), epilepsy (is a neurological condition that causes unprovoked, recurrent seizures [a sudden rush of abnormal electrical activity in the brain]), and Parkinson's disease (a progressive neurological disorder that affects movement, balance, and coordination).</p> <p>A review of Resident 59's History and Physical (H&P) dated 12/3/2024, indicated the resident does not have the capacity to understand and make decisions.</p> <p>During a review of Resident 59's MDS, dated [DATE], indicated Resident 59's cognitive (ability to think and reason) skills for daily decisions making was moderately impaired. The MDS indicated Resident 59 required setup or clean-up assistance for activities of daily living (ADL, tasks you do regularly to take care of your body and overall well-being, that include bathing, dressing, toileting, feeding, and ambulating [walking]).</p> <p>During a medication pass observation on 8/6/2025 between at 8:22 a.m. through 8:33 a.m., with LVN 1, while at Station 1 Medication Cart West, LVN 1 was observed preparing and administering the following medications for Resident 59:</p> <ul style="list-style-type: none"> a. Amantadine (used in managing symptoms of Parkinson's disease and drug-induced movement disorders) 100 mg Capsule, one capsule. b. Divalproex sodium (used to treat or prevent seizures) 125 MG Delayed Release Oral Tablet, one tablet. c. Quetiapine (used to treat mental disorder) 100 MG Oral Tablet, one tablet d. Fish oil (dietary supplement) 1000 mg/ Omega-3 300 mg, one capsule e. Systane Original (used to treat dry eyes) Eye Drop, one drop into each eye <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/6/2025 at 8:31 a.m., before entering Resident 59's room, LVN 1 failed to perform hand hygiene.</p> <p>On 8/6/2025 at 8:31 a.m., LVN 1 exited Resident 59's room, opened the medication cart, removed tissues, and reentered Resident 59's room without performing hand hygiene. LVN 1 put on gloves without performing hand hygiene and administered Systane Original eye drops into Resident 59's eyes. LVN 1 left Resident 59's room with gloves on.</p> <p>During an interview on 8/6/2025 at 8:36 a.m., with LVN 1 outside of Resident 59's room, LVN 1 stated, "I should have sanitized my hands before entering resident's room." LVN 1 stated her hands should have been sanitized when exiting Resident 59's room before grabbing tissues from the medication cart and before putting on gloves to administer eye drops to the resident.</p> <p>During an interview on 8/7/2025 at 2:23 p.m., with the Infection Prevention Nurse (IPN), the IPN stated licensed nurses should perform hand hygiene by sanitizing the hands with alcohol-based hand sanitizer or washing the hands with soap and water. The IPN stated hand hygiene should be done before passing medications, during, and after medication pass, when the licensed nurses are exiting the resident's room and as needed. The IPN stated hands must be sanitized or washed before putting on gloves and again once the licensed nurse remove or takes off gloves. The IPN stated the license nurses must sanitize or wash hands to ensure hands or clean; to prevent the spread of infection to our residents and protecting their self and others from the spread of infection, this is standard infection control precaution.</p> <p>During a review of the facility's undated policy and procedure (P&P), titled "Hand Hygiene," the P&P indicated All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. The facility's P&P defined, "Hand Hygiene as a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based rub (ABHR)." The P&P indicated:</p> <ul style="list-style-type: none"> - Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. - Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. - Additional considerations. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. <p>During a review of the facility's undated, "Hand Hygiene Table," indicated to use either antimicrobial soap and water or alcohol-based hand rub, under conditions that included, but not limited to:</p> <ul style="list-style-type: none"> - Between resident contact. - Before applying and after removing personal protective equipment (PPE), including gloves - Before preparing or handling medications. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Before performing resident care procedures.</p> <p>- When in doubt.</p> <p>During a review of the facility's P&P, titled Medication Administration General Guidelines, dated 7/2007, the P&P indicated, "Hands are washed with soap and water and gloves applied before administration of topical, ophthalmic, optic, parenteral, enteral, enteral, rectal, and vaginal medications. Hands are washed with soap and water again after administration and with any resident contact. Antimicrobial sanitizer may be used in place of soap and water as allowed per stated nursing regulations and facility policy."</p> <p>B. During a review of Resident 304's admission Record (AR), the AR indicated Resident 304 was initially admitted to the facility on [DATE] and re admitted back on 11/13/2024 with diagnoses that included Parkinson's disease (a progressive disorder of the nervous system that primarily affects movement), type 2 diabetes (a chronic condition where the body either doesn't produce enough insulin, or the cells become resistant to insulin, leading to high blood sugar levels), dysphagia (difficulty or pain in swallowing), encounter for attention to gastrostomy (a surgically created opening in the stomach for feeding or medication administration).</p> <p>During a review of Resident 304's Health and History (H&P) dated 11/13/2024 indicated Resident 304 does not have the capacity to understand and make decisions.</p> <p>During a concurrent review of Resident 304's CP initiated on 11/13/2024, the CP indicated EBP related to G-tube. Goals indicated, "Will identify signs and symptoms of active infection and will minimize risk and complications of infection." Interventions indicated, "Observe proper cleaning technique during cleaning of wounds or medical devices.</p> <p>During a review of Resident 304's Care Plan (CP) initiated on 11/14/2024, the CP indicated, Resident with G-Tube feeding, at risk for irritation/infection around G-tube site. Goals indicated to minimize signs and symptoms of infections around GT site daily.</p> <p>During a review of Resident 304's Order Summary Report dated 11/22/2024, the OSR indicated, an "Enteral Feed Order continuous G-Tube feeding (a feeding tube inserted into the stomach through a small opening in the abdomen) of Fibersource (a brand name for a line of nutritionally complete, fiber-containing liquid formulas designed for tube feeding) at 60mL/hr. x20 hours to provide 1200mL/1440cal in 24 hours via enteral feeding pump (nutrition or formula is being delivered directly into a person's digestive system (stomach or small intestine) using a specialized pump). On at 2pm and off at 10am or until dose completed for dysphagia. The OSR also indicated, "Enteral Feed Order every day shift for gastrostomy tube site (GT site- the location on the body where a gastrostomy tube is inserted) cleaning cleanse GT site with Normal Saline (NS- salt water), Pat dry then cover with dry dressing.</p> <p>During a review of Resident 304's Minimum Data Set (MDS- a resident assessment tool), dated 5/27/2025, the MDS indicated Resident 304 is dependent (helper does all of the effort) on the staff for all Activities of Daily Living (ADLs) such as oral and personal hygiene, toileting hygiene, shower, upper and lower body dressing and putting on and taking off footwear.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent review of Resident 304's OSR dated 8/06/2025, the OSR indicated, "May have [NAME] valve (a medical device used with feeding tubes to provide a closed system for administering medications and feeding solutions while minimizing the risk of contamination and exposure to bodily fluids) changed on the 1st of each month. Every day shift starting on the 1st and ending on the 1st every month for G-Tube label and date [NAME] valve when changed. The OSR also indicated Enhanced Barrier Precautions (EBP- Staff wear gowns and gloves when providing care to residents) indication while on G-tube feeding monitor for signs and symptoms of infection every shift.</p> <p>During an observation of Resident 304 on 8/05/2025 at 11:07 AM, Resident 304 was resting in bed, the tube feeding was infusing at the bedside. Resident 304's [NAME] valve was to be wrapped with a towel. Upon closer inspection, the [NAME] valve port was not capped, had dry black and brown crust and formula residue inside the connector port (one of the openings on the valve where other medical tubing or devices can be attached).</p> <p>During observation and interview with License Vocational Nurse (LVN1) on 8/06/2025 at 9:26 AM while inside Resident 304's room, LVN1 stated the [NAME] valve port looked dirty and crusty and should have been changed. Per LVN1, the port should be covered to prevent infection. LVN1 stated the [NAME] valve should not appear crusty and it should be kept clean. LVN stated she did not know if the facility had any [NAME] valve port covers.</p> <p>During an interview with the Director of Nursing (DON) on 8/06/2025 at 10:56 AM, the DON stated, "The [NAME] Valve provides access to enteral systems (is a method of delivering nutrients directly into the gastrointestinal [GI- organs that process food like the mouth and stomach] tract without opening lines.) The resident can receive the nutrients needed and the nurses can administer medication through the ports." Per DON, the [NAME] valve also protects staff from exposure to gastric fluids. The DON stated, the [NAME] valve must be kept clean, and the ports should be covered. The DON stated, "If the port is dirty, the resident is at risk for infection." Per the DON, it can be harmful to a resident if the [NAME] valve port is dirty or crusty and not covered because it can cause potential infection and even death.</p> <p>During an interview with the Infection Prevention Nurse (IPN2) on 8/06/2025 at 11:11 AM, IPN2 stated that when a resident is receiving a tube feeding, the staff need to follow proper cleaning and maintenance procedures to help ensure the safe and effective use of the [NAME] valve connector and reduce the risk of complications associated with residue buildup. IPN2 stated the port on the [NAME] valve [NAME] be covered to prevent entry of infection. Per IPN2, bacteria can grow in warm environments and if there is crust or residue it can potentially be a high risk of infection to the resident. IPN2 stated, "We have replacements to cover the ports in the facility. Is it not acceptable to simply cover the [NAME] valve with a towel in case it leaks. Also, if there is leakage from the port, the stomach contents can leak out from an open or improperly sealed port causing irritation to the skin and creating a breeding ground (an area where bacteria can easily multiply and thrive) for bacteria."</p> <p>During an interview with Registered Nurse (RN3) on 8/07/2025 at 9:16 AM, RN3 stated, the residents who are receiving a G-tube feed should have the [NAME] valve covered to prevent any type of possible infection to the site. RN3 stated, "There is an increased risk of infection due to an open port that can allow bacteria and other microorganisms (bacteria, viruses, fungi) to enter the stomach or the surrounding tissue, potentially leading to infection.</p> <p>(continued on next page)</p>		

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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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facilities Policies and Procedures (P&Ps) titled, "Activities of Daily Living (ADLs) revised 2023, the policy indicated, "A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene."</p> <p>During a review of the facilities undated P&Ps titled, "Infection Prevention and Control Program", the P & P indicated, "It is a policy of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections."</p> <p>During a review of the facilities P&Ps titled, "Quality of Life", revised 2023 indicated, "Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality."</p>		