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	04/11/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46687 Based on observation, interview, and record review, the facility failed to maintain the dignity of one of four sampled residents (Residents 2) when staff failed to promptly respond to Resident 2 ' s call light. This failure had the potential to result in Resident 2 feeling unimportant and disrespected and for Resident 2 ' s needs not being met. Cross Reference F677 Findings: During a review of Resident 2 ' s Admission Record (AR), the AR indicated the facility admitted Resident 2 on 3/4/25, with diagnoses that included end stage renal disease (ESRD- irreversible kidney failure), hypoglycemia (low blood sugar level), muscle weakness, and other abnormalities of gait (pattern of walking) and mobility (ability to move freely). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 3/8/25, the MDS indicated Resident 2 had intact cognition (ability to think, learn, and remember). The MDS indicated Resident 2 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, showering/bathing self, and upper and lower body dressing and partial/moderate assistance (helper does less than half the effort) with personal hygiene. The MDS indicated Resident 2 was frequently incontinent of urine and bowel. During a review of Resident 2 ' s care plan (CP) titled, Care Plan Report, revised 3/24/25, the CP indicated Resident 2 was at risk for falls related to episodes of incontinence. The CP interventions included for staff to anticipate and meet Resident 2 ' s needs and ensure the call light was within reach and encourage Resident 2 to use it to call for assistance as needed. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 4/10/25 at 4:27 pm with Resident 2, in Resident 2 ' s room, Resident 2 ' s call light was activated. Resident 2 stated Resident 2 pressed the call light because Resident 2 needed a brief change. Resident 2 stated staff (in general) would take 30 minutes to answer Resident 2 ' s call light and staff would say staff would come back to help Resident 2, but staff would not come back for over 30 minutes. Resident 2 stated she would then wait for an hour to get assistance with brief change. Resident 2 stated staff (in general) would sometimes tell Resident 2 that Resident 2 needed to wait until staff finished their rounds before staff could change Resident 2. Resident 2 stated if the staff assigned to Resident 2 was not available and another staff answered Resident 2 ' s call light, that staff would then tell Resident 2 to wait for the assigned staff to help Resident 2. During an observation on 4/10/25 at 4:34 pm, in Resident 2 ' s room, Resident 2 ' s call light had not been answered. There were six staff observed walking by Resident 2 ' s room while Resident 2 ' s call light was on. During an observation on 4/10/25 at 4:36 pm, in Resident 2 ' s room, Resident 2 ' s call light alert was announced and the light above Resident 2 ' s door was lit indicating Resident 2 ' s call light was on. During an observation on 4/10/25 at 4:37 pm, in Resident 2 ' s room, Resident 2 pressed Resident 2 ' s call light again. During a concurrent observation and interview on 4/10/25 at 4:38 pm with Certified Nursing Assistant (CNA) 1, in Resident 2 ' s room, CNA 1 stated residents (in general) should not wait for more than five minutes for staff to answer the residents ' call lights because the residents may be in pain or may need something right away. During an interview on 4/11/25 at 3:55 pm with CNA 2, CNA 2 stated licensed nurses (LNs- unidentified) did not help with answering residents ' call lights. CNA 2 stated sometimes when CNA 2 would go on her (15 minute) break or lunchbreak, the LNs would not answer the call lights for CNA 2. CNA 2 stated it was frustrating when the LNs did not help with answering call lights and did not help with residents ' (in general) simple requests like needing water or comb or changing residents ' television channel. During an interview on 4/11/25 at 4:12 pm with CNA 1, CNA 1 stated LNs did not help in answering residents ' call lights. CNA 1 stated CNAs (in general) needed to ask LNs for help to answer the call light and LNs would not just help if the call light was going off. CNA 1 stated LNs would put it on the CNAs to do all of it. During an interview on 4/11/25 at 4:35 pm with Licensed Vocational Nurse (LVN) 1, LVN 1 stated it was everyone ' s responsibility to answer residents ' call lights. LVN 1 stated residents (in general) should not wait more than one (1) to two (2) minutes for the residents ' call lights to be answered because everyone (all staff) should be on the floor. LVN 1 stated even if LVN 1 was not assigned to the resident and LVN 1 saw a call light on, LVN 1 needed to answer it if LVN 1 was available. LVN 1 stated it was important to answer the call light within 1 to 2 minutes because it could be a safety or emergency issue. LVN 1 stated residents were in the facility to get help, so staff needed to help the residents because the facility was the residents ' home and residents deserved to have their needs met. (continued on next page)

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/11/25 at 5:33 pm with the Director of Nursing (DON), the DON stated it was everyone ' s (all staff) responsibility to answer call lights. The DON stated it was important that all staff answer the call lights as soon as possible so residents could get the residents ' needs met. The DON stated it could be upsetting to the resident to wait a long time for the call light to be answered. The DON stated everyone including LNs needed to answer call lights. During a review of the facility ' s policy and procedure (P&P) titled, Call Light/Bell, undated, the P&P indicated, It is the policy of this facility to provide the resident a means of communication with nursing staff. The P&P indicated . 1. Answer the light/bell within a reasonable time. 2. Listen to the resident ' s request/need. 3. Respond to the request. If the item is not available or you are unable to assist, explain to the resident and notify the charge nurse for further instructions. 4. Turn off the call light/bell after request/need have been resolved.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 46687 Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 2) who required assistance with activities of daily living (ADLs- tasks of everyday life such as bathing, dressing, and toileting) was provided care timely when staff did not answer Resident 2 ' s call light promptly and assist Resident 2 with incontinence (involuntary loss of urine or feces) care. This failure resulted in Resident 2 to not receive timely assistance with ADL as needed and had the potential to result in skin breakdown and affect Resident 2 ' s well-being. Cross Reference F550 Findings: During a review of Resident 2 ' s Admission Record (AR), the AR indicated the facility admitted Resident 2 on 3/4/25, with diagnoses that included end stage renal disease (ESRD- irreversible kidney failure), hypoglycemia (low blood sugar level), muscle weakness, and other abnormalities of gait (pattern of walking) and mobility (ability to move freely). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 3/8/25, the MDS indicated Resident 2 had intact cognition (ability to think, learn, and remember). The MDS indicated Resident 2 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, showering/bathing self, and upper and lower body dressing and partial/moderate assistance (helper does less than half the effort) with personal hygiene. The MDS indicated Resident 2 was frequently incontinent of urine and bowel. During a review of Resident 2 ' s care plan (CP) titled, Care Plan Report, revised on 3/24/25, the CP indicated Resident 2 had ADL Self Care Performance Deficit and required assistance completing ADLs. The CP goal indicated Resident 2 would safely perform . dressing, grooming, toilet use and personal hygiene with assistance through the review date. The CP interventions included for staff to encourage Resident 2 to fully participate with each interaction. During a review of another Resident 2 ' s CP titled, Care Plan Report, revised 3/24/25, the CP indicated Resident 2 was at risk for falls related to episodes of incontinence. The CP interventions included for staff to anticipate and meet Resident 2 ' s needs and ensure the call light was within reach and encourage Resident 2 to use it to call for assistance as needed. (continued on next page)

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