

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056360	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Arbor Glen Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1033 E. Arrow Highway 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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44114</p> <p>Based on interview and record review, the facility failed to provide sufficient nursing staffing for one of three shifts (the nocturnal shift [NOC- night shift, 11 pm to 7 am]) on 08/24/2024, from 3 am to 7 am, to provide safe and timely nursing care to four of eight sampled residents (Residents 1, 3, 4, and 5).</p> <p>This failure resulted in Residents 1, 3, 4, and 5 to feel unsafe during the NOC shift on 08/24/2024 from 3 am to 7 am, and had the potential to delay the provision of care for the residents.</p> <p>Findings:</p> <p>1. During a review of Resident 1's Admission Record (AR), the AR indicated, Resident 1 was admitted to the facility on [DATE], with diagnoses including peripheral vascular disease (narrowed blood vessels reduce blood flow to the arms or legs)) and muscle wasting (a weakening, shrinking, and loss of muscle caused by disease or lack of use) and atrophy (wasting away of a body part or tissue).</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and screening tool), dated 06/01/2024, the MDS indicated Resident 1 was cognitively intact (able to think, learn, remember, use judgement, and make decisions).</p> <p>2. During a review of Resident's 3 AR, the AR indicated, Resident 3 was admitted to the facility on [DATE], with diagnoses including acute respiratory failure with hypoxia (a serious medical condition that occurs when the lungs have trouble exchanging oxygen and carbon dioxide with the blood) and dysphagia (difficulty or discomfort in swallowing, as a symptom of disease).</p> <p>During a review of Resident 3's MDS, dated [DATE], the MDS indicated, Resident 3 was cognitively intact.</p> <p>3. During a review of Resident's 4 AR, the AR indicated, Resident 4 was admitted to the facility on [DATE], with diagnoses including metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood) and end stage renal disease (a permanent condition where the kidneys stop functioning, requiring dialysis [treatment that helps the body remove extra fluid and waste products from the blood when the kidneys are not able to] or a kidney transplant to survive).</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 4's MDS, dated [DATE], the MDS indicated, Resident 4 was cognitively intact.</p> <p>4. During a review of Resident's 5 AR indicated, the AR indicated, Resident 5 was admitted to the facility on [DATE], with diagnoses including Parkinson's Disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination) and anemia (a condition in which the body does not have enough healthy red blood cells [cells that provide oxygen to body tissues]).</p> <p>During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5 was cognitively intact.</p> <p>During an interview on 09/10/2024 at 10:46 am with Licensed Vocational Nurse (LVN) 2, LVN 2 stated the normal staffing for licensed nurses on the NOC shift was two (2) LVNs. LVN 2 stated on 08/24/2024, from 3:00 am to 7:00 am, there was only one (1) nurse (LVN 1) assigned to care for 86 residents in the facility. LVN 2 stated it was impossible for LVN 1 to do everything by herself, and it was not safe for the residents in case of an emergency like a code.</p> <p>During an interview on 09/10/2024 at 11:30 am with Resident 1, Resident 1 stated Resident 1 knew only LVN 1 was taking care of everyone in the facility sometime last month. Resident 1 stated Resident 1 did not feel safe with 1 LVN because there was always 2 LVNs on the NOC shift. Resident 1 stated if there would have been an emergency what would LVN 1 do alone. Resident 1 stated it was not safe for the residents.</p> <p>During an interview on 09/10/2024 at 1:30 pm with LVN 1, LVN 1 stated the NOC shift nursing staffing was always 2 LVNs, but on 08/24/2024, from 3 am to 7 am, there was only 1 LVN in the facility with 86 residents. LVN 1 stated this was not safe for the residents, and it delayed the care.</p> <p>During a concurrent interview and record review on 9/10/2024 at 2:23 pm with the Director of Staff Development (DSD), the facility's nursing staffing chart ladder (NSCL, a chart that indicated how many staff on each shift for the number of residents in facility) was reviewed. The DSD stated the facility followed the nursing staffing chart ladder to staff the facility (depending on the census). The DSD stated the NSCL indicated for a facility census of 86, 2 LVNs and six (6) Certified Nursing Assistants (CNAs) were required to work on the NOC shift. The DSD stated on 08/23/2024 to 08/24/2024, during the 11 p.m. to 7 a.m. shift, LVN 1 was the only LVN working with 86 residents from 3 a.m. to 7 a.m. The DSD stated it was unsafe for the residents to only have one LVN in the facility during those hours and LVN 1 not having any support. The DSD stated the facility did not follow its chart ladder for staffing.</p> <p>During an interview on 09/10/2024 at 3:00 pm with Resident 3, Resident 3 stated LVN 1 was taking care of all residents in the facility (on 8/24/24 from 3 am to 7 am) which was unsafe. Resident 3 stated LVN 1 had to pass some medications early and the next shift (morning shift) nurse had to pass some medications late.</p> <p>During an interview on 09/10/2024 at 3:15 pm with Resident 4, Resident 4 stated it was unsafe for all the residents to have only 1 LVN in the facility. Resident 4 stated LVN 1 could not give everyone's medications on time.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 09/10/2024 at 3:30 pm with Resident 5, Resident 5 stated LVN 1 was the only LVN taking care of all the residents in the facility (unable to recall exact date). Resident 5 stated LVN 1 was early with medication pass and the morning nurses were late with medication pass. Resident 5 stated that was not safe for the residents.</p> <p>During a concurrent interview and record review on 09/11/2024 at 11 am with the Director of Nursing (DON), the facility's Nursing Staffing Assignment and Sign-In Sheet (Staff Assignment) dated 08/23/2024 for 11 pm to 7 am shift were reviewed. The Staff Assignment indicated one LVN was assigned to care for 86 residents. The DON stated it was unsafe for LVN 1 to be assigned to care for the 86 residents in the facility from 3 am to 7 am (total of four hours) on 8/24/2024. The DON stated the nursing staffing was always 2 LVNs in the facility for the NOC shift.</p> <p>During an interview on 09/11/2024 at 1 pm with CNA 2, CNA 2 stated on 08/24/2024 from 3 am to 7 am, LVN 1 was the only LVN assigned to 86 residents which was not safe for the residents in the facility. CNA 2 stated the staffing needed to have 2 LVNs on the NOC shift.</p> <p>During an interview on 9/11/24 at 4:30 pm with the Administrator, the Administrator stated it was not safe for the residents and/or LVN 1 to be the only LVN in the facility with 86 residents. The Administrator stated the normal facility staffing was 2 LVNs for the NOC shift.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Nursing Services Staffing Adequate, dated 1/2024, the P&P indicated, It is the policy of this facility to provide adequate staffing to meet the needs of the resident population . The P&P indicated, The facility maintains adequate staff on each shift to assure that the resident's needs are met. Inquiries concerning staffing should be referred to the Director of Nursing Services and/or the administrator.</p> <p>During a review of the facility's Facility Assessment (FA), dated 2024, the FA indicated, Staffing decisions are determined at the facility level (corporate input may be included) to ensure there are enough staff with appropriate competencies and skill set necessary to care for its residents' needs as identified through resident assessments and plans of care.</p>