

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 12/13/2024
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 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34273</p> <p>Based on observation, interview, and record review, the facility failed to ensure 1 of 13 sampled residents (Resident 2) was provided peripherally inserted central catheter (PICC - a thin, flexible tube that's inserted into a vein in the arm and threaded into a large vein near the heart. It is used to administer intravenous (IV) fluids, blood transfusions, chemotherapy, and other drugs, and to draw blood samples) care according to the physician's order and the facility's policy and procedure.</p> <p>This failure had the potential for Resident 2 to develop an infection on Resident 2's PICC site and/or develop sepsis (a life-threatening blood infection).</p> <p>Findings:</p> <p>During a review of Resident 2's Admission Record (AR), the AR indicated Resident 2 was admitted to the facility on [DATE] with multiple diagnoses which included cellulitis (a skin infection that causes swelling and redness) of the right lower limb and Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 2's Physician's Order (PO), dated 12/1/24, the PO indicated to monitor Resident 2's PICC site for complications every 8 hours. The PO, dated 12/2/24, indicated to administer levofloxacin (antibiotic-medication used to prevent and treat infections) 500 milligrams (mg-unit of measure) IV solution to Resident 2 one time a day for diabetic infection of the lower limb. The PO, dated 12/3/24, indicated to administer daptomycin (antibiotic) 500 mg IV solution to Resident 2 every evening for diabetic infection of the lower limb.</p> <p>During a review of Resident 2's IV Medication Administration Record (IV MAR), dated 12/1/24-12/31/24, the IV MAR indicated Registered Nurse 1 (RN 1) administered levofloxacin 500 mg IV to Resident 2 and checked Resident 2's IV site at 9 am on 12/12/24 and on 12/13/24. The IV MAR indicated RN 2 administered daptomycin 500 mg IV to Resident 2 and checked Resident 2's IV site at 5 pm on 12/12/24. The IV MAR indicated Resident 2's PICC site had not been cleaned and the dressing had not been changed until 12/13/24 at 3 pm.</p> <p>During a review of Resident 2's History and Physical (H&P-physician's clinical evaluation and examination of the resident), dated 12/4/24, the H&P indicated Resident 2 had the capacity to understand and make decisions.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and observation on 12/12/13 at 4:44 pm with Resident 2, Resident 2's left upper arm PICC site had dried blood on it and the transparent dressing which was supposed to cover the PICC site had dried blood on it, was falling off, and did not completely cover the PICC site. Resident 2 stated the nurses would take care of Resident 2's PICC site dressing when the nurses give Resident 2's IV medication later that night. Resident 2 stated it was Resident 2's fault for not telling the nurses the dressing for Resident 2's PICC was coming off.</p> <p>During an interview on 12/13/24 at 1:14 pm with Resident 2, Resident 2 stated the nurses had not changed the dressing on Resident 2's PICC site. Resident 2 stated the nurses gave Resident 2 IV medication last night (12/12/24) and this morning (12/13/24). Resident 2 stated it was Resident 2's fault the PICC site dressing was not changed because I haven't told them (nurses), and they (nurses) can't really see it (PICC site) unless I pull my sleeve up.</p> <p>During an interview on 12/13/24 at 2 pm with RN 1, RN 1 stated RN 1 administered Resident 2's levofloxacin 500 mg IV at 9 am on 12/12/24 and on 12/13/24. RN 1 stated RN 1 did not pull up Resident 2's sleeve to check Resident 2's PICC site after RN 1 administered levofloxacin 500 mg IV at 9 am on 12/13/24. RN 1 stated RN 1 must assess the PICC site for any irritation and any signs of infection. RN 1 stated it was important to have a clean dressing on the PICC site to avoid infection.</p> <p>During an interview on 12/13/24 at 2:21 pm with the Interim Director of Nursing (IDON), the IDON stated PICC site dressings were changed every 7 days and as needed if soiled. The IDON stated RNs must check PICC sites when flushing the PICC every day and when giving IV medications to prevent infections.</p> <p>During an interview on 12/13/24 at 3:19 pm with RN 2, RN 2 stated RN 2 administered IV medication to Resident 2 at 5 pm on 12/12/24. RN 2 stated RN 2 did not check Resident 2's PICC site on 12/12/24 after IV medication administration. RN 2 stated RNs must check the PICC site after IV medication administration to ensure there were no signs of infection, no redness, no pain, and no bleeding from the PICC site.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Care of Peripheral Inserted Central Lines (PICC) - Dressing Change and Site Care, undated, the P&P indicated PICC site dressing change and PICC site care is done to minimize the possibility of local and systemic infection. Transparent PICC line dressings are routinely changed every 7 days or when the dressing becomes loose, wet or soiled, unless otherwise ordered.</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>34273</p> <p>Based on observation, interview, and record review, the facility failed to provide a sanitary (clean) environment to prevent the spread of infections for 3 of 13 sampled residents (Resident 5, Resident 12, and Resident 13) by failing to ensure Certified Nursing Assistant 3 (CNA 3) and Licensed Vocational Nurse 1 (LVN 1) performed hand hygiene (cleaning hands by either washing them with soap and water, or by using an alcohol-based hand sanitizer) according to the facility's Hand Washing policy and procedure (P&P).</p> <p>These failures had the potential to spread infection to all residents, staff, and visitors in the facility.</p> <p>Findings:</p> <p>During an observation on 12/13/24 at 12:16 pm, LVN 1 fist bumped (greeting someone by lightly tapping each other's clenched fist) with a male resident (Resident 12) in the dining room while passing out lunch trays to the residents. After LVN 1 fist bumped with the resident, LVN 1 started touching residents' trays inside the meal cart while checking residents' trays, without washing hands or using hand sanitizer first.</p> <p>During an interview on 12/13/24 at 12:20 pm with LVN 1, LVN 1 stated LVN 1 must use hand sanitizer after fist bumping with a resident and before touching the lunch trays. LVN 1 stated it was important to use hand sanitizer and/or wash hands to prevent the spread of infection.</p> <p>During an observation on 12/13/24 at 12:31 pm, CNA 3 was observed assisting Resident 5 to set-up Resident 5's lunch tray at the bedside. CNA 3 touched Resident 5's overbed table and privacy curtain. CNA 3 did not wash hands and/or use hand sanitizer after exiting Resident 5's room. CNA 3 then picked up a tray from inside the meal cart and delivered the tray to Resident 13.</p> <p>During an interview on 12/13/24 at 12:35 pm with CNA 3, CNA 3 stated CNA 3 forgot to use hand sanitizer after exiting Resident 5's room. CNA 3 stated CNA 3 must use hand sanitizer or wash hands after exiting a resident's room.</p> <p>During an interview on 12/13/24 at 2:21 pm with the Interim Director or Nursing (IDON), the IDON stated staff must perform hand hygiene before and after handling/touching meal trays to prevent infection and perform hand hygiene before and after touching a resident and/or equipment in a resident's room, and in between residents. The IDON stated it was important to perform hand hygiene to prevent the spread of infection.</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 review of the Centers for Disease Control and Prevention's (CDC-the national public health agency of the United States) Clinical Safety: Hand Hygiene for Healthcare Workers, dated 2/27/24, the CDC recommendations indicated for healthcare workers to clean their hands immediately before touching a patient, before performing an aseptic (free from disease-causing microorganisms) task such as placing an indwelling device or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or patient's surroundings, after contact with blood, bloody fluids, or contaminated surfaces, and immediately after glove removal.</p> <p>[Source: https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html]</p>		