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	02/20/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure Certified Nursing Assistant 2 (CNA 2) turned and repositioned one of two sampled residents (Resident 2) with pressure ulcer/injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) in accordance with the resident's plan of care.This deficient practice had the potential for worsening or delaying healing of Resident 2's Stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone).Findings:During a review of Resident 2's admission Record (AR), the AR indicated the facility originally admitted Resident 2 on [DATE] with diagnoses that included muscle weakness and displaced subtrochanteric fracture of the left femur (broken bone of the left leg).During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], the MDS indicated Resident 2 had moderately impaired cognitive skills (ability to make daily decisions) and required substantial/maximal assistance (helper does more than half the effort to complete the activity) with toileting and personal hygiene, and with upper and lower body dressing. The MDS indicated Resident 2 required partial/moderate assistance (helper lifts, holds or supports trunk or limbs, but provides less than half the effort) in rolling left and right. The MDS indicated Resident 2 had a Stage 4 pressure ulcer.During a review of Resident 2's Care Plan Report (CPR), initiated on [DATE], the CPR indicated Resident 2 has a pressure ulcer or potential for pressure ulcer development related to weakness, pain, impaired mobility, episodes of incontinence, and risk for impaired circulation. The CPR interventions indicated Resident 2 needed monitoring, reminding, and assistance to turn and reposition. The CPR also indicated to turn and reposition Resident 2 every two hours and as needed.During a review of Resident 2's CPR, initiated on [DATE], the CPR indicated Resident 2 was resistive to care related to non-compliance with turning and repositioning. The CPR interventions indicated educating Resident 2 of the possible outcomes of not complying with treatment or care.During an observation on [DATE] at 10:11 AM, Resident 2 was lying in bed, on his back. During an observation on [DATE] from 9:06 AM to 9:36 AM, the Treatment Nurse (TN) provided wound care treatment to Resident 2's pressure ulcer.During an observation on [DATE] from 9:52 AM to 10:03 AM, CNA 1 and CNA 2 provided a bed bath and perineal care to Resident 2. CNA 1 and CNA 2 then turned and positioned Resident 2 to face slightly towards the right side and placed a pillow on Resident 2's left side. The pillow was positioned lengthwise from Resident 2's left side of the neck, under the left shoulder down to the waistline.During an observation on [DATE] at 12:55 PM, Resident 2 was sitting up in bed eating lunch, there was a pillow under the left shoulder down to the waistline.During an observation on [DATE] at 2:55 PM, Resident 2 was lying in bed slightly turned to the right, with a pillow on the left side positioned from the shoulder down to the waistline.During an interview with CNA 2 on [DATE] at 3 PM, CNA 2 stated CNA 2 changed Resident 2's diaper but did not reposition Resident 2 because Resident 2 refused to turn. CNA 2 stated CNA 2 did not inform the charge nurse or any licensed nurse that Resident 2 (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refused to turn.During an interview with the Treatment Nurse (TN) on [DATE] at 3:12 PM, the TN stated the facility follows a turning schedule to remind staff to position residents (in general) at a certain position at certain times. The TN stated CNA 2 needed to inform the charge nurse of Resident 2's non-compliance with turning and repositioning so that the charge nurse could provide education, encouragement and explain the risk and benefits of turning and repositioning. Once the nurse becomes aware of Resident 2's continued non-compliance to turning and repositioning, we could notify the physician. The TN stated Resident 2 already had impaired skin integrity and the parts of the wound that had healed can easily reopen.During an interview on [DATE] at 4:26 PM, the Director of Nursing (DON) stated CNAs (in general) needed to follow the repositioning schedule and report to the charge nurse for refusal to turn so the licensed nurse could do a proper follow up.During a review of the facility's policy and procedure (P&P) titled Prevention and Management of Pressure Injuries, undated, the P&P indicated, Encourage to reposition; consider the resident's condition, the support surface in use, tolerance, and the resident's stated preferences. The facility will promote turning schedule. Reposition frequently as needed.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview and record review, the facility failed to provide pain medication to one of two sampled residents (Resident 2) and let the pain medication take effect prior to continuing with Resident 2's wound care to Resident 2's Stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) and prior to providing a bed bath to Resident 2.This deficient practice resulted in Resident 2 experiencing unrelieved pain for 40 minutes on 2/20/2026.Findings:During a review of Resident 2's admission Record (AR), the AR indicated the facility originally admitted Resident 2 on 7/7/2025 with diagnoses that included muscle weakness and displaced subtrochanteric fracture of the left femur (broken bone of the left leg).During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 12/28/2025, the MDS indicated Resident 2 had moderately impaired cognitive skills (ability to make daily decisions) and required substantial/maximal assistance (helper does more than half the effort to complete the activity) with toileting and personal hygiene, and with upper and lower body dressing. The MDS indicated Resident 2 required partial/moderate assistance (helper lifts, holds or supports trunk or limbs, but provides less than half the effort) in rolling left and right. The MDS indicated Resident 2 had a Stage 4 pressure ulcer.During a review of Resident 2's Order Summary Report (OSR), dated 1/31/2026, the OSR indicated there was a physician's order, dated 10/8/2025, for Resident 2 to consult with a Pain Management physician. The OSR also indicated there was a physician's order to give Resident 2 hydrocodone-acetaminophen (medication used to treat sever pain) 5-325 milligrams (mg- unit of measure) tablet every six hours as needed for severe pain of 7-10 on the pain scale (tool used to measure pain intensity).During an observation on 2/20/2025 from 9:17 AM to 9:57 AM at Resident 2's bedside, the Treatment Nurse (TN) asked Resident 2 what Resident 2's pain level was, prior to starting the wound care on Resident 2's pressure ulcer. Resident 2 stated Resident 2's pain level was 7. Certified Nursing Assistant 1 (CNA 1) removed the pillow under Resident 2's heels and Resident 2 moaned when CNA 1 lifted both of Resident 2's feet. CNA 1 and CNA 2 turned Resident 2 to the right side and Resident 2 stated Resident 2's groin and back hurt. Resident 2 stated, You're doing everything else to hurt me. The TN proceeded with wound care to Resident 2's pressure ulcer. At 9:36 AM, while providing wound care to Resident 2, the TN asked Resident 2 what Resident 2's pain level was and Resident 2 stated Resident 2's pain level was 7. The TN asked Resident 2 if Resident 2 wanted the TN and CNA 1 and 2 to stop and come back after Resident 2 has had pain medication. Resident 2 stated, Let's get this done. After Resident 2's wound care, CNA 1 and Lead CNA provided Resident 2 with a bed bath. During the bed bath, Resident 2 cried out in pain three times. At 9:57 AM, Resident 2 stated, I've had 45 minutes of pain, Oh my God.During an interview on 2/20/26 at 3:12 PM, the TN stated pain management is important prior to treatment to promote resident's comfort. During an interview on 2/20/2026 at 4:26 PM, the Director of Nursing (DON) stated pain management was important prior to wound care treatment to ensure the resident would not be in pain and suffer during the procedure. The DON stated the treatment nurse and the charge nurse need to communicate with each other to premedicate residents prior to wound care treatment.During a review of the facility's Policy and Procedure (P&P) titled Pain Management 5/2007, the P&P indicated, The facility assists each resident with pain to maintain or achieve the highest practicable level of well-being and functioning by: Screening to determine if the resident has been or is experiencing pain. Comprehensively assessing the pain. Identifying circumstances when pain can be anticipated. Developing and implementing a plan, using pharmacologic and/or non-pharmacologic interventions to manage the pain and/or try to prevent the pain consistent with the resident's goals.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement proper infection control procedures for one of two sampled residents (Resident 4) when Certified Nursing Assistant 3 (CNA 3) did not change protective gown and performed hand hygiene after providing care to Resident 3 and before providing care to Resident 4.This deficient practice had the potential to spread MDRO infection to Resident 4.Findings:a. During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 3/3/2021 with diagnoses that included urinary tract infection (UTI- an infection in the bladder/urinary tract) and diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 12/16/2025, the MDS indicated Resident 3 had an active diagnosis of MDRO (multidrug-resistant organism or bacteria that resists many antibiotics, making infections difficult to treat). The MDS indicated Resident 3's cognition (thinking, knowing, and being aware) was intact. The MDS indicated Resident 3 was dependent on staff (in general) with showering/bathing and required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort to complete the activity) with personal hygiene.During a review of Resident 3's Order Summary Report (OSR), the OSR indicated there was a physician's order, dated 8/12/2025, to place Resident 3 on Enhanced Barrier Precautions (EBP- gown and glove use when performing specific high-contact resident care activities for residents with wounds and/or indwelling medical device [inserted into the body and remain in place for an extended period]) due to indwelling urinary catheter (a flexible tube inserted and left inside the bladder to drain urine) and MDRO.b. During a review of Resident 4' s AR, the AR indicated the facility admitted Resident 4 on 3/5/2025 with diagnoses that included infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts, endocarditis.During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4's cognition was intact. The MDS indicated Resident 4 was dependent on staff (in general) with showering/bathing.During an observation on 2/20/2026 at 10:43 AM, Certified Nursing Assistant 3 (CNA 3) was providing a bed bath to Resident 3.During an observation on 2/20/2026 at 11:04 AM, CNA 3 completed the bed bath for Resident 3. CNA 3 did not remove the protective gown CNA 3 used while CNA 3 provided care to Resident 3, took clean gloves from the box, and prepared all the items for Resident 4's bed bath.During a concurrent observation and interview on 2/20/2025 at 11:10 AM, CNA 3 closed the privacy curtains around Resident 4's bed and proceeded to provide a bed bath to Resident 4. CNA 3 stated CNA 3 would wear the same gown and only change gloves to care for Resident 3 and Resident 4 because Resident 3 was not on any precautions. CNA 3 stated the gown was just for prevention.During an interview on 2/20/2025 at 4:43 PM, the Infection Prevention Nurse (IPN) stated Resident 3 was on EBP for a history of MDRO in the urine. EBP was to protect Resident 3 and other residents around Resident 3 from getting MDRO. During a review of the facility's Policy and Procedure (P&P) titled, IPCP Standard and Transmission-Based Precautions, dated 3/2024, the P&P indicated, Enhanced Barrier Precautions used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDRO's to staff hands and clothing then indirectly transferred to residents or from resident - to resident. The P&P indicated the MDRO's for which the EBP applies include ESBL producing Enterobacterales. Examples of high contact resident care activities requiring gown and gloves use for Enhanced Barrier Precaution include bathing/showering, dressing, providing hygiene, changing linens.During a review of the facility's P&P titled, Isolation and Prevention, dated 3/2024, the P&P indicated, Change gloves and gowns after each resident encounter (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and perform hand hygiene.