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	05/22/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to promptly notify one (1) of 17 sampled residents' (Resident 2's) primary physician and Resident Representative (RR 1) regarding Resident 2's fall on [DATE].This failure had the potential for Resident 2 not to receive timely care and treatment for Resident 2's changes in condition and had the potential for Resident 2's representative of not being informed of Resident 2's change in condition and not making an informed decision (decision based on facts, relevant information, and clear understanding of potential risks, benefits, and alternatives) regarding Resident 2's fall.(Cross Reference F684)During a review of Resident 2's Face Sheet (FS, front page of the chart that contains a summary of basic information about the resident), the FS indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including abnormalities of gait and mobility, muscle weakness, hypertension (high blood pressure), and acute respiratory failure with hypoxia (when the lungs suddenly fail to supply enough oxygen to the body).During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated [DATE], the MDS indicated Resident 2 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 2 was dependent (helper does all the effort to complete the activity) on staff for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 2's Care Plan Report (CPR), created on [DATE], the CPR indicated Resident 2 was at risk for falls related to weakness, impaired mobility, pain, and risk for episodes of shortness of breath (SOB). The CPR indicated Resident 2 had an assisted fall during transfer from bed to shower chair on [DATE].During a review of Resident 2's SBAR Communication Form (Situation, Background, Assessment, Recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated [DATE], the SBAR indicated Resident 2 had an assisted fall on [DATE] when a certified nursing assistant (CNA) transferred Resident 2 from the bed to the shower chair and Resident 2 lost balance. The SBAR indicated Registered Nurse (RN) 1 was waiting for Resident 2's primary physician to respond and was unable to reach and inform RR 1 regarding Resident 2's fall.During a phone interview on [DATE] at 2:50 PM with CNA 6, CNA 6 stated Resident 2 had an assisted fall when CNA 6 transferred Resident 2 from bed to shower chair on [DATE].During a concurrent interview and record review on [DATE] at 8:45 AM with Licensed Vocational Nurse (LVN) 1, Resident 2's SBAR, dated [DATE] was reviewed. LVN 1 stated a licensed nurse should notify the resident's (in general) physician and the resident's representative right away after a fall.During an interview on [DATE] at 9:45 AM with RN 1, RN 1 stated Resident 2 had an assisted fall on [DATE] at 8 PM and RN 1 was unable to reach Resident 2's primary physician and RR 1 on [DATE] to inform them of Resident 2's fall. RN 1 stated a licensed nurse must have notified Resident 2's physician and representative right away after the resident's fall on [DATE].During an interview on [DATE] at 12:50 PM with RR 1, RR 1 stated RR 1 did not receive any notification on [DATE] regarding Resident 2's fall on [DATE]. RR 1 stated the facility should have informed RR 1 about Resident 2's fall on the day Resident 2 had a fall.During a concurrent interview and record review on [DATE] at 4:30 PM with the (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing (DON), Resident 2's SBAR, dated [DATE], was reviewed. The DON stated RN 1 was unable to reach RR 1 after Resident 2 had a fall on [DATE]. The DON stated RN 1 should have followed up with informing RR 1 on [DATE] after RN 1 was unable to reach RR 1 on the first attempt.During a review of the facility's policy and procedure (P&P) titled, Change in Condition, revised 4/2025, the P&P indicated that at any time, the licensed nurse or nurse supervisor should be made aware if any team members recognize the condition or care needs of the resident (including fall or other related incident) have changed. The P&P indicated, The nurse will perform and document an assessment of the resident and identify need for additional interventions, considering implementation of existing orders or nursing interventions or through communication with the resident's provider using SBAR or similar process to obtain new orders or interventions. The resident/resident representative will be notified of the change of condition and any changes in the resident's medical or nursing care.During a review of the facility's Policy and Procedure (P&P) titled, Fall Prevention, undated, the P&P indicated, Physician and responsible party/ resident representative will be notified. Notification will be documented in the resident's medical record.

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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 - Few	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 one (1) of 17 sampled residents (Resident 2) received the necessary care and services when Resident 2's vital signs (measurements of the body's basic functions, such as heart rate, breathing rate, oxygen saturation, blood pressure, and temperature) and neuro-check (neurological exam, a check of how well the brain, nerves, and muscles work often performed after a suspected head injury) were monitored every shift for 72 hours after the resident had a fall on [DATE].This failure had the potential for Resident 2 not to receive appropriate and necessary care timely.(Cross Reference F580)During a review of Resident 2's Face Sheet (FS, front page of the chart that contains a summary of basic information about the resident), the FS indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including abnormalities of gait and mobility, muscle weakness, hypertension (high blood pressure), and acute respiratory failure with hypoxia (when the lungs suddenly fail to supply enough oxygen to the body).During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated [DATE], the MDS indicated Resident 2 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 2 was dependent (helper does all the effort to complete the activity) on staff for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 2's Care Plan Report (CPR), created on [DATE], the CPR indicated Resident 2 was at risk for falls related to weakness, impaired mobility, pain, and risk for episodes of shortness of breath (SOB). The CPR indicated Resident 2 had an assisted fall during transfer from bed to shower chair on [DATE].During a review of Resident 2's SBAR Communication Form (Situation, Background, Assessment, Recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated [DATE], the SBAR indicated Resident 2 had an assisted fall on [DATE] when a certified nursing assistant (CNA) transferred Resident 2 from the bed to the shower chair and Resident 2 lost balance. The SBAR indicated Resident 2's vital signs and neuro-check were not monitored.During a review of Resident 2's Medication Administration Record (MAR) for 5/2026, the MAR indicated Resident 2's vital signs should be documented every shift. The MAR indicated that there were no vital signs documented on [DATE] NOC shift (from 11 PM on [DATE] to 7 AM on [DATE]).During a review of Resident 2's Medical Record (MR), the MR indicated there was no document regarding Resident 2's 72 hours neuro-check after Resident 2's fall on [DATE].During a phone interview on [DATE] at 2:50 PM with Certified Nursing Assistant (CNA) 6, CNA 6 stated that Resident 2 had an assisted fall when CNA 6 transferred Resident 2 from bed to shower chair on [DATE].During a concurrent interview and record review on [DATE] at 8:45 AM with Licensed Vocational Nurse (LVN) 1, Resident 2's SBAR, dated [DATE] was reviewed. LVN 1 stated a care plan should have been developed and implemented right after the fall on [DATE] and the interventions should include 72 hours of neuro-check.During an interview on [DATE] at 9:45 AM with Registered Nurse (RN) 1, RN 1 stated that RN 1 did not start 72 hours neuro-check for Resident 2 after Resident 2 had a fall on [DATE].During a concurrent interview and record review on [DATE] at 4:30 PM with the Director of Nursing (DON), Resident 2's SBAR, dated [DATE], Resident 2's MAR, dated 5/2026, and Resident 2's MR were reviewed. The DON stated that there were no documented vital signs on [DATE] night shift and no 72 hours neuro-check after Resident 2 had a fall on [DATE]. The DON stated Resident 2's vital signs and neuro-check should have been monitored every shift for 72 hours after Resident 2 had a fall on [DATE]. The DON stated it was important to check and document the vital signs every shift post fall to monitor the resident's health condition.During a review of the facility's policy and procedure (P&P) titled, Change in Condition, revised 4/2025, the P&P indicated that at any time, the licensed nurse or nurse supervisor should be made aware if any team members recognize the condition or care needs of the resident (including fall or other related incident) have (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changed. The P&P indicated examples of changes in condition include, Change or a trending change in vital signs, to include temperature, pulse, blood pressure, heart rate, and oxygen saturation.Change in mental status. The P&P indicated, The nurse will perform and document an assessment of the resident and identify need for additional interventions, considering implementation of existing orders or nursing interventions or through communication with the resident's provider using SBAR or similar process to obtain new orders or interventions.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two (2) of 17 sampled residents' (Resident 1's and Resident 10's) medical records were complete and accurate when Resident 1's and Resident 10's medical records did not contain documentation that the residents were turned and repositioned every two hours in accordance with the residents' care plans.This failure resulted in Resident 1's and Resident 10's medical records containing inaccurate information and had the potential for Resident 1and Resident 10 to receive inappropriate care and treatment.1. During a review of Resident 1's Face Sheet (FS, front page of the chart that contains a summary of basic information about the resident), the FS indicated the facility originally admitted Resident 1 on [DATE] and readmitted Resident 1 on [DATE] with diagnoses which included metabolic encephalopathy (brain disease, damage, or malfunction caused by an illness or organs that are not working as well as they should), acute kidney failure (when kidneys suddenly stopped working), and dementia (a progressive state of decline in mental abilities). During a review of Resident 1's History and Physical (H&P), dated [DATE], the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated [DATE], the MDS indicated Resident 1 was dependent (helper does all the effort to complete the activity) on staff for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) and to turn and reposition in bed. During a review of Resident 1's Care Plan Report (CPR), dated [DATE], the CPR indicated Resident 1 had a pressure ulcer on the coccyx (tailbone) with potential for further impairment related to disease process, history of ulcers, and immobility. The CPR interventions included encouraging and assisting Resident 1 to turn and reposition and turning and repositioning Resident 1 every two hours and as needed. During a review of Resident 1's Task Chart for Activities of Daily Living (TCADL) for [DATE], there was no entry under Turning and Repositioning Q 2 hours (every 2 hours) and PRN (as needed). During a review of Resident 1's medical record, certified nursing assistant (CNA) documentation regarding turning and repositioning the resident every 2 hours was not found. 2. During a review of Resident 10's FS, the FS indicated the facility originally admitted Resident 10 on [DATE] and readmitted on [DATE] with diagnoses which included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), dementia (a progressive state of decline in mental abilities), and muscle weakness. During a review of Resident 10's MDS, dated [DATE], the MDS indicated Resident 10 was severely impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 10 was dependent on staff for bathing, toileting hygiene, and lower body dressing. The MDS indicated Resident 10 required partial/moderate assistance (helper does less than half the effort to complete the activity) from staff for oral, personal hygiene, and to turn and reposition in bed. During a review of Resident 10's CPR, dated [DATE], the CP indicated Resident 10 had potential for (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	skin impairment due to a history of pressure ulcers. The CPR interventions included encouraging and assisting Resident 10 to turn and reposition and turning and repositioning Resident 10 every two hours. During a review of Resident 10's TCADL for [DATE], there were no entries for Turning and Repositioning Q2 hours until [DATE]. During a review of Resident 10's medical record, CNA documentation regarding turning and repositioning the resident every 2 hours was not found from [DATE] - [DATE]. During an interview on [DATE] at 2:35 PM with CNA 1, CNA 1 stated Resident 1 needed turning and repositioning every 2 hours and as needed for wound prevention. CNA 1 stated the nursing staff (in general) who turned and repositioned the resident should document turning and repositioning Q2 hours in the chart (medical record) for ADL charting every shift. During an interview on [DATE] at 9:45 AM with Registered Nurse (RN) 1, RN 1 stated that the CNA (in general) who turned and repositioned the resident (in general) should document in the chart (medical record). During a concurrent interview and record review on [DATE] at 4:30 PM with the Director of Nursing (DON), Resident 1's CPR, dated [DATE], and TCADL for [DATE] were reviewed. The DON stated there was no documentation regarding turning and repositioning the resident every 2 hours found in Resident 1's medical record. The DON stated it was important to complete the documentation to verify the resident's health condition and to document the care provided and following the resident's care plan. During a concurrent interview and record review on [DATE] at 2:10 PM with the DON, Resident 10's TCADL for [DATE] was reviewed. The DON stated the TCADL was the facility's proof that Resident 10 was provided turning and repositioning every 2 hours. The DON confirmed, from the resident's admission until [DATE], Resident 10's medical record did not contain documentation that Resident 10 was turned and repositioned every 2 hours. During a review of the facility's policy and procedure (P&P) titled, Turning and Repositioning, undated, the P&P indicated that the facility needs to provide a systematic method for turning and repositioning At Risk residents utilizing the turning and repositioning program. The P&P indicated, All designated staff will be monitoring the turning and repositioning program for resident in each shift. During a review of the facility's P&P titled, Charting and Documentation, dated 3/2026, the P&P indicated documentation needs to provide a complete account of the resident's care, treatment, response to the care, signs, symptoms, etc., and the progress of the resident's care. The P&P indicated, Documentation pertaining to special observations and monitoring should include: a. Date and time observations made.f. All pertinent observations.