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	01/20/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure physician assessment and continued management of a high-risk medication (drugs that can cause serious harm, injury, or death if used incorrectly) for one of three sampled residents (Resident 5). Resident 5 was on insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication), a high-risk medication, for management of diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and Resident 5's Hemoglobin A1C (Hgb A1C - a blood test which measures a person's average blood sugar levels over the past 2-3 months) laboratory test results indicated Resident 5's HgB A1C was 13.6 percent (normal range is below 5.7 percent). This deficient practice resulted in Resident 5 not receiving insulin for eight days and placed Resident 5 at risk for diabetic ketoacidosis (DKA, a serious, life-threatening complication of diabetes) and coma (a prolonged state of deep unconsciousness where a person cannot be awakened).Findings: During a review of Resident 5's admission Record (AR), the AR indicated Resident 5 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with ketoacidosis and long-term use of insulin. During a review of Resident 5's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 8/24/2025, the H&P indicated Resident 5 had the capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool), dated 10/23/2025, the MDS indicated Resident 5's cognitive skills (ability to make daily decisions) was intact. The MDS indicated Resident 5 had clear speech and was understood by others and usually understood others. During a review of Resident 5's Order Summary Report (OSR), dated 1/20/2026, the OSR indicated the following:1. A physician's order (PO), dated 10/20/2025, indicated to inject (to give with a syringe) Humalog insulin (a rapid-acting man-made insulin used to treat high blood sugar) 8 units into Resident 5 before meals for DM management for 30 days. The PO indicated Humalog insulin 8 units started on 10/21/2025 and ended on 11/20/2025.2. A PO, dated 10/20/2025, indicated to inject Lantus insulin (a long-acting man-made insulin used to control high blood sugar) 25 units into Resident 5 every 12 hours for DM management for 30 days. The PO indicated Lantus insulin 25 units started on 10/21/2025 and ended on 11/20/2025.3. A PO, dated 11/26/2025, indicated Resident 5 may discharge on [DATE] to group home (GH, a licensed facility which provides 24-hour nonmedical care and supervision) with medications per Resident 5's request.4. A PO, dated 11/28/2025, indicated to inject Humalog insulin 8 units into Resident 5 before meals for DM management. The PO indicated Humalog insulin 8 units started on 11/28/2025.5. A PO, dated 11/28/2025, indicated to inject Lantus insulin 25 units into Resident 5 before meals for DM management. The PO indicated Lantus insulin 25 units started on 11/28/2025.6. The OSR indicated Resident 5 did not have a PO for oral or injectable medication for DM management after Humalog insulin and Lantus insulin orders ended on 11/20/2025 through 11/27/2025. During a (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of Resident 5's Medication Administration Record (MAR), for October 2025, November 2025, and December 2025, the MARs indicated Resident 5 received Humalog insulin and Lantus insulin from 10/21/2025 through 11/19/2025 and from 11/28/2025 through 12/13/2025. The MARs indicated Resident 5 did not receive oral or injectable medication for DM management from 11/20/2025 through 11/27/2025. During a review of Resident 5's Hgb A1C laboratory test results, dated 10/20/2025, the test results indicated Resident 5's HgB A1C was 13.6 percent (normal range is below 5.7 percent). During a review of Resident 5's progress notes (PN), dated 11/27/2025, the PN indicated Resident 5 was currently not on any diabetic medications (used to manage high blood sugar) due to hospital orders for insulin orders ended on 11/20/2025 and Resident 5 was to be discharged under care of a home health agency (HHA, organizations that provide skilled nursing assistance and other health services to patients in their homes). The PN indicated Resident 5's physician could not be reached and Resident 5 and the administrator from the HHA requested to hold Resident 5's discharge until insulin medication regimen was established. During an interview and concurrent record review of Resident 5's medical record, with Registered Nurse 2 (RN 2), on 1/20/2026 at 12:04 pm, RN 2 stated Resident 5 did not receive insulin or any medication for DM management for eight days, from 11/20/2025 through 11/27/2025. RN 2 stated RN 2 would have clarified with Resident 5's physician regarding the discontinuation of insulin orders. RN 2 stated a licensed nurse should have informed Resident 5's physician to reassess Resident 5 and that Resident 5's insulin was only ordered until 11/19/2025 because Resident 5 was diabetic and could experience complications from not getting diabetic medication. RN 2 stated Resident 5 did not receive insulin for eight days and could have experienced hyperglycemia and could have gone into a coma. During an interview with the Director of Nursing (DON) on 1/20/2026 at 12:26 pm, the DON stated it was best practice for the nurses to communicate with Resident 5's physician to reassess Resident 5's insulin order because it was discontinued. The DON stated Resident 5 did not receive insulin for eight days and could have experienced hyperglycemia. During a review of the facility's policy and procedure (P&P) titled, Resident Assessment and Associated Processes, revised 12/2024, the P&P indicated, It is the policy of this facility that residents will be assessed, and the findings documented in their clinical health record. These will be comprehensive, accurate, standardized reproducible assessments of each resident and will be conducted initially and periodically as part of an ongoing process through which each resident's preferences and goals of care, functional and health status and strengths and needs will be identified. During a review of the facility's P&P titled, Monitoring, Supervision and Reporting, revised 1/2023, the P&P indicated, It is the policy of this facility that all residents will be monitored and supervised, and abnormalities communicated to the physician. During a review of the facility's Job Description (JD) for both Registered Nurse (RN) and Licensed Vocational Nurse (LVN)/Licensed Practical Nurse (LPN), dated 12/17/2021, the JD indicated, under Essential Duties and Responsibilities:Consult with the physician concerning resident evaluation and assist the Director of Nursing Services in planning and developing the nursing services to be performed for the resident.Examine the resident and his/her records and charts to distinguish between normal and abnormal findings in order to recognize early stages of serious physical, emotional or mental problems.Determine when to refer the resident to a physician for evaluation, supervisor, or directions.Make written and oral reports/recommendations to the attending physician, Medical Director, or the Administrator or concerning the status and care of the assigned resident.