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	12/18/2025

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. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promptly respond to call lights (device used by a resident to signal his or her need for assistance from staff) and/or promptly respond to a resident's request for toileting assistance for two of four sampled residents (Residents 6 and 7). This failure had the potential to result in residents (in general) feeling like their concerns were unheard and feeling frustrated.Findings: During a review of Resident 6's admission Record (AR), the AR indicated the facility admitted Resident 6 on [DATE] with diagnoses including peripheral vascular disease (reduced circulation of blood to a body part), sickle-cell disease (an inherited blood disorder), and muscle wasting and atrophy (loss of muscle tissue). During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated [DATE], the MDS indicated Resident 6 had no impairment in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 required supervision or touch assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity; assistance may be provided throughout the activity or intermediately) from staff for personal and oral hygiene, bathing, and dressing. During a review of Resident 7's AR, the AR indicated the facility admitted Resident 7 on [DATE] and readmitted Resident 7 on [DATE] with diagnoses including lymphoma (cancer of the lymph nodes), urinary tract infection (UTI, an infection in any part of the urinary system, including the kidneys, bladder, or urethra), and muscle weakness. During a review of Resident 7's MDS, dated [DATE], the MDS indicated Resident 7 had no impairment in cognitive skills. The MDS indicated Resident 7 required substantial/maximal assistance (helper does more than half the effort) from staff for bathing and required supervision or touch assist from staff for dressing and toileting hygiene. During a review of Resident 7's Care Plan Report (CPR), undated, the CPR indicated a care plan was initiated on [DATE] to address Resident 7's deficits in activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). The care plan indicated an intervention of, Encourage to use bell (call light) to call for assistance. During an interview on [DATE] at 2:46 PM with Resident 6, Resident 6 stated that sometimes Resident 6 waited a long time for facility staff (in general) to answer Resident 6's call light. Resident 6 stated Resident 6 would wait 30 minutes to 1 hour for staff (in general) to answer the call light. Resident 6 stated the afternoon was generally the time it took staff (in general) a long time to answer Resident 6's call light. During an interview on [DATE] at 10:25 AM with Resident 7, Resident 7 stated facility staff (in general) were bad at answering call lights. Resident 7 stated that on [DATE], Resident 7 waited 2 hours for staff (in general) to answer Resident 7's call light. Resident 7 stated Resident 7 pressed the call light because Resident 7 needed to use the bathroom. Resident 7 stated Resident 7 knew it took 2 hours for staff (in general) to respond because Resident 7 watched the clock on the wall at the foot of Resident 7's bed. During an interview on [DATE] at 11:04 AM with the Director of Nursing (DON), the DON stated residents (in general) should not have to wait 30 minutes for the residents' call lights to be answered by staff (in general). During a review of the facility's P&P titled, Dignity and Respect, reviewed 2/2025, the P&P indicated, It is the policy of this facility that all residents be treated with kindness, dignity and respect. The P&P indicated, The staff shall display respect for Resident's when . caring for. as constant affirmation of their individuality and dignity as human beings. The P&P indicated, Schedules of daily activities allow maximum flexibility for residents to exercise choices about what they will do and when they will do it. During a review of the facility's P&P titled, Call Light, reviewed 1/2025, the P&P indicated, Answer the light/bell within a reasonable time.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility failed to ensure the facility created a Plan of Action form for concerns which 2 of 23 residents (unidentified) expressed during resident council (a formal gathering of residents to discuss shared concerns, improve quality of life, and communicate with management) meetings, according to the facility's Policy and Procedure (P&P) titled, Resident Council Meeting, reviewed 01/2025. This failure had the potential for residents' (in general) concerns to be unheard and had the potential for residents' (in general) needs to be unmet. Findings: During a concurrent interview and record review on 12/18/2025 at 9:45 AM, with the Activities Director (AD), the facility's Resident Council Meeting minutes (RCM), dated 7/17/2025 and 10/21/2025, were reviewed. The RCM, dated 7/17/2025, indicated a resident (unidentified) complaint about waiting a long-time during shift change for assistance from staff (in general). The RCM, dated 10/21/2025, indicated another resident (unidentified) complained again of waiting a long-time during shift change for assistance from staff (in general). The AD stated for each incident of residents (in general) complaining of long wait times for assistance on 7/17/2025 and 10/21/2025, the AD alerted the DON of the complaints. The AD stated the DON did not submit a Plan of Action form as indicated in the facilities P&P. During a review of the facility's P&P titled, Resident Council Meeting, reviewed 01/2025, the P&P indicated, It is the policy of this facility to. Provide a forum through which constructive suggestions, ideas and concerns may be offered and projects initiated for the mutual benefit of the institution and the residents of the facility . The P&P indicated, The Council allows residents to discuss any special concerns they may be having. It is the responsibility of the Activity Director to refer these matters to the appropriate personnel while preserving confidentiality, if requested. A Plan of Action form will be submitted to the Activities Director for plans of actions that will be taken to correct concerns or suggestions to be shared with residents, along with reading of minutes.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to maintain a complete and accurate medical record for one of three sampled residents (Resident 1) when facility staff (in general) failed to document Resident 1's visit to a physician on 9/4/2025 in Resident 1's medical record. This failure resulted in Resident 1's medical record containing incomplete information and had the potential for Resident 1 to receive inappropriate care. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 7/12/2025 and readmitted Resident 1 on 10/5/2025 with diagnoses including urinary tract infection (UTI, an infection in any part of the urinary system, including the kidneys, bladder, or urethra), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and hypertension (high blood pressure). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 11/18/2025, the MDS indicated Resident 1 had no impairment in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for lower body dressing, bathing, and toileting hygiene. During a telephone interview on 12/16/2025 at 12:48 PM with Resident 1's granddaughter (RR 1), RR 1 stated that on 9/4/2025, RR 1 went with Resident 1 to an appointment to see a Urologist (a medical doctor specializing in the urinary system). During a concurrent interview and record review on 12/18/2025 at 11:04 AM with the Director of Nursing (DON), Resident 1's medical records were reviewed. Resident 1's medical records failed to indicate a summary of Resident 1's appointment with a Urologist on 9/4/2025. The DON stated when a resident (in general) leaves the facility for an appointment, facility staff (in general) should document in the residents' progress notes. The DON confirmed Resident 1's appointment to the Urologist on 9/4/2025 was not documented in Resident 1's progress notes. During a review of the facility's Policy and Procedure (P&P) titled, Charting and Documentation, reviewed 2/2025, the P&P indicated, The purpose of this procedure is to provide: A complete account of the resident's care, treatment, response to the care, signs, symptoms, etc., as well as the progress of the resident's care. The P&P indicated, The following are examples of conditions which will require documentation every shift. Physician's visits and orders.