STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056360	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Glen Care Center	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 37198 Based on observation, interview, and record review, the facility failed to implement a care plan for the use of an abdominal binder (a wide band of elastic or cotton material that fits around the abdomen) for one of eight sampled residents (Resident 1). This deficient practice had the potential for Resident 1 to receive inconsistent care and services. Findings: During an observation on 1/28/2025 at 11:03 am, in the presence of Licensed Vocational Nurse 2 (LVN 2), Resident 1 was observed with an abdominal binder around Resident 1's abdomen. During a review of Resident 1's Admission Record (AR), the AR indicated the facility originally admitted Resident 1 on 3/13/2021 and recently admitted the resident on 12/29/2023 with diagnoses that included cerebral infarction due to thrombosis of right carotid artery (a stroke caused by a blood clot that blocks or disrupts blood flow to the brain), malignant neoplasm of colon (cancer of the large intestine), and gastrostomy status (having the presence of a gastrostomy tube [a flexible tube that delivers food, liquids, and medicine directly into the stomach or small intestine]). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 11/1/2024, the MDS indicated Resident 1 was rarely/never understood by others and rarely/never had the ability to understand others. The MDS indicated Resident 1 was dependent (helper does all of the effort) with eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 1 had a feeding tube (gastrostomy tube). During a review of Resident 1's Progress Notes (PN), dated 1/16/2025 at 1:13 pm, the PN indicated the Case Manager (CM) spoke to Resident 1's Responsible Party (RP) about Resident 1's gastrostomy tube being dislodged (pulled out or fell out) multiple times. The PN indicated the CM discussed with Resident 1's RP the option of an abdominal binder to be placed on Resident 1. The PN indicated the CM notified the physician and obtained the order for an abdominal binder. During a review of Resident 1's Order Summary Report (OSR), dated 1/28/2025 and timed at 11:38 am, the OSR indicated Resident 1 had a physician's order to have an abdominal binder with an order date of 1/21/2025. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/2025 at 3:21 pm, with the CM, the CM stated Resident 1's RP requested for the facility to implement a measure to prevent Resident 1's gastrostomy tube from dislodging. The CM stated the CM was not sure if there was a care plan for the abdominal binder. During an interview on 1/29/2025 at 4:20 pm, with the Director of Nursing (DON), the DON stated a care plan should be created anytime there was a new physician's order. The DON stated, It was important to have a care plan to show what the plan of care is for the resident. The DON stated each work shift should be provided an in-service so the staff would know how to provide the care to the resident. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Resident Centered Care Plan: Care Planning, revised in January 2021, the P&P indicated It is the policy of the facility that the interdisciplinary team (IDT) shall develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 37198 Based on observation, interview, and record review, the facility failed to follow the facility's policy and procedure (P&P) titled, Medication Administration: Controlled Medications, for five of five sampled residents (Resident 2, Resident 3, Resident 4, Resident 5, Resident 6) by failing to: 1. Ensure the facility's controlled medication (refers to a substance [narcotics] that is regulated by the government due to its potential for abuse and addiction) count sheets were signed after Licensed Vocational Nurse 1 (LVN 1) administered the controlled medications for Resident 2, Resident 3, Resident 4, Resident 5, and Resident 6. 2. Ensure LVN 1 signed the Medication Administration Record (MAR) after the controlled medications were administered for Resident 4 and Resident 6. These deficient practices had the potential for controlled medications to not be properly accounted for. Findings: During a concurrent observation and interview on 1/29/2025 at 1:15 pm, LVN 1 and LVN 3 were observed counting the controlled medications that were in one of the facility's medication carts (Cart 3). During the count, five controlled medication count sheets for Resident 2, Resident 3, Resident 4, Resident 5, and Resident 6 were observed with missing signatures. LVN 1 stated LVN 1 administered the controlled medications to the five residents. During a concurrent interview and record review on 1/29/2025 at 1:36 pm, with LVN 1, Resident 4's MAR indicated the hydrocodone-acetaminophen (medication for moderate to severe pain) oral tablet 5-325 mg (milligram) had no signature to indicate the medication was given on 1/29/2025 to Resident 4. Resident 6's MAR indicated the Norco (medication to relieve moderate to severe pain) oral tablet 7.5-325 mg had no signature to indicate the medication was given to Resident 6 on 1/29/2025. LVN 1 stated LVN 1 administered the controlled medications to Resident 4 and Resident 6 on 1/29/2025 but did not document on the MAR. During an interview on 1/29/2025 at 1:56 pm, with LVN 1, LVN 1 stated it was important to sign the controlled medication count sheet to prevent double dosing or underdosing the resident in case LVN 1 had to walk away or in case another staff member had to take over administering medications. LVN 1 stated medications could go missing any time and staff would have to be responsible for the medication and for the residents. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/29/2025 at 2:48 pm and at 4:20 pm, with the Director of Nursing (DON), the DON stated staff was supposed to follow the MAR if a resident complained of pain. The DON stated staff was supposed to look at the MAR and the resident's pain level, pop the controlled medication out of the pack, sign the controlled medication count sheet, administer the controlled medication to the resident, and sign the MAR. The DON stated it was important to sign the controlled medication count sheet and the MAR for resident's safety. The DON stated it was important to accurately document the administration of controlled medications to know that the staff was administering the controlled medication and not performing diversion (a medication is taken for use by someone other than whom it is prescribed for). During a review of the facility's P&P titled, Medication Administration: Controlled Medications, revised in January 2025, the P&P indicated when a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record: date and time of administration, amount administered, and signature of the nurse administering the dose, completed after the medication is actually administered.