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	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Glen Care Center	1033 E. Arrow Highway Glendora, CA 91740

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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	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on interview and record review, the facility failed to treat one of one sampled resident (Resident 39) with respect and dignity when Certified Nursing Assistant 4 (CNA 4) was observed saying, not right now, I am busy now to Resident 39 when Resident 39 asked CNA 4 for assistance on 2/6/2025. This deficient practice had the potential to compromise Resident 39's dignity and individuality and result in psychosocial decline to Resident 39. Findings: During a review of Resident 39's an Admission Record (AR), the AR indicated Resident 39 was admitted to the facility on [DATE] with diagnosis that included Alzheimer's disease (disease causing memory loss and other mental functions), generalized muscle weakness, and abnormal posture. During a review of Resident 39's History and Physical Reports (H&P), dated 11/4/2024, the H&P indicated Resident 39 did not have the capacity to understand and make decisions. During a review of a Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 8/23/2024, the MDS indicated Resident 39's cognition (ability to understand and process information) was severely impaired and Resident 39 needed maximal assistance (helper does more than half the effort) with personal hygiene, sit to stand, and chair to bed transfers. During an observation on 2/6/2025 at 4:10 PM, CNA 4, CNA 5 and CNA 6 were observed passing water to the residents from a cart located in the hallway. Resident 39 was sitting on her wheelchair in the hallway and followed (wheeling self) CNA 4, CNA 5, and CNA 6, stated help, help, while pointing down the hallway. CNA 4 turned to address Resident 39 and stated, not right now, I am busy. CNA 4 turned her back to Resident 39 and continued to pass water to other residents. During an interview with CNA 6 on 2/6/2025, at 4:14 PM, CNA 6 stated CNA 6 would not have turned CNA 6's back from Resident 39. CNA 6 stated Resident 39 was confused and just wanted some assistance. CNA 6 stated I feel bad for Resident 39. During an interview with CNA 5 on 2/6/2025 at 4:17 PM, CNA 5 stated CNA 5 should not have told Resident 39 I'm busy. CNA 5 stated CNA 5 should have asked another CNA to help Resident 39. CNA 5 stated Resident 39 deserved service, help, and [to be treated with] dignity. (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	During an interview with the Director of Nursing (DON), on 2/6/2025 at 4:20 PM, the DON stated the facility should treat all residents with compassion and empathy. The DON stated, all residents should be treated with dignity, even confused residents. During a review of the facility's policy and procedure (P&P), titled Resident Rights: Dignity and Respect, revised 1/2025, the P&P indicated it was the policy of the facility for all residents to be treated with kindness, dignity, and respect.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 50016 Based on observation, interview, and record review, the facility failed to provide reasonable accommodation to meet the resident's needs by failing to ensure the resident's call light system was accessible and functional for one of six sampled residents (Resident 53). This deficient practice had the potential to negatively impact the psychosocial well-being of Resident 53 or result in delayed provision of services. Findings: During a review of Resident 53's Admission Record (AR), the AR indicated the facility admitted Resident 53 on 3/19/2024, and readmitted the resident 4/4/2024, with diagnoses including metabolic encephalopathy (a change in how your brain works due to an underlying condition) Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) without dyskinesia (involuntary muscle movements that can feel like tremors, spasms, or writhing), and muscle weakness. During a review of Resident 53's History and Physical (H&P), dated 4/9/2024, the H&P indicated Resident 53 did not have the capacity to understand and make decisions. During a review of Resident 53's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 1/8/2025, the MDS indicated Resident 53 was dependent (helper does all the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and dependent with mobility. During an observation on 2/3/2025 at 9:45 AM, Resident 53's bilateral (both) hands appeared rigid (when something is stiff, inflexible, and unable to bend or change easily) and Resident 53 had a push call light system. During a concurrent interview and record review on 2/3/2025 at 2:35 PM, with Licensed Vocational Nurse (LVN) 1, Resident 53's Care Plan (CP), initiated on 3/20/2024, and revised on 1/23/2025 was reviewed. Resident 53's CP indicated Resident 53 had a diagnosis of Parkinson's disease and the resident was at risk for stiffness of the arms, legs, and trunk, decline in range of motion (ROM- a measure of joint functionality and flexibility), decline in mobility, speech difficulty, constipation, alteration in balance and coordination that may lead to a fall, fall reoccurrence and injuries. LVN 1 stated Resident 53 did not have a call light suitable for Resident 53's hand rigidity and a push button call light system made it difficult for Resident 53 to operate the call light. LVN 1 stated a tap or mechanical pad call system was more appropriate for Resident 53. LVN 1 stated the facility should continuously assess every resident to determine the most appropriate and suitable call system for that resident. LVN 1 stated ta suitable call system allowed residents to quickly alert staff if they need assistance, whether for medical attention, help with mobility, or to address immediate needs. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/6/2025 at 11:37 AM, with the Director of Nursing (DON), the DON stated staff should assess residents' needs for an adequate and suitable call system both at admission and periodically thereafter. The DON stated it was crucial to evaluate the individual's mobility, communication abilities, and level of care required to ensure call systems were appropriate for resident needs. The DON stated ongoing assessments ensured the facility provided the most effective care and maintained a safe environment for residents. During a review of the facility's policy and procedure (P&P) titled, Resident's Rights/Accommodations of Needs, undated, the P&P indicated that it was the policy of the facility to provide accommodation of reasonable needs to the residents while in the facility. Examples of Accommodation of needs but is not limited to the following: Bed Size Room and Roommates Devices to Use Special Diet Location of placement in the facility Showers Call lights, etc.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 50016 Based on interview and record review, the facility failed to ensure an accurate assessment was completed to reflect the history of falls within the past 3 months of the assessment for one of one sampled resident (Resident 59). This deficient practice had the potential to negatively affect Resident 59's plan of care and delivery of necessary care and services. Findings: During a review of Resident 59's Admission Record (AR), the AR indicated the facility admitted Resident 59 on 5/21/2024, and readmitted the resident on 10/18/2024, with diagnoses including psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), muscle weakness, abnormalities of gait (the way a person walks or moves, including the pattern of foot movements and arm swing) and mobility, and dementia (a progressive state of decline in mental abilities). During a review of Resident 59's History and Physical (H&P), dated 10/19/2024, the H&P indicated Resident 59 did not have the capacity to understand and make decisions. During a review of Resident 59's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 11/25/2024, the MDS indicated Resident 59 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and required substantial/maximal assistance (helper does more than half the effort) with mobility. During a record review of Resident 59's Situation, Background, Assessment and Recommendation (SBAR, structured communication framework that helps teams share information about the condition of a resident), Communication Form, dated 12/23/2024, the SBAR indicated Resident 59 sustained a fall. During a review of Resident 59's SBAR Communication Form, dated 12/31/2024, the SBAR indicated Resident 59 sustained a fall. During a review of Resident 59's SBAR Communication Form, dated 12/31/2024, the SBAR indicated Resident 59 sustained a fall. During a review of Resident 59's Change in Condition Evaluation (COC, a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains) Evaluation, dated 1/22/2025, the evaluation indicated Resident 59 slid from the bed to the floor. During a review of Resident 59's Fall Risk Evaluation, dated 1/22/2025, the evaluation indicated Resident 59 was at high risk for falls with an overall score of 14. The Fall Risk Assessment indicated Resident 59 had 3 or more falls in the past 3 months. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 59's Fall Risk Evaluation, dated 1/31/2025, the evaluation indicated Resident 59 was a medium risk for falls with an overall score of 8. The evaluation indicated Resident 59 had 1 to 2 falls in the past 3 months. During a concurrent interview and record review on 2/5/2025 at 3:33 PM, Resident 59's SBAR's and COC evaluation for December 2024 and January 2025 regarding falls were reviewed with Licensed Vocational Nurse (LVN) 2, LVN 2 stated LVN 2 inaccurately documented Resident 59 had only one or two falls in the past 3 months when LVN 2 completed Resident 59's Fall Risk assessment on 1/31/2025. LVN 2 stated Resident 59 sustained 3 or more falls in the past 3 months. LVN 2 stated sliding from the bed to the floor was considered a fall as the resident experienced on 1/22/2025. LVN 2 stated by not accurately documenting the history falls on the fall risk assessment on 1/31/2025, this significantly changed the category from a high fall risk to a medium fall risk as previously indicated on the fall risk evaluation that was completed on 1/22/2025. LVN 2 stated completing an accurate fall risk assessment provided a safer, more effective care and improved the quality of life for the residents. LVN 2 stated accurate assessments helped identify individuals who were at higher risk for falls and allowed for the implementation of targeted interventions to avoid further or future falls. During an interview on 2/6/2025 at 4:31 PM, with Registered Nurse (RN) 1, RN 1 stated accurate fall risk assessments were essential for preventing injuries, ensuring effective care, improved patient outcomes, tailored fall risk care plans, and maintained ethical and legal standards. During a review of the facility's policy and procedure (P&P) titled, Resident Assessment and Associated Processes, revised 12/2023, the P&P indicated: -It is the policy of the facility that resident's will be assessed, and the findings documented in their clinical health record. These will be comprehensive, accurate, standardized reproducible assessment 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, strengths and needs will be identified. -Assessment information will be used to develop, review, and revise the resident's comprehensive care plan.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 45), who was a newly admitted resident was pre-screened for PASARR (Preadmission Screening and Resident Review - a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) prior to admission to the facility and a record of the PASARR was retained in Resident 45's medical record. These deficient practices had the potential for Resident 45's mental disorder was not identified and could result in Resident 45 not receiving specialized care and/or rehabilitative services as needed. Findings: During a review of Resident 45's Admission Record (AR), the AR indicated Resident 45 was admitted to the facility on [DATE] with multiple diagnoses including unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, without behavioral disturbance, psychotic (relating to or affected with a psychosis - a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) disturbance, mood disturbance, anxiety (intense, excessive, and persistent worry and fear about everyday situations), unspecified psychosis not due to a substance or known physiological condition, depression (a mental disorder of persistent feeling of sadness and loss of interest and can interfere with your daily life), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 45's History and Physical (H&P), dated 1/9/25, the H&P indicated Resident 45 currently possessed the general capacity to make his own decisions. During a review of Resident 45's Minimum Data Set (MDS, a resident assessment tool), dated 1/12/25, the MDS indicated, Resident 45's BIMS (Brief Interview for Mental Status - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) Summary Score was intact. The MDS indicated, Resident 45 was taking antipsychotic, antianxiety and antidepressant medications. During a concurrent observation and interview on 2/4/25 at 9:29 a.m. with Certified Nursing Assistant (CNA) 9, Resident 45 was asleep in bed with Resident 45's breakfast tray on the bedside table. CNA 9 stated, Resident 45 sometimes did not want to eat breakfast. During an observation and interview on 2/4/25 at 12:47 p.m. with Resident 45, Resident 45 was in bed with a flat affect (low or lack of an emotional expression). Resident 45 stated, Resident 45 did not want to participate in activities at the facility. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/5/25 at 10:07 a.m. with the Admission Coordinator (AD), Resident 45's medical record was reviewed. The AD stated, Resident 45's admitting diagnoses included diagnoses that were considered mental disorder. The AD stated, Resident 45 should have been screened for PASARR prior to admission to the facility. The AD stated, the AD could not find a PASARR in Resident 45's medical record. The AD stated, it was important for Resident 45 to have a PASARR so facility would know if Resident 45 would need a higher level care as far as the mental disorder. During a concurrent interview and record review on 2/6/25 at 9:55 a.m. with the Director of Nursing (DON), Resident 45's admitting diagnoses were reviewed. The DON stated, Resident 45's admitting diagnoses included mental disorder. The DON stated, there should have been a PASARR done from the hospital for Resident 45 upon admission to the facility. The DON stated, It was important for Resident 45 to have a PASARR so the facility would know if Resident 45 was getting outside treatment for mental issues. During a review of the facility's policy and procedure (P&P) titled, Admission Practice, revised 01/2011, the P&P indicated, it was the policy of the facility to assure that appropriate medical and financial records were provided to the facility prior to or upon the resident's admission. During a review of the facility's P&P titled, PASARR, revised 01/2024, the P&P indicated, it was the policy of the facility to ensure that each resident was properly screened using the PASARR specified by State. The P&P indicated, a PASARR should be completed on every resident upon admission.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50016 Based on interview, and record review, the facility failed to revise a care plan (CP) for two of two sampled residents (Resident 59 and 183), by failing to: A. Revise a CP for Resident 59 after the resident sustained a fall on 12/31/2024 and was at risk for recurrent falls. B. Revise a CP for Resident 183 after the resident developed a pressure injury [PI, localized injury to the skin and or underlying tissue usually over a bony prominence as result of pressure or pressure in combination with shear (mechanical force that cause the skin to break off) and/or friction) and when Resident 183 refused to turn and be repositioned. This deficient practice had the potential to result in unmet individualized needs for Residents 59 and 183 and the potential to affect the resident's physical well-being. Findings: A. During a review of Resident 59's Admission Record (AR), the AR indicated the facility admitted Resident 59 5/21/2024, and readmitted the resident 10/18/2024, with diagnoses including psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), muscle weakness, abnormalities of gait (the way a person walks or moves, including the pattern of foot movements and arm swing) mobility, and dementia (a progressive state of decline in mental abilities). During a review of Resident 59's History and Physical (H&P), dated 10/19/2024, the H&P indicated Resident 59 did not have the capacity to understand and make decisions. During a review of Resident 59's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 11/25/2024, the MDS indicated Resident 59 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and required substantial/maximal assistance (helper does more than half the effort) with mobility. During a review of Resident 59's Situation, Background, Assessment and Recommendation (SBAR, structured communication framework that helps teams share information about the condition of a resident) Communication Form, dated 12/23/2024, the SBAR indicated Resident 59 sustained a fall. During a review of Resident 59's SBAR Communication Form, dated 12/31/2024, the SBAR indicated Resident 59 sustained a fall. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/5/2025 at 3:33 PM, Resident 59's at risk for falls Care Plan (CP), created 10/22/2024, and SBAR dated 12/31/2024, was reviewed with Licensed Vocational Nurse (LVN) 2. The SBAR indicated Resident 59 sustained a fall on 12/31/2024. LVN 2 stated Resident 59's CP was not revised after Resident 59 fell on [DATE]. LVN 2 stated fall CPs should be updated after every fall to ensure resident individual needs were reassessed and any factors contributing to the falls were addressed. During an interview on 2/6/2025 at 4:31 PM, with Registered Nurse (RN) 1, RN 1 stated fall CPs should be updated after each fall. RN 1 stated updating CPs after a fall was key to identify the cause, reassess health status, adjust interventions, and prevent future falls. RN 1 stated updating CPs after an incident helped reduce the likelihood of recurrence, enhanced safety, and supported the individual's overall well-being. During a review of the facility's undated policy and procedure (P&P) titled, Fall Prevention, undated, the P&P indicated: If a resident sustains a fall, a Risk Management is initiated. A Post Fall Review is also completed to assist in identifying factors that might have contributed to the fall. The care plan or an update to an existing care plan will then be generated. 40913 B. During a review of Resident 183's AR, the AR indicated the facility initially admitted Resident 183 on 1/31/2024, and readmitted Resident 183 on 1/29/2025, with diagnoses that included cerebral infarction, fracture of the sacrum, fracture of the left pubis. During a review of Resident 183's MDS, dated [DATE], the MDS indicated Resident 183 usually understands verbal content and was usually able to express ideas and wants. The MDS indicated Resident 183 was dependent with bed mobility such as rolling left and right, sit to lying, lying to sitting on the side of the bed, and sit to stand. During a review of Resident 183's change of condition (COC), dated 2/5/2025, the COC indicated upper right and upper left buttocks pressure injury and worsening MASD in the inner buttocks. During an observation on 2/5/2025 at 11:50 AM, CNA 2 repositioned Resident 183 to the left side when requested for skin observation. Resident 183 was resistant by holding on to the bedrails on both sides. CNA 2 asked another staff for assistance to turn Resident 183. During this same observation, there were discolored areas on Resident 183's upper part of the right and left buttocks. CNA 2 positioned Resident 183 on her back and moved the HOB up approximately 30 degrees. During an observation on 2/5/2025 at 1:25 PM, Treatment Nurse (TN) 1 cleaned the discolored area on the upper right & left buttocks with NS and the inner peri-anal area (near the anus area). TN 1 measured the discolored areas as follows: 4-centimeter (cm) x 2 cm on the right upper buttocks. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913 Based on observation, interview and record review, the facility failed to ensure activities was provided to one of two residents (Resident 62). This deficient practice had the potential to affect Resident 62's psychosocial wellbeing. Findings: During an observation on 2/5/2025 from 8:30 AM to 12:07 PM and from 12:30 PM to 3 PM, Resident 62 was in bed, lying on her back. During an interview on 2/6/2025 at 1:59 PM with the Activities Director, the Activities Director (AD) stated the facility provides one to one (1:1) activities to residents who stay inside their room and would not join group activities. The Activities Director (AD) stated the Activities Staff (AS) would conduct 1:1 room visits between 8:30-9 AM and 1:30-2 PM. The Activities Director was unable to provide proof or documentation of activities provided to Resident 62. The Activities Director stated the AS do not document activities provided to residents (in general). During the same interview, the AD stated the documentation of 1:1 room visits would be the angel rounds documentation conducted by different department heads. During an interview on 2/6/2025 at 2:05 PM, the Director of Admissions stated they do not provide activities to the residents and would check the residents (in general) for any concerns during the angel rounds. The DA provided a copy of the Angel Rounds. During an interview and record review on 2/5/2025 at 2:10 PM, there was no Admission Activities Assessment for Resident 62. The AD stated there was an activity preference assessment on the MDS. The MDS dated [DATE] was reviewed with the AD, the staff assessment of daily and activity preferences was blank. The AD stated based on the assessment, it would not guide the AS on what activities would be meaningful for Resident 62. During a review of the facility's Policy and Procedure titled Quality of Life, Activities Program dated 3/2019. The P&P indicated it is the policy of this facility to implement an ongoing resident centered activities program that incorporates the resident's interests, hobbies and cultural preferences which is integral to maintaining and/or improving a resident's physical, mental, and psychosocial well-being and independence.

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Arbor Glen Care Center	1033 E. Arrow Highway Glendora, CA 91740

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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** 42307 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 42), was provided care in accordance with professional standards of practice by failing to: 1. Notify Resident 42's physician when Resident 42 had multiples bowl movements and refused to take Milk of Magnesia suspension (MOM, a laxative, medication used to relieve occasional constipation) when the resident had constipation. 2. Follow Resident 42's physician's orders for Dulcolax suppository (a medication that stimulates bowel movements [bm] designed to be inserted into the anus). These deficient practices resulted in Resident 42 having multiple bm and Resident 42 feeling anxious and miserable. Resident 42 was transferred to the General Acute Care Hospital (GACH) for further evaluation. Findings: During a review of Resident 42's Admission Record (AR), the AR indicated, Resident 42 was admitted to the facility on [DATE] with multiple diagnoses including unspecified intracapsular fracture (a partial or complete break in the bone within the joint capsule) of right femur (thigh bone), subsequent encounter for closed fracture (simple fracture - a broken bone with the skin still intact) with routine healing, muscle weakness (generalized) and old myocardial infarction (MI - heart attack). During a review of Resident 42's History and Physical (H&P), dated 1/11/25, the H&P indicated, Resident 42 was alert, oriented x 3 (referring to person, place and time) and not in distress or having acute (sudden) concerns except occasional constipation (when a person has difficulty passing stool [poo]). During a review of Resident 42's Minimum Data Set (MDS, a resident assessment tool), dated 1/30/25, the MDS indicated, Resident 42's BIMS (Brief Interview for Mental Status - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) Summary Score was intact. The MDS indicated, Resident 42 had symptoms of feeling down, depressed (in a state of general unhappiness), or hopeless. The MDS indicated, Resident 42 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement). The MDS indicated, Resident 42 was frequently incontinent [two or more episodes of bowel incontinence, but at least one continent bm] of bowel and had no constipation. During a review of Resident 42's Order Summary Report (OSR), active orders as of 1/26/25, the OSR indicated, medication orders on 1/25/25 for bowel management as follow: 1. Docusate Sodium (a stool softener, medication used to increase the amount of water the stool absorbs in the gut, making the stool softer and easier to pass) capsule 100 milligram (mg, unit of measurement) give 1 capsule by mouth two times a day for bowel management. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Dulcolax (a stimulant laxative, medication used to increase the movement of the intestines, helping the stool to come out) Suppository 10 mg, insert 1 suppository rectally every 24 hours as needed for constipation if MOM (Milk of Magnesia) ineffective. 3. Milk of Magnesia suspension 400 mg/5 ml (milliliters - a unit of measurement), give 30 ml by mouth every 24 hours as needed for constipation. 4. Senna Tablet (medication used on a short-term basis to treat constipation) 8.6 mg (Sennosides) give 2 tablets by mouth at bedtime for bowel management - hold for loose stool. The OSR indicated, medication orders on 1/26/25 as follow: 1. Aspirin EC (used to treat pain and can cause bleeding) adult low dose oral tablet delayed release 81 mg, give 1 table by mouth one time a day for CVA (cerebrovascular disease - stroke, a medical emergency where blood flow to the brain is interrupted) 2. Lactulose (medication used to treat constipation and liver disease) oral solution 10 gm (grams - a unit of measurement)/15 ml, give 15 ml by mouth, one time a day for hepatic encephalopathy (brain dysfunction due to a damaged liver) 3. Rivaroxaban (a blood thinner used to treat and prevent blood clots) oral (by mouth) tablet 10 mg, give 1 tablet in the evening for atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). During an observation and interview on 2/3/25 at 10:55 a.m. Resident 42 was awake and alert in bed and appeared anxious. Resident 42 stated, Resident 42 was miserable. Resident 42 stated, Resident 42 had constipation for a year and now I keep going and wished somebody would take care of it. Resident 42 stated Resident 42 has had maybe 5-6 times (bm) today. During an interview on 2/5/25 at 9:10 a.m. with Certified Nursing Assistant (CNA) 9, CNA 9 stated, Resident 42 was having bm, averaging twice during CNA 9's shift (7:00 a.m. - 3:00 p.m.). CNA 9 stated, Resident 42 had a bloody bm on 2/4/25. During a review of Resident 42's Progress Notes (PN), dated 2/5/25, timed at 5:26 p.m., the PN indicated, Resident 42 was transferred to the GACH at 5:00 p.m. for further evaluation related to blood in stool. The PN indicated, Resident 42 started having episodes of blood in the stool on 2/4/25 during the morning shift and had gotten worse. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/5/25 at 2:01 p.m. with Licensed Vocational Nurse (LVN) 4, Resident 42's Bowel movement/Bowel continence (BMBC), dated 1/24/25 - 2/5/25, Medication Administration Record (MAR), dated 2/1/25 - 2/28/25 and OSR, were reviewed. The BMBC indicated, Resident 42 had multiple bm since 1/31/25. The BMBC indicated, Resident 42 had medium amount bm on 2/3/25 at 2:27 p.m., 2:28 p.m., 2:59 p.m. and a large amount at 9:08 p.m. The BMBC indicated, Resident 42 had large amount bm on 2/4/25 at 1:13 a.m. and 6:19 a.m. and a medium amount at 11:37 a.m. The OSR indicated orders that included MOM suspension 400 mg/5 ml, give 30 ml by mouth every 24 hours as needed for constipation and Dulcolax Suppository 10 mg, insert 1 suppository rectally every 24 hours as needed for constipation if MOM ineffective. The MAR indicated, LVN 4 administered (given) one Dulcolax Suppository 10 mg rectally on 2/4/25 at 12:47 p.m. LVN 4 stated, Dulcolax suppository was for constipation and did not administer the MOM as ordered since Resident 42 did not like the MOM. LVN 4 stated, LVN 4 administered the Dulcolax suppository since Resident 42 kept saying there's something stuck in there. LVN 4 stated, LVN 4 was just trying to make Resident 42 feel comfortable since Resident 42 kept saying that Resident 42 needed something and LVN 4 was just trying to help Resident 42. LVN 4 stated, LVN 4 should have checked first how many times Resident 42 had bm before administering the Dulcolax suppository and should have notified Resident 42's physician that Resident 42 had been having bm and had refused the MOM previously for constipation. LVN 4 stated, it was important to notify the physician so the physician could give new orders or could have given an alternative. LVN 4 stated, a suppository could be traumatizing too. During a concurrent interview and record review on 2/6/25 at 9:55 a.m. with the Director of Nursing (DON), Resident 42's BMBC and MAR were reviewed. The DON stated, Resident 42 had some blood in the stool and Resident 42 was transferred to the GACH on 2/5/25. The DON did not want to use the word constipation but the DON stated, Resident 42 was having bm before LVN 4 administered the Dulcolax suppository. The DON stated, LVN 4 was not following the physician's orders. The DON stated, the DON did not know what LVN 4's nursing judgement was and why LVN 4 administered the Dulcolax suppository. The DON stated, staff should have documented Resident 42 refused the MOM and staff should have notified the physician that Resident 42 refused the MOM and Resident 42 had been having bm you got to let them know. The DON stated, it was important to notify the physician so the doctor can decide what he wants to do. During a review of Resident 42's undated care plan (CP - provides direction on the type of nursing care an individual needs that include goals of treatment, specific nursing interventions [actions, treatments, procedures, or activities designed to meet an objective] and an evaluation plan]), titled [Resident 42] has constipation r/t (related to) decreased mobility, medication side effects, pain, the CP indicated, interventions included to administer medications as ordered, monitor medications for side effects of constipation and keep physician informed of any problems. During a review of the facility's policy and procedure (P&P) titled, Change of Condition Reporting, revised 11/2024, the P&P indicated, any change in a resident's condition manifested by a marked change in physical or mental behavior would be communicated to the physician. During a review of the facility's undated P&P titled, Specific Medication Administration Procedures, the P&P indicated, medications were administered as prescribed in accordance with good nursing principles and practices. The P&P indicated, note any allergies or contraindications the resident may have to drug administration. The P&P indicated, if resident refused medication, document refusal on MAR or TAR (Treatment Administration Record).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913 Based on observation, interview and record review, the facility failed to ensure to provide care and services to prevent and manage pressure ulcers for three of four residents (Resident 32, Resident 62 and Resident 183) by failing to: 1. Ensure Certified Nursing Assistant 1 (CNA 1) turned and repositioned Resident 62 who had a Stage 4 pressure ulcer (ulcer that extends into the muscle and bone and causing extensive damage on the sacrococcyx (the fused sacrum and coccyx. Sacrum is the large, triangular bone at the base of the spine. Coccyx is the triangular arrangement of bone that makes up the very bottom portion of the spine below the sacrum). 2. Ensure Certified Nursing Assistant 2 (CNA 2) turned and repositioned Resident 183, Resident 183 was assessed as high risk for the development of pressure ulcer. 3. Ensure the low air loss mattress (LAL - tiny laser made air holes in the mattress top surface continually blow out air causing the patient to float) pump was turned on for Resident 32 who had a Stage 3 pressure ulcer (Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present) on the right trochanter (bony knob at the top of the thigh bone on the outside of your hip) and a diabetic ulcer (open wound or sore that can be difficult to heal) on the right heel. These deficient practices had the potential to result in the worsening of Resident 32 and Resident 62's pressure ulcers and resulted in Resident 183 to develop a pressure injury (unidentified) Findings: 1. During a review of Resident 62's Admission Record (AR), the AR indicated the facility admitted Resident 62 on 8/16/24, with diagnoses that included cerebral infarction (stroke - type of ischemic [deficient supply of blood] stroke [sudden death of brain cells in a localized area due to inadequate blood flow] resulting from a blockage in the blood vessels supplying blood to the brain, metabolic encephalopathy (means damage or disease that affects the brain). During a review of Resident 62's Initial Admission Record dated 8/15/2024, the record indicated Resident 62 with a stage 4 sacral wound. During a review of Resident 62's Minimum Data Set (MDS - a federally mandated resident assessment too) dated 10/23/24, the MDS indicated Resident 62 had severe cognitive impairment. The MDS indicated Resident 62 was dependent with toileting hygiene and bed mobility such as rolling left and right, sit to lying, lying to sitting and sit to stand. During a review of Resident 62's Braden Scale for Predicting Pressure Sore Risk dated 11/12/2024, the Braden Scale indicated a score of 13 that indicated Resident was assessed as moderate risk for the development of pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/5/2025 at 9:11 AM, Resident 62 was awake, lying on her back. The Low air loss mattress was on and was set at 100. During an observation on 2/5/2025 at 9:14 AM, CNA 1 brought a resident from room [ROOM NUMBER] back to the room from the shower. During an observation on 2/5/2025 at 9:51 AM, RNA 1 coming out of Resident 62's room, RNA 1 stated RNA 1 was providing exercises to Resident 62's roommate in Bed A. During an observation on 2/5/2025 at 9:54 AM, CNA 1 was inside Resident 62's room, CNA 1 was providing care to Resident 62's roommate in Bed A and the roommate was later wheeled out of the room to activities. During an observation on 2/5/2025 at 10:04 AM, Resident 62 was lying on her back, lying diagonal in bed, with the head on the left side of the bed near the bedrails and the lower body on the right side of the bed. Licensed Vocational Nurse 1 (LVN 1) was preparing medications for Resident 62's roommate in Bed C and CNA 1 was preparing Resident 62's roommate in Bed C to transfer to the shower chair. During an observation on 2/5/2025 10:26 AM, CNA 1 wheeled Resident 62's roommate in Bed C to the shower area on a shower chair. During an observation on 2/5/2025 at 10:37 AM, CNA 1 was waiting outside the shower room with Resident 62's roommate in Bed C. During an observation 2/5/2025 at 10:58 AM, CNA 1 wheeled Resident 62's roommate on a shower chair back to the room. Physical Therapy Assistant 1 went inside to assist. PTA1 stated PTA 1 assisted CNA 1 to transfer Resident 62's roommate back to bed. During an observation on 2/5/2025 at 11:14 AM, CNA 1 was assisting Resident 62's roommate in Bed C. During an observation on 2/5/2025 at 11:21 AM, Resident 62 was lying on her back, lying diagonally in bed, with the head on the left side, close to the bedrails and the lower part of the body on the right side of the bed. During an observation on 2/5/2025 at 11:25 AM, CNA 1 was assisting Resident 62's roommate in Bed C. During an observation on 2/5/2025 at 11:38 AM, Resident 62 was lying on her back, lying diagonally in bed, with the head near the left side of the bedrails and the lower body on the right side of the bed. Resident 62 was holding a carton of ensure in her left hand. During an observation on 2/5/2025 at 12:04 PM, Resident 62 was lying on her back, lying diagonally in bed, with the head near the left side of the bedrails and the lower body on the right side of the bed. Resident 62 was holding a carton of ensure in her left hand. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/5/2025 at 12:34 pm, Resident 62 was lying on her back, lying diagonally in bed with the head on the left side of the bedrails and the lower body on the right side of the bed. During a concurrent observation and interview on 2/5/25 at 1:35 PM, Resident 62 was getting agitated when Treatment Nurse 1 (TN 1) and CNA 1 approached Resident 62. Resident 62 was yelling Get out of here. TN 1 stated CNA 1 had not informed TN 1 that CNA 1 was not able to turn and reposition Resident 62. During an observation on 2/5/2025 at 1:50 PM, Resident 62 was lying on her back with her head close to the left side of the bedrails. There was a pillow under Resident 62's left shoulder from the left shoulder towards the waist. During a concurrent interview and observation on 2/5/2025 at 1:57 PM, CNA 1 stated CNA 1 placed the pillow on Resident 62's left side when CNA 1 was assisting Resident 1's roommate in the A bed. CNA 1 stated CNA 1 did not know exactly what time CNA 1 assisted Resident 1's roommate in Bed A. CNA 1 stated that would be before Bed A was brought to activities. CNA 1 stated Resident 62 was lying on her back with the pillow under the left shoulder. CNA 1 stated CNA 1 did not ask for help from other staff to reposition Resident 62. During a concurrent observation and interview on 2/5/2025 at 1:58 PM, Resident 62 was lying on her back with a pillow under the left shoulder, Resident 62's head was close to the left bedrail and the lower part of the body towards the right side of the bed. Registered Nurse 1 (RN 1) stated when a resident (in general) is repositioned and the resident would turn back to a preferred side, the staff needed to use multiple pillows or a wedge to keep the resident from turning back to a preferred side. Resident 62 was lying on her back even with the pillow on the left shoulder, RN 1 stated Resident 62 was not repositioned well towards the right side; Resident 62 could be at risk for further skin breakdown. RN 1 stated if the resident was resistant to repositioning, CNA 1 needed to ask help from another staff. RN 1 stated CNA 1 needed to inform the charge nurse to assess Resident 62 because the resident could be in pain and that could be the reason for refusing to turn. During an observation on 2/5/2025 at 2:12 PM, RN 1 and CNA 1 attempted to reposition Resident 62. Resident 62 was screaming Get out of here. RN 1 and CNA 1 were able to move Resident 62 towards the middle of the bed, away from the bedrails. RN 1 stated RN 1 and CNA 1 were unable to turn Resident 62 who became agitated. During an interview on 2/5/2025 at 3:25 PM, CNA 3 stated Resident 62's would usually start to get agitated and upset after lunch. CNA 3 stated this behavior is not new. During an interview on 2/6/2025 at 10:37 AM, the Lead Certified Nursing Assistant (Lead CNA) stated Resident 62 had this behavior of refusing patient care since Resident 62 had been admitted . The Lead CNA stated when Resident 62 would refuse repositioning, the Lead CNA would ask Resident 62 at a later time. The Lead CNA stated it would be better to reposition Resident 62 with 2 or more staff because Resident 62 would fight sometimes, and we need to ensure Resident 62 would not get hurt during the repositioning. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and observation on 2/6/2025 10:40 AM with the Lead CNA, the Lead CNA stated the facility would follow the repositioning schedule, the Lead CNA stated 9:00 AM to 11:00 AM, Resident 62 needed to be on Resident 62's left side. During an observation with the Lead CNA, Resident 62 had a pillow in the right and left side, in between the legs and under Resident 62's legs. The Lead CNA stated Resident 62 was lying on her back with the shoulder slightly turned to the left. The Lead CNA stated when positioning a resident to the left, the whole body needed to be turned to the left. The Lead CNA proceeded to reposition Resident 62 towards the left by placing a pillow under Resident 62's right side, Resident 62's whole body was turned to the left side. Resident 62 verbalized resident was comfortable. During an interview on 2/6/25 at 12:17 PM, Treatment Nurse 2 (TN2) stated Resident 62 had refused wound care treatment one time since Admission. TN 2 stated Resident 62 would initially refuse, and TN 2 would go back and talk to Resident 62. During a review of Resident 62's care plan titled At risk for alteration in skin integrity dated 11/24/2024, the care plan indicated to turn and reposition every 2 hours and as needed (prn). During a review of Resident 62's care plan titled has pressure ulcer to sacrococcyx stage 4 the care plan indicated encourage to turn and reposition and provide assistance as necessary. During a review of Resident 62's care plan titled refusing care manifested by yelling and screaming, Patient has yelling and screaming for no apparent reason dated 12/3/2024, the care plan indicated if resident resists with activities of daily living (ADL), reassure resident, leave and return 5-10 minutes later and try again. The care plan indicated Social Services Director (SSD) to provide visit for psychosocial needs and to assure all needs are being met. During a review of Resident 62's Interdisciplinary Team (IDT) Skin Review on the following dates: 1/3/2025, 1/10/2025, 1/17/2025, 1/31/2025. The IDT did not address Resident 62's refusal of care. 2. During a review of Resident 183's AR, the AR indicated the facility initially admitted Resident 183 on 1/31/2024 and readmitted Resident 183 on 1/29/2025, with diagnoses that included cerebral infarction, fracture of the sacrum, fracture of the left pubis. During a review of Resident 183's MDS, dated [DATE], the MDS indicated Resident 183 usually understands verbal content and was usually able to express ideas and wants. The MDS indicated Resident 183 was dependent with bed mobility such as rolling left and right, sit to lying, lying to sitting on the side of the bed, and sit to stand. During a review of Resident 183's Braden Scale for Predicting Pressure Sore Risk dated 1/29/25, the Braden Scale indicated a score of 11 that indicated Resident 183 was at high risk for the development of a pressure ulcer. During a review of Resident 183's care plan initiated on 1/29/24 and revised on 2/4/2025, titled, At risk for alteration in skin integrity, the care plan indicated to turn and reposition as tolerated, During an observation on 2/5/2025 at 9:10 AM, Resident 183 was lying on her back with the head of the bed (HOB) elevated approximately 45 degrees. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/5/2025 at 9:51 AM, Resident 183 was lying on her back with a pillow on her chest, the head of the bed was up, there was no pillow under her head. During an observation on 2/5/2025 at 10:27 AM, Resident 183 was lying on her back with a pillow in front of her chest, the HOB was elevated 45 degrees. During an observation on 2/5/2025 at 10:32 AM, CNA 2 was assisting a resident in 111 out of bed to the chair. During an observation on 2/5/2025 at 11:05 AM, CNA 2 was not on the floor, CNA 2 was not inside the rooms assigned to CNA 2. Resident 183 was lying on her back with a pillow in front of her chest, the HOB was elevated approximately 45 degrees. During an observation on 2/5/2025 at 11:32 AM Resident 183 was lying on her back with the HOB elevated approximately 45 degrees. During an observation on 2/5/2025 at 11:50 AM, CNA 2 repositioned Resident 183 to the left side when requested for skin observation. Resident 183 was resistant by holding on to the bedrails on both sides. CNA 2 asked another staff for assistance to turn Resident 183. During this same observation, there were discolored areas on Resident 183's upper part of the right and left buttocks. CNA 2 positioned Resident 183 on her back and moved the HOB elevated approximately 30 degrees. During an observation on 2/5/2025 at 1:01 PM, Resident 183 was lying on her back with the HOB elevated. During an observation on 2/5/2025 at 1:10 PM the TN 1 prepared materials for wound care. During an observation on 2/5/2025 at 1:25 PM, TN 1 cleaned the discolored area on the upper right & left buttocks with NS and the inner peri-anal area (near the anus area). TN 1 measured the discolored areas which measured as follows: 4-centimeter (cm) x 2 cm on the right upper buttocks. 3 cm X 3 cm on the left upper buttocks. During this same observation, TN 1 stated some discoloration was light red and some areas were dark. TN1 stated the discolored areas were non-blanchable. During an observation on 2/5/2025 at 1:33 PM, TN 1 and CNA 2 positioned Resident 183 on her back and did not reposition the resident to another side after wound care. During an interview on 2/5/2025 at 2:42 PM, CNA 2 stated CNA 2 reported to the Lead CNA that CNA 2 was unable to turn Resident 183. CNA 2 stated CNA 2 had tried to reposition Resident 183 at 7:30 am, but Resident 183 would hold the bedrails so CNA 2 was unable to turn Resident 183 and moved the HOB up to get Resident 183 ready for breakfast. CNA 2 stated the staff needed to turn and reposition the residents every two hours, but CNA 2 stated CNA 2 did not turn Resident 183 because CNA 2 did not want Resident 183 to fall off the bed. (continued on next page)

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	056360	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Glen Care Center	1033 E. Arrow Highway Glendora, CA 91740

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/5/2025 at 2:52 PM, the Lead CNA stated CNA 2 did not inform the Lead CNA that CNA 2 was unable to reposition Resident 183 and if CNA 2 did inform the Lead CNA, then the Lead CNA would assist CNA 2. During an observation on 2/5/2025 at 3:40 PM, Resident 183 was lying on her back. Resident 183's family member was at the bedside. During an interview on 2/6/2025 at 10:27 AM, the lead CNA stated the responsibilities of the Lead CNA would be to complete the CNA staffing, the CNA daily assignments, find replacements for CNA's who called off, ensure residents get their showers and getting incontinent care. The Lead CNA stated CNA 2 was aware of the turning schedule and if CNA 2 was unable to turn/reposition Resident 183, CNA 2 needed to ask for assistance, CNA 2 did not ask the Lead CNA for assistance in turning/repositioning Resident 183. The Lead CNA stated the turning schedule needed to be followed because that was the schedule in place for the residents who could not turn/reposition themselves. The Lead CNA stated the Lead CNA had not observed Resident 183 turn independently but had observed Resident 183 wiggle in bed. During an observation on 2/6/2025 at 11:30 AM, the Wound Care Physician who was visiting was unable to observe and assess Resident 183 skin condition in the upper right and upper left buttocks. Resident 183 was refusing to turn and reposition. During an interview on 2/6/2025 at 12:49 PM, Treatment Nurse 2 (TN2) stated TN2 admitted Resident 183 and did not see any discoloration or MASD upon admission. TN2 stated TN2 wrote Resident 183 change of condition dated 2/3/2025. TN 2 stated the Moisture Associated Skin Damage (MASD) was located around the anal area, the area was moist and macerated because Resident 183 had diarrhea, the diarrhea only lasted that one day, the MASD was not located on the upper buttocks. During an observation on 2/6/2025 at 3:15 PM, Resident 183 continued to refuse turning and repositioning offered by RN 1 and an unidentified CNA. During a concurrent record review of Resident 183's plan of care and interview on 2/6/2025 at 3:58 PM, the care plan indicated to avoid scratching, keep fingernails short, encourage good nutrition and hydration, encourage turning and repositioning, identify causative factors, monitor skin injury and report to MD. RN 1 stated the interventions were not specific to Resident 183's new pressure injury. RN 1 stated the care plan was Generic. RN 1 stated the care plan needed to be specific. RN 1 stated encourage to turn was generic. RN 1 stated the care plan needed other interventions to take if Resident 183 continued to refuse turning. During a review of Resident 183's change of condition (COC) dated 2/5/2025, the COC indicated Resident 183 had an upper right and upper left buttocks pressure injury and a worsening MASD on the inner buttocks. During a review of Resident 183's undated care plan with a print date on 2/6/2025, the care plan indicated to turn and reposition every 2 hours and as needed (prn). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled Care and Treatment, Pressure Ulcers the P&P indicated it is the policy of the facility that a resident who enters the facility without pressure ulcer does not develop pressure ulcers. A resident having pressure ulcers receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. The P&P indicated for prevention: A. Stabilize, reduce or remove underlying risk, monitor impact of interventions and modify interventions as appropriate B. Turning and Repositioning at least every 2 hours and as needed during nursing staff rounds. C. Support surface, pressure relieving devices . For Treatment A. Continue preventive measure and pressure reduction . 42307 3. During a review of Resident 32's AR, the AR indicated, Resident 32 was originally admitted to the facility on [DATE] and last readmitted on [DATE] with multiple diagnoses including other acute (sudden in onset) osteomyelitis (inflammation of bone or bone marrow, usually due to infection), muscle weakness (generalized) and type 2 diabetes mellitus (DM II - adult onset disorder characterized by difficulty in blood sugar control and poor wound healing) without complications. During a review of Resident 32's undated History and Physical Examination (H&P), the H&P indicated, Resident 32 had the capacity to understand and make decisions. During a review of Resident 32's Minimum Data Set (MDS, a resident assessment tool), dated 11/4/24, the MDS indicated, Resident 32's BIMS (Brief Interview for Mental Status - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) Summary Score was intact. The MDS indicated Resident 32 was dependent (helper does all of the effort and resident does none of the effort to complete the activity) for rolling left and right (the ability to roll from lying to back to left and right side and return to lying on back on the bed). The MDS indicated, Resident 32 had a PU, was at risk of developing PU, and had one or more unhealed PU. The MDS indicated, Resident 32 had a pressure reducing device for bed and PU care. During a review of Resident 32's Care Plan (CP - provides direction on the type of nursing care an individual needs that include goals of treatment, specific nursing interventions [actions, treatments, procedures, or activities designed to meet an objective] and an evaluation plan), titled, Has pressure ulcer to right hip stage 3, date initiated 11/12/24, the CP indicated, one of the interventions was LAL mattress for tissue load management, check placement, motor and setting every shift. During a review of Resident's Order Summary Report (OSR), active orders as of 2/1/25, the OSR indicated, an order on 12/17/24 for LAL mattress for tissue load management, check placement, motor and setting every shift. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 2/4/25 at 8:01 a.m. with Certified Nursing Assistant (CNA) 2, Resident 32 was in bed, on a LAL mattress being fed by CNA 7. The LAL mattress pump was off and was unplugged from the wall electrical outlet located behind Resident 32's head of the bed. CNA 2 stated the LAL mattress pump was the motor for the LAL mattress and CNA 2 did not know how long the pump had been off. CNA 2 stated the LAL mattress was to prevent resident's (in general) back from PU. During an interview on 2/6/25 at 8:38 a.m. with Treatment Nurse (TN) 1, TN 1 stated, Resident 32's LAL mattress should not be off because the LAL mattress was for preventative measures so Resident 32's PU could be improved and not worsened. During an observation on 2/6/25 at 8:48 a.m. with TN 1 and the Wound Consultant (WC), during Resident 32's wound care, Resident 32 had a dry, closed healing wound that measured .5 cm (centimeters, a unit of measurement) x .7 cm x .3 cm on Resident 32's right heel. Resident 32 had a small 1 cm x 8 cm moist wound draining very small clear drainage with purplish discoloration around the wound edges on Resident 32's right trochanter (bone of your hip) area. During a review of the facility's policy and procedure (P&P) titled, Low Air Loss, Alternating Pressure Pad or Mattress, revised 01/2025, the P&P indicated, the use of LAL, alternating-pressure mattress or other types of mattresses as prescribed by physician was to prevent skin breakdown and to treat pressure ulcers. The P&P indicated, one of the instructions for use of the LAL mattress was to attach tubing to the pump connectors and plug into appropriate electrical outlet.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307 Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents' (Resident 233 and Resident 59) environment remained free of accident (refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident) hazards to prevent a falls (refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force) by failing to: A. Ensure Resident 233's bed always remained in a low position. B. Ensure Resident 59 received staff assistance on 1/31/2025 to prevent Resident 59 from falling. These deficient practices had the potential for Resident 233 who was a risk for fall to sustain a fall and result in injury and resulted in Resident 59 sustaining a fall on 1/31/2025. Findings: A. During a review of Resident 233's Admission Record (AR), the AR indicated, Resident 233 was admitted to the facility on [DATE] with multiple diagnoses including muscle weakness (generalized), other abnormalities of gait (a person's manner of walking), mobility, and type 2 diabetes mellitus (DM II - adult-onset disorder characterized by difficulty in blood sugar control and poor wound healing) without complications. During a review of Resident 233's History and Physical (H&P), dated 1/28/2025, the H&P indicated, Resident 233 currently possessed the general capacity to make Resident 233's own decisions. During a review of Resident 233's Minimum Data Set (MDS, a resident assessment tool), dated 1/31/2025, the MDS indicated, Resident 233's cognition (ability to understand and process information) was intact. The MDS indicated, Resident 233 required partial/moderate assistance (helper does less than half the effort) to substantial/maximal assistance (helper does more than half the effort) with mobility. During a review of Resident 233's Order Summary Report (OSR), active orders as of 2/1/2025, the OSR indicated, an order dated 1/27/2025 to have Resident 233's bed at the lowest position for safety precautions. During a review of Resident 233's Fall Risk Evaluation (FRE), dated 1/27/2025, the FRE indicated, Resident 233 was a medium risk for fall. During a review of Resident 233's Care Plan (CP), dated initiated 1/28/2025, for at risk for falls related to history of falls. The CP indicated, one of the interventions was for Resident 233's bed to remain in the lowest position. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/3/2025 at 10:12 AM, with Certified Nursing Assistant (CNA) 8, Resident 233 was awake in bed and had a long blue colored floor mat (a cushioned floor pad designed to help prevent injury should a person fall) located on the right side of Resident 233's bed. Resident 233's bed was in a high position about 3 1/2 feet above the floor. CNA 8 stated the floor mat was for fall risk residents and the bed should be in a low position to follow fall precautions. During an interview on 2/6/2025 at 4:04 PM, with Registered Nurse (RN) 1, RN 1 stated, it was important for Resident 233's bed to be at the lowest position to lessen the risk of injury if a fall occurred. During a review of the facility's policy and procedure (P&P) titled, 'Fall Management System, revised 1/2022, the P&P indicated, it was the policy of the facility to provide an environment that remained as free of accident hazards as possible. The P&P indicated to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurred. The P&P indicated, the care plan interventions would be developed to prevent falls by addressing the risk factors and would consider the particular elements of the evaluation that put the resident at risk. During a review of the facility's P&P titled, Safety, Resident revised date 01/2025, the P&P indicated, it was the policy of the facility to create a safe environment for the resident. 50016 B. During a review of Resident 59's AR, the AR indicated the facility admitted Resident 59 on 5/21/2024 and readmitted the resident on 10/18/2024, with diagnoses including psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), muscle weakness, abnormalities of gait (the way a person walks or moves, including the pattern of foot movements and arm swing) and mobility, and dementia (a progressive state of decline in mental abilities). During a review of Resident 59's H&P, dated 10/19/2024, indicated Resident 59 did not have the capacity to understand and make decisions. During a review of Resident 59's MDS, dated [DATE], the MDS indicated Resident 59 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and required substantial/maximal assistance (helper does more than half the effort) with mobility. During a review of Resident 9's (Resident 59's roommate)Admission Record (AR), the AR indicated the facility admitted Resident 9 on 6/13/2017 and readmitted the resident on 4/22/2024, with diagnoses including hypertensive heart disease (a collection of heart issues that develop over time due to high blood pressure[the force of blood against the walls of your arteries as your heart pumps blood]) with heart failure (occurs when the heart can't pump enough blood and oxygen to the body), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and anxiety disorder. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9's cognition (the ability to think and process information) was intact. The MDS indicated Resident 9 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and required partial/moderate assistance (helper does less than half the effort) with mobility. During a record review of Resident 59's At Risk for Falls/Injuries CP, initiated date on 10/22/2024, the CP indicated that part of the interventions/tasks was to anticipate and meet the needs of Resident 59. During a record review of Resident 59's FRE, created 1/22/2025, the evaluation indicated Resident 59 was a high risk for falls with an overall score of 14. The evaluation indicated Resident 59 had 3 or more falls in the past 3 months. During a review of Resident 59's Situation, Background, Assessment and Recommendation (SBAR, structured communication framework that helps teams share information about the condition of a resident) Communication Form, dated 1/31/2025, the SBAR indicated Resident 59 sustained a fall. During an interview on 2/4/2025 at 4:20 PM, with CNA 10, CNA 10 stated on 1/31/2025, between 5:30 PM AND 6 PM, CNA 10 was assisting residents from the dining area back to their rooms. CNA 10 stated she happened to be walking past room [ROOM NUMBER] when she overheard LVN 2 tell Resident 59 that's not my job, it's the aides responsibility. CNA 10 stated LVN 2 walked out the room and before CNA 10 could react CNA 10 witnessed Resident 59 fall to the floor next to her bed. CNA 10 stated the incident happened so fast that CNA 10 was unable to get to Resident 59 before Resident 59's fall. CNA 10 stated Resident 59 had dementia and had the tendency to get confused and disoriented and occasionally tried to get up from Resident 59's bed without calling for staff assistance. CNA 10 stated CNA 10 immediately assisted Resident 9 back to bed, didn't notice any physical injuries, and CNA 10 took Resident 59's vital signs. CNA 10 stated CNA 10 reported the incident to LVN 5. CNA 10 stated LVN 2 had the tendency to get so preoccupied in her tasks and forgot the work environment required teamwork and collaboration regardless of LVN 2's role or title as this ensured patient safety and well-being. During an interview on 2/4/2025 at 4:36 PM, with CNA 11, CNA 11 stated CNA 11 understood LVN 2 had specific responsibilities as part of her scope of practice. CNA 11 stated in his experience working with LVN 2 there was a lack of teamwork and collaboration from LVN 2, especially when LVN 2 resisted doing basic patient care tasks and relied heavily on the CNAs. CNA 11 stated, this behavior from LVN 2 created several serious issues that could compromise resident safety. CNA 11 stated LVN 2 got so caught up with medication administration that she forgot about her ethical and professional obligation to provide direct care and ensure resident safety. CNA 11 stated relying solely on CNAs for basic care could jeopardize patient well-being and compromise the quality of care provided. CNA 11 stated LVN 2 acted superior because of her title and had repeatedly told CNAs she did not perform certain basic patient care tasks because that was not her job or responsibility. CNA 11 stated teamwork and communication were essential to ensure safe patient care no matter what title you held. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/5/2025 at 9:07 AM, with Resident 9, Resident 9 stated Resident 59 had a recent fall in their room. Resident 9 stated Resident 9 could not recall the exact date but stated the event had happened recently. Resident 9 stated Resident 9 noticed Resident 59 had been trying to get up from Resident 59's bed without assistance and was concerned for her safety. Resident 9 stated, the day of the fall, Resident 9 pressed the call light for help and LVN 2 responded. Resident 9 stated Resident 9 told LVN 2 Resident 59 needed assistance because she was trying to get up from her bed. Resident 9 stated LVN 2 seemed oblivious to the situation and disregarded her concern, and stated, that's not my job or responsibility. Resident 9 stated LVN 2 had also mentioned she was busy passing medications. Resident 9 stated CNA 10 assisted Resident 59 back to bed and couldn't tell if Resident 59 had sustained any injuries. Resident 9 stated LVN 2 hardly demonstrated willingness to help with basic care needs when the CNAs were unavailable to assist. During an interview on 2/6/2025 at 11:37 AM, with the Director of Nursing (DON), the DON stated staff should be working together to ensure all aspects of the residents' needs were met from physical care to emotional support. The DON stated, staff should communicate effectively about changes in the resident's condition, promoting a more coordinated and efficient care environment. The DON stated collaboration enhanced the resident's comfort and safety and helped reduce the chance of oversights in care. The DON stated even though LVNs have more advanced responsibilities and training, they still played a hands-on role in basic patient care, ensuring the residents received consistent, comprehensive care. The DON stated LVNs should perform basic care tasks, such as: ADLs, taking vital signs (the basic measurements of your body's functions, like your temperature, heart rate (pulse), breathing rate, and blood pressure [the force of blood against the walls of your arteries as your heart pumps blood]), and helping with mobility and transfers. During an interview on 2/6/2025 at 4:31 PM, with RN 1, RN 1 stated LVNs might not be responsible for performing all basic care tasks, their role included ensuring patient safety and well-being, especially in emergency or urgent situations. RN 1 stated when a resident attempted to get out of bed and a CNA was unavailable, the LVN must intervene to protect the patient from harm and provide the necessary care until further support was available. During a review of the facility's P&P titled, Fall Risk Assessment, revised 5/2007, the P&P indicated any resident identified as high risk will have a prevention protocol initiated and documented on the care plan. The P&P indicated Prevention protocol examples, but not limited to: Provide supervision. During a review of the facility's P&P titled, Fall Management System, revised 1/2022, the P&P indicated it is the policy of the facility to provide an environment that remains as free of accident hazards as possible. The P&P indicated it is also the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307 Based on observation, interview and record review, the facility failed to post oxygen (02 - a colorless, odorless, tasteless gas that's essential for life) signage per facility's policy and procedure (P&P) for one of three sampled residents (Resident 233) when Resident 233 was receiving supplemental continuous oxygen. This deficient practice had the potential for an unsafe environment for Resident 233, other residents, staff and visitors due to the risk of fire related to the use of supplemental 02. Findings: During a review of Resident 233's Admission Record (AR), the AR indicated, Resident 233 was admitted to the facility on [DATE] with multiple diagnoses including respiratory failure (a serious condition that makes it difficult to breathe on your own), unspecified, unspecified whether with hypoxia (low levels of oxygen in your body tissues) or hypercapnia (when you have too much carbon dioxide in your blood), shortness of breath and heart failure, unspecified. During a review of Resident 233's History and Physical (H&P), dated 1/28/25, the H&P indicated, Resident 233 currently possessed the general capacity to make Resident 233's own decisions. During a review of Resident 233's Minimum Data Set (MDS, a resident assessment tool), dated 1/31/25, the MDS indicated, Resident 233's BIMS (Brief Interview for Mental Status - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) Summary Score was intact. The MDS indicated, Resident 233 was receiving 02 therapy. During a review of Resident 233's Order Summary Report (OSR), active orders as of 2/1/25, the OSR indicated, an order on 1/27/25 for continuous 02 to titrate (slowly increasing the dose) starting at 2 LPM (liters per minute) via NC (nasal cannula - a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen)/mask to keep 02 saturation (your blood oxygen level) above 88% R/T (related to) COPD (chronic obstructive pulmonary disease - a chronic lung disease causing difficulty in breathing) every shift. During a review of Resident 233's Medication Administration Record (MAR), dated 2/1/25 - 2/28/25, the MAR indicated, Resident 233 had been getting continuous 02 at 2 LPM every shift. During an observation on 2/3/25 at 10:12 a.m. Resident 233 was awake and alert in bed on 2 LPM of continuous 02 via N/C. Resident 233's room did not have an 02 warning signage posted. During a concurrent observation and interview on 2/3/25 at 11:19 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated, Resident 233 was on 02. LVN 3 stated, there should have been a signage posted regarding 02 use so Resident 233 and Resident 233's visitors would be alerted and not use anything flammable anything cause fire such as a cigarette, for safety. During a review of the facility's undated P&P titled, Oxygen, Use of, the P&P indicated, It was the policy of the facility to promote safety in administering 02. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Oxygen Therapy, date revised 01/2019, the P&P indicated, it was the policy of the facility to administer 02 in a safe manner under physician's orders and during emergencies following emergency protocols. The P&P indicated, one of the equipment in administering 02 included NO SMOKING/OXYGEN IN USE signs.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Glen Care Center	1033 E. Arrow Highway Glendora, CA 91740

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729 Based on observation, interview, and record review, the facility failed to have sufficient staff to ensure timely incontinence care and dignity was provided for two of two sampled residents (Resident 233 and Resident 39). This failure had the potential for Resident 233 and Resident 39 to experience skin breakdown and loss of dignity. a decline in psychosocial well-being. Cross reference F550 Findings: During a review of Resident 233's Admission Record, the AR indicated Resident 233 was admitted to the facility on [DATE] with multiple diagnoses including heart failure (condition that develops when one's heart does not pump enough blood to meet the body's needs) and type 2 diabetes (-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 233's Minimum Data Set (MDS - a resident assessment tool) dated 1/31/2025, the MDS indicated Resident 233 had intact cognition (ability to reason, think, plan) and required substantial or maximum assistance (helper does more than half the effort) for toileting hygiene and toilet transfers. During an interview on 2/5/2025 at 11 AM with Resident 233's Family Member (FM), the FM stated the FM observed multiple times when Resident 233 had to wait 30 minutes to one hour for Resident 233's soiled brief to be changed. During an interview on 2/6/2025 at 3:42 PM with the FM, the FM stated this morning around 9 AM, Resident 233 had soiled herself with feces and pressed Resident 233 the call light for assistance. The FM stated Resident 233 was not changed until 11AM. During an interview on 2/6/2025 at 4 PM with Certified Nursing Assistant (CNA) 4, CNA 4 stated the facility was short staffed at times especially during the evening and night shifts. CNA 4 stated the previous night on 2/5/2025 CNA 4 was assigned to care for eighteen residents which was difficult and unusual. CNA 4 stated the average amount of residents CNA 4 normally cared for was 10 to 11 residents which was manageable. During a review of the facility's 11-7 AM CNA Assignment (CNAA), dated 2/5/2025, the CNAA indicated five CNAs were responsible for the care of 90 residents. Four out of Five CNAs were assigned to care for 18 residents each. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/6/2025 at 4:05 PM with Resident 233, Resident 233 stated Resident 233 was supposed to go to physical therapy at 9 AM but was unable to because Resident 233 had soiled Resident 233's diaper. Resident 233 stated the Physical Therapist pressed the call light for Resident 233 to be changed. Resident 233 stated no staff came into the room to change Resident 233's soiled diaper until 11 AM. Resident 233 stated Resident 233 often had to wait a long time to get help from staff (in general). Resident 233 stated Resident 233 did not always press the call light because Resident 233 was worried about bothering the staff because the staff was always so busy. During a review of Resident 39's AR, indicated Resident 39 was admitted to the facility on [DATE] with diagnosis that included Alzheimer's disease (disease causing memory loss and other mental functions), generalized muscle weakness, and abnormal posture. During a review of a History and Physical Reports (H&P), dated 11/4/2024, the H&P indicated Resident 39 did not have the capacity to understand and make decisions. During a review of Resident 39's MDS dated [DATE], the MDS indicated Resident 39 needed maximal assist (helper does more than half the effort) with personal hygiene (maintain body hygiene) sit to stand, and chair to bed transfers. During an observation on 2/6/2025 at 4:10 PM, CNA 4, CNA 5, and CNA 6 were observed passing water from a cart located in the hallway. During the same observation, Resident 39 was observed sitting on her wheelchair in the facility hallway, following CNA 4, CNA 5, and CNA 6, stating help, help, while pointing down the hallway. CNA 4 turned to address Resident 39, stated not right now, I am busy. CNA 4 then turned her back to Resident 39 and continued to pass water. During an interview with CNA 6, on 2/6/2025 at 4:14 PM, CNA 6 stated CNA 6 would not have turned CNA 6's back from Resident 39. CNA 6 stated Resident 39 was confused and just wanted some assistance. CNA 6 stated I feel bad for Resident 39. During an interview with CNA 5, on 2/6/2025 at 4:17 PM, CNA 5 stated CNA 5 should not have told Resident 39 I'm busy. CNA 5 stated CNA 5 should have asked another CNA to help Resident 39. CNA 5 stated Resident 39 deserved service, help, and [to be treated with] dignity. During an interview with the Director of Nursing (DON), on 2/6/2025 at 4:20 PM, the DON stated the facility should treat all residents with compassion and empathy. The DON stated, all residents should be treated with dignity, even the confused residents. During a review of the facility's policy and procedure, titled Resident Rights: Dignity and Respect, revised 1/2025, indicated it was the policy of the facility that all residents be treated with kindness, dignity and respect. During a review of the facility's policy and procedure (P&P), titled Nursing Administration - Staffing, Adequate, dated 10/2014, the P&P indicated the facility maintains adequate staff on each shift to assure that the resident's needs are met.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50016 Based on observation, interview, and record review, the facility failed to ensure one of two sanitation buckets (bucket 1) in the kitchen had adequate amount of quaternary sanitizing solution (an ammonium solution used for sanitizing surfaces) for the disinfection of key areas in the kitchen utilized to prepare resident's food. This deficient practice placed the residents at increased risk of infections and could have impacted the health and safety of residents. Findings: During an observation on 2/3/2025 at 8:57 AM, the [NAME] (CK) checked the quaternary sanitizing solution and used a quaternary test strip for two sanitation buckets located in the kitchen. The CK placed the test strip in bucket 1 for 10 seconds. The strip indicated 100 ppm (ppm-parts per million, unit of measurements). The CK placed the quaternary test strip in bucket 2 for 10 seconds, the strip indicated 300 ppm. During an interview and record review on 2/3/2025 at 9:05 AM, with the CK, the CK stated the quaternary test strip was used to check if the sanitizing solution was effective. The CK stated the strip should be in the solution for at least ten seconds before the results were checked. The CK stated the quaternary solution should be between 200ppm to 400ppm to ensure the sanitizing solution was effective and strong enough to disinfect. The CK stated sanitation bucket 1 was out of range with a reading of 100 ppm and the result indicated a reduced effectiveness in the sanitizing solution. During an interview on 2/3/2025 at 11:49 AM, with the Registered Dietician (RD), the RD stated the sanitation buckets were rechecked and the RD determined sanitation bucket 1 had too many washcloths in the bucket which affected the effectiveness of the quaternary sanitizing solution. The RD stated the efficacy of the solution could have been compromised if there were too many washcloths in the solution. The RD stated if the washcloths were too dirty or heavily soiled, they could absorb the disinfectant solution reducing the potency needed to kill germs. During an interview on 2/6/2025 at 1:10 PM, with the Director of Dining Services (DDS), the DDS stated ensuring proper quaternary solution levels was critical for preventing cross contamination (process by which bacteria can be transferred from one area to another) because if the disinfectant was not at the correct strength, it may not effectively kill harmful microorganisms, like bacteria (living organism that can cause an infection) and viruses, that can spread between surfaces. The DDS stated maintaining proper quaternary sanitizing solution levels ensured the disinfectant was strong enough to kill germs, lowering the risk of cross-contamination and kept the environment clean and safe for the residents. During a review of the undated Hydrion QT-10 test strip instructions, the instructions indicated to immerse the test strip paper for ten seconds in the sanitizing solution. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the undated [NAME] Chemicals the manufacturer's instructions indicated to test sanitizing solution to assure proper solution strength between 200 ppm-400 ppm. During a review of the facility's policy and procedure (P&P) titled, Quaternary Ammonium Log Policy, dated 2018, the P&P indicated: -The concentration of the ammonium in the quaternary sanitizer will be tested to ensure the effectiveness of the solution. -The food & nutrition worker will place the solution in the appropriate bucket labeled for its contents and will test concentration of the sanitation solution. -The solution will be tested at least every shift or when the solution is cloudy. -The solution will be replaced when the reading is below 200 ppm.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 40913 Based on interview and record review, the facility failed to ensure a Director of Nursing (DON) attended the Quality Assurance Performance Improvement quarterly meeting. This deficient practice had the potential to affect residents' physical, mental and psychosocial well-being. Findings: During a concurrent record review of the QAPI Sign in Sheet and interview on 2/6/2025 at 5:30 PM, there was no Director of Nursing among the attendees. The Administrator stated there was no DON during the QAPI meeting om 1/24/2025. During an interview on 2/6/20255 at 5:40 PM, the Administrator stated the DON needed to be in all the QAPI meetings. The DON is the head of the nursing department, so she needs to be in the planning and monitoring nursing related services. The Administrator stated he needed to have an acting DON attend the QAPI meeting when the previous DON left. During a review of the facility's 2025 Quality Assurance and Performance Improvement Plan (QAPI), the plan indicated the department heads who had been named to the QAPI leadership team and indicated what their individual roles within the program entailed, including the DON as the clinical care sub-committee leader.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307 Based on observation, interview and record review, the facility failed to implement the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program (IPCP) Standard and Transmission-Based Precautions, for nine of nine sampled residents (Residents 42, 235, 236, 234, 23, 61, 237, 40 and 46) by failing to: a. Ensure unlabeled personal toiletries were not stored inside Residents 42, 235, 236 and 234's [NAME] n' [NAME] restroom (a restroom that has two doors and is sandwiched between two bedrooms and is accessible by both bedrooms). b. Ensure staff was wearing and/or changed personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environment) during care for Residents 61 and 237 who were in contact isolation (a set of precautions that help prevent the spread of germs from a resident to others by separation of residents with an infection from residents without an infection). c. Ensure Certified Nursing Assistant 2 (CNA 2) was wearing PPE upon entering Resident 40 and Resident 46's room when Residents 40 and 46 were on contact precautions for Candida Auris (C. auris - is an emerging fungus that can cause severe, often multidrug-resistant, infections. It spreads easily among patients in healthcare facilities). These deficient practices had the potential to result in cross contamination and/or the development and transmission of disease (an illness or sickness) and infection for Residents 42, 235, 236, 234, 23, 61, 237, 40 and 46, other residents, staff and visitors. Findings: a1. During a review of Resident 42's Admission Record (AR), the AR indicated, Resident 42 was admitted to the facility on [DATE] with multiple diagnoses including unspecified intracapsular fracture (a partial or complete break in the bone within the joint capsule) of right femur (thigh bone), subsequent encounter for closed fracture (simple fracture - a broken bone with the skin still intact) with routine healing, muscle weakness (generalized), and old myocardial infarction (MI - heart attack). During a review of Resident 42's History and Physical (H&P), dated 1/11/25, the H&P indicated, Resident 42 was alert, oriented x 3 (referring to person, place and time) and not in distress or having acute (sudden) concerns except occasional constipation (when a person has difficulty passing stool [poo]). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 42's Minimum Data Set (MDS, a resident assessment tool), dated 1/30/25, the MDS indicated, Resident 42's BIMS (Brief Interview for Mental Status - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) Summary Score was intact. The MDS indicated, Resident 42 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement). The MDS indicated, Resident 42's ability to shower/bath self (the ability to bathe self, including washing, rinsing, and drying self) was not attempted due to medical condition or safety concerns. The MDS indicated, Resident 42 was occasionally incontinent (involuntary loss of urine or stool) [less than 7 episodes of incontinence] of bowel and had no constipation. a2. During a review of Resident 235's AR, the AR indicated, Resident 235 was admitted to the facility on [DATE] with multiple diagnoses including muscle weakness (generalized), difficulty in walking, not elsewhere classified and urinary tract infection (UTI - an infection in the bladder/urinary tract). During a review of Resident 235's H&P, dated 1/22/25, the H&P indicated, Resident 235 currently possessed the general capacity to make Resident 235's own decisions. During a review of Resident 235's MDS, dated [DATE], the MDS indicated, Resident 235's BIMS Summary Score was intact. The MDS indicated, Resident 235's ability for toileting hygiene and shower/bathe self (the ability to bathe self, including washing, rinsing, and drying self) was not attempted due to medical condition or safety concerns. The MDS indicated, Resident 235 was frequently incontinent of urine (7 or more episodes of urinary incontinence) and bowel (2 or more episodes of bowel incontinence). a3. During a review of Resident 236's AR, the AR indicated, Resident 236 was admitted to the facility on [DATE] with multiple diagnoses including type 2 diabetes mellitus (DM II - adult-onset disorder characterized by difficulty in blood sugar control and poor wound healing) without complications, muscle weakness (generalized), and heart failure, unspecified. During a review of Resident 236's H&P, dated 1/29/25, the H&P indicated, Resident 236 had the capacity to understand and make decisions. a4. During a review of Resident 234's AR, the AR indicated, Resident 234 was admitted to the facility on [DATE] with multiple diagnoses including cellulitis (a skin infection that causes swelling and redness), type 2 diabetes mellitus with other skin ulcer (a small open sore or wound generally found in the stomach or on the skin) and unspecified atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). During a review of Resident 234's H&P, dated 1/26/25, the H&P indicated, Resident 234 had the capacity to understand and make decisions. During a review of Resident 234's MDS, dated [DATE], the MDS indicated, Resident 234's BIMS Summary Score was intact. The MDS indicated, Resident 234 required substantial/maximal assistance with toileting hygiene. The MDS indicated, Resident 234's ability for shower/bathe self was not attempted due to medical condition or safety concerns. The MDS indicated, Resident 235 was frequently incontinent of urine and bowel. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 2/3/25 at 10:36 a.m. with Certified Nursing Assistant (CNA) 5, an opened, unlabeled 220 ml (milliliters - a unit of measurement) bottle of PeriFresh Rinse Free Perineal Cleanser and an opened 8 fl oz (fluid ounce - a unit of volume used for measuring liquid) bottle of [NAME] Shampoo & Body Wash were stored on the sink inside the [NAME] n' [NAME] restroom shared by Residents 42, 235, 236 and 234. CNA 5 stated, the PeriFresh Rinse Free Perineal Cleanser and the [NAME] Shampoo & Body Wash were supposed to clean the private (the genital organs on the outside part of the body) and to clean the body. CNA 5 stated, the personal toiletries were supposed to be labeled with the resident's (in general) name and bed number and kept at the resident's bedside table for infection control. During an interview on 2/4/25 at 4:02 p.m. with the Infection Preventionist Nurse (IPN), the IPN stated, anything used for personal should always be labeled, not kept in public spaces or shared. The IPN stated keeping personal belongings at the bedside for dignity and of course, infection control. The IPN stated, I wouldn't want anybody using mine. b1. During a review of Resident 23's AR, the AR indicated, Resident 23 was originally admitted to the facility on [DATE] and last readmitted on [DATE] with multiple diagnoses including type 2 diabetes mellitus without complications, pneumonia (an infection/inflammation in the lungs) and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly into the stomach common for people with swallowing problems) status. During a review of Resident 23's MDS, dated [DATE], the MDS indicated, Resident 23's BIMS Summary Score was intact. The MDS indicated, Resident 23 required substantial/maximal assistance to dependent with self-care. The MDS indicated, Resident 23 was always incontinent (no episodes of continence) of urine and bowel. During a review of Resident 23's H&P, dated 12/26/24, the H&P indicated, Resident 23 could make needs known but could not make medical decisions. During a review of Resident 23's Order Summary Report (OSR), active order status as of 2/1/25, the OSR indicated, an order on 1/31/25 for Enhanced Barrier Precautions (a set of infection control measures that use gowns and gloves to reduce the spread of multidrug-resistant organisms (MDROs]): PPE required for high resident contact care activities, indication: indwelling medical device every shift. b2. During a review of Resident 61's AR, the AR indicated, Resident 61 was originally admitted to the facility on [DATE] and last readmitted on [DATE] with multiple diagnoses including muscle weakness (generalized), essential (primary) hypertension (HTN - high blood pressure) and hypothyroidism (underactive thyroid disease), unspecified. During a review of Resident 61's H&P, dated 12/8/24, the H&P indicated, Resident 61 did not have the capacity to understand and make decisions. During a review of Resident 61's MDS, dated [DATE], the MDS indicated, Resident 61's cognitive skills (ability to think and process information) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated, Resident 61 substantial/maximal assistance with toileting hygiene and shower/bathe self. The MDS indicated, Resident 61 was frequently incontinent of urine and bowel. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b3. During a review of Resident 237's AR, the AR indicated, Resident 237 was admitted to the facility on [DATE] with multiple diagnoses including unspecified atrial fibrillation, urinary tract infection, site not specified and type 2 diabetes mellitus without complications. During a review of Resident 237's H&P, dated 1/19/25, the H&P indicated, Resident 237 was alert and oriented x 3. During a review of Resident 237's MDS, dated [DATE], the MDS indicated, Resident 237's BIMS Summary Score was intact. The MDS indicated, Resident 237 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) to substantial/maximal assistance with toileting hygiene and shower/bathe self. The MDS indicated, Resident 237 was frequently incontinent of bowel. During a review of Resident 237's OSR, active orders as of 2/6/25, the OSR indicated, an order on 2/3/25 for contact isolation precautions for VRE (Vancomycin-resistant enterococci - a type of bacteria that is resistant to many antibiotics) in the urine every shift. During an observation on 2/3/25 at 12:46 p.m. Residents 23, 61 and 237 were cohorted (grouped together) in the same room. A Contact Precautions signage posted and a black trimmed colored 3-drawer PPE cart outside of Residents 23, 61 and 237's room. During an interview on 2/4/25 at 4:02 p.m. with the IPN, the IPN stated, Residents 23, 61 and 237 who were cohorted in the same room were on contact precautions. The IPN stated Resident 237 was in contact isolation for VRE in the urine. Resident 23 was on EBP for GT (gastrostomy tube) and Resident 61 is nothing (not requiring to be on precautionary isolation). The IPN stated, Residents 237, 23 and 61 were treated for contact isolation precautions and the highest level precaution contact signage was posted. The IPN stated, staff would have to change PPE in between when providing care for Residents 23, 61 and 237. During an observation on 2/5/25 at 7:55 a.m. in Resident 23, 61 and 237's cohorted room, CNA 2, CNA 8 and CNA 9 had PPE on while assisting/repositioning Resident 237 in bed to get ready for breakfast. During a concurrent observation of CNAs 8 and 9 and interview with CNA 2 on 2/5/25 at 8:02 a.m., CNA 9 removed gloves without changing gown and donning (putting) new gloves after assisting Resident 237, CNA 9 went to set up Resident 61's breakfast tray then proceeded to assist CNA 8. CNA 8 removed gloves, set up Resident 237's breakfast tray and moving/adjusting Resident 237's bedside table while CNA 9 was carrying Resident 237's breakfast tray. CNA 9 placed Resident 237's breakfast tray on Resident 237's bedside table after CNA 8 set up Resident 237's bedside table. CNA 8 proceeded to sit at Resident 237's bedside to feed Resident 237 without wearing gloves. CNA 9 proceeded to feed Resident 61 without changing gown and donning gloves. CNA 2 stated staff (in general) was supposed to wear gown and gloves when in contact with residents in isolation so there would be no cross contamination. CNA 2 stated staff's understanding for the use of PPE was to protect staff. During an interview on 2/5/25 at 12:37 p.m. with the IPN, the IPN stated, it was important to change PPE in between caring for residents in isolation for infection control and making sure the patients are safe. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, IPCP Standard and Transmission-Based Precautions, last revised 3/2024, the P&P indicated, It was the policy to the facility to implement infection control measures to prevent the spread of communicable diseases and conditions. The P&P indicated, Residents on contact precautions should be restricted to their rooms and restricted from participation in group activities. The P&P indicated, for staff to wear a gown and gloves for all interactions that may involve contact with the patient/resident or the patient's/resident's environment. 40913 c1. During a review of Resident 40's Admission Record (AR), the AR indicated the facility admitted Resident 40 on 1/21/2021, with diagnoses that included immunodeficiency (weak immune system, allowing infections and other health problems to occur more easily) due to drugs, candidiasis (a yeast that lives in parts of the body, grows out of control). During a review of Resident 40's Physician Order dated 6/6/2022, the order indicated to place Resident 40 on contact isolation for C. auris. During a review of Resident 40's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 1/22/2025, the MDS indicated Resident 40 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity most activities and bed mobility. c2. During a review of Resident 46's AR, the AR indicated the facility admitted Resident 46 on 6/19/23, with diagnoses that included urinary tract infection (UTI, an infection in the urinary system that could include the kidneys, bladder and urethra), acute respiratory failure (Respiratory failure is a serious condition that happens when your lungs cannot get enough oxygen into your blood). During a review of Resident 46's Physician Order dated 6/23/2023, the order indicated contact isolation precautions for C. auris. During an observation on 2/4/2025 at 3:30 PM, CNA 2 entered the room which had a contact precaution sign on the door. CNA 2 was not wearing a gown and gloves while carrying two pitchers of water. CNA 2 dropped off the pitchers then took the used pitchers from both Resident 40 and Resident 46's table and left the room. During a follow up interview on 2/4/2025 at 3:32 PM, CNA 2 stated CNA 2 would wear a gown and gloves only when providing care. During an interview on 2/4/2025 at 3:58 PM, the IPN stated when a resident (in general) was on contact precautions, staff needed to wear a gown and gloves every time staff would enter the room of the resident on contact precautions. The IPN stated Resident 40 and Resident 46 were both on contact precautions for C. auris, staff needed to wear PPE before entering Resident 40 and 46's room. The IPN stated C auris would get passed easily and the staff needed to wrap the contaminated tray and pitcher when coming from a contact isolation room.

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	056360	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Glen Care Center	1033 E. Arrow Highway Glendora, CA 91740

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on interview and record review, the facility failed to implement its antibiotic (ABX, medication used to treat infections) stewardship program (efforts that ensure antibiotics are used only when necessary and appropriate) for three of seven sampled residents (Resident 10, Resident 72, and Resident 134) sampled residents. Residents 10, 72, and 134 did not meet McGreer's criteria (infection surveillance checklist to help determine appropriate antibiotic) for antibiotic use. These deficient practices had the potential for unnecessary administration of antibiotics and lead to resistance (when the antibiotic can no longer kill the bacteria [living organism that can cause an infection]) to antibiotics for Residents 10, 72, and 134. Findings: A. During a review of Resident 10's Admission Record (AR), indicated Resident 10 was readmitted to the facility on [DATE] with diagnosis that included sepsis (life-threatening complication of an infection), dementia (a group of conditions, decline in mental ability that interfere with daily activities) and generalized weakness. During a review of Resident 10's Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 11/22/2024, the MDS indicated Resident 10 had clear speech and had the ability to understand and be understood. During a review of Resident 10's Order Summary Report (OSR), dated active as of 2/1/2025, the OSR included a physician's order, dated 1/31/2025, for Ertapenem Sodium (ABX used to treat a wide range of bacterial infections) 500 milligrams (mg, unit of measurement) given intravenous (IV, a soft flexible tube placed inside a vein, usually in the hand or arm and used to give a person medicine or fluids) at bedtime for seven days. During a review of Resident 10's IV Medication Administration Record (IVMAR) for February 2025, the IVMAR indicted Resident 10 was administered Ertapenem Sodium 500 mg on 2/1/2025m 2/2/2025, 2/3/2025, 2/4/2025, 2/5/2025 and 2/6/2025. During a review of Resident 10's care plan (CP), titled Diarrhea related to antibiotic use (Ertapenem Sodium), created on 2/4/2025, the CP's goal indicated Resident 10 would have reduced or no episodes of diarrhea. During an interview with the Infection Prevention Nurse (IPN 2), and a concurrent record review of Resident 10's electronic and paper medical record (chart), on 2/6/2025 at 11:01 PM, IPN 2 stated the facility used McGreer's criteria for infection surveillance. IPN 2 stated an Infection Surveillance - V2 Form (ISV2F), was competed for every resident who was administered ABXs. IPN 2 stated Resident 10 did not have a ISV2F filled out for the use of Ertapenem Sodium. IPN 2 stated the form was never filled out to determine if Resident 10 met the criteria for the use of the antibiotic [Ertapenem Sodium]. IPN 2 stated any resident with an ABX order must have ABX surveillance and the facility must determine if the resident met the criteria to deter the risks of resistance from happening. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. During a review of Resident 72's AR indicated Resident 72 was admitted to the facility on [DATE] with diagnosis that included sepsis and generalized muscle weakness. During a review of a Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 1/12/2025, the MDS indicated Resident 72 was cognitively intact, had clear speech, and had the ability to understand and be understood. The MDS indicated Resident 72 needed moderate assistance (staff does less than half the effort) with toilet and personal hygiene, lower body dressing, and with sit to stand (ability to stand/sit from a chair). During a review of Resident 72's OSR, the OSR indicated an order, dated 1/13/2025, for Ampicillin Sodium (an ABX), three grams (G, unit of measurement), given IV every 6 hours (q6h). During a review of Resident 72's IVMAR, the IVMAR indicted Resident 72 was administered Ampicillin Sodium 3G q6h on 2/1/2025, 2/2/2025, 2/3/2025, 2/4/2025, 2/5/2025 and 2/6/2025. During a review and concurrent interview with IPN 2, on 2/6/2025 at 11:01 PM, Resident 72's Infection Surveillance -V2 (ISV2), dated 1/8/2025 was reviewed. The documented indicated at least one McGreer's criteria must be present to start ABX treatment for cellulitis (infection in the skin), soft tissue, or wound infection. IPN 2 stated Resident 72's ISV2 was not completed. IPN 2 stated Resident 72's ISV2 did not indicated if Resident 72 met the criteria for ABX administration for cellulitis, soft tissue, or wound infection. IPN stated IPN did not follow up with Resident 72's physician regarding Resident 72 ABX use. IPN stated it was important to follow up with physician regarding ABX use to ensure criteria was met and to prevent ABX resistance. C. During a review of Resident 134's AR, the AR indicated Resident 134 was admitted to the facility on [DATE] with diagnosis that acute respiratory failure (not enough oxygen in the lungs), generalized muscle weakness, and diabetes (elevated blood sugar). During a review of Resident 134's OSR, dated active as of 2/6/2025, the OSR indicated a physician's order, dated 2/4/2025, for Zosyn (an antibiotic) intravenous solution 3/0.375 mg IV q8h for pneumonia (infection that inflames the air sacs of the lungs). During a review of Resident 134's IVMAR, the IVMAR indicted Resident 72 was administered Zosyn intravenous solution 3/0.375 mg IV q8h on 2/4/2025, 2/5/2025 and 2/6/2025. During an interview with the IPN 2 on 2/6/2025 at 11:01 PM, and concurrent record review of Resident 134's ISV2 for Respiratory Tract Infections (RTI), dated 1/31/2025, IPN 2 stated Resident 134's ISV2F was in-complete. IPN 2 stated the ISV2 did not indicate if Resident 134 had McGreer's criteria needed to determine the need for ABX use. ICN 2 stated any resident with an ABX order must have ABX surveillance to determine if they met the criteria and to deter the risk of ABX resistance. During a review of the facility's policy titled Antibiotic Stewardship, revised 12/2023, indicated it was the policy to implement an Antibiotic Stewardship Program (ASP) that is incorporated in the overall infection prevention and control program which will promote appropriate use of antibiotic while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic use. This policy has the potential to limit antibiotic resistance in the post-acute care setting, while improving treatment efficacy and resident safety, and reducing treatment -related cost.

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F 0911 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729 Based on observation and interview, the facility failed to ensure one out of 34 rooms had no more than 4 residents (room [ROOM NUMBER]) in the room. This failure had the potential to result in lack of space and privacy for the residents residing in that room. Findings: During an observation and interview on 2/6/2025 at 10:46 AM with Treatment Nurse (TN) 1, TN 1 stated there were six residents inside room [ROOM NUMBER]. During an interview on 2/6/2025 at 2:56 PM with the Administrator (ADM), the ADM stated when the ADM was first hired at the facility 8/2024, room [ROOM NUMBER] had five beds and five residents. The ADM stated the facility added the sixth bed on 1/20/2025 and admitted the sixth resident to occupy the bed on 1/21/2025. During an interview on 2/6/2025 at 4:42 PM with the ADM, the ADM stated the facility did not have a policy that indicated how many residents could be accommodated in a single room.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 50016 Based on observation, interview, and record review, the facility failed to ensure the call light was within reach for one of one sampled resident (Resident 283). This deficient practice had the potential to result in a delay or the inability for Resident 283 to obtain necessary care and services. Findings: During a review of Resident 283's Admission Record (AR), the AR indicated the facility admitted Resident 283 on 1/19/2025, with diagnoses including unspecified head injury, muscle weakness, and epilepsy (a brain disorder that causes seizures, which are abnormal electrical activity in the brain). During a review of Resident 283's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 1/23/2025, the MDS indicated Resident 283 cognition (the ability to think and process information) was moderately impaired. The MDS indicated Resident 283 required substantial/maximal assistance (helper does more than half the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and required substantial/maximal assistance with mobility. During an observation on 2/3/2025 at 9:45 AM, Resident 283's call light was found on the floor and underneath Resident 283's bed. The call light was not within the resident's reach. During an interview on 2/3/2025 at 2:35 PM, with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 283's call light wasn't within reach. LVN 1 stated all call lights should be easily accessible to all residents. LVN 1 stated call lights within reach enhanced the resident's safety and well-being as it allowed residents to quickly alert staff if they need assistance, whether for medical attention, help with mobility, or addressing immediate needs. LVN 1 stated call lights within the resident's reach helped prevent and reduced the risk of accidents, such as falls. During an interview on 2/6/2025 at 11:37 AM, with the Director of Nursing (DON), the DON stated staff should ensure call lights were always accessible to the residents. The DON stated ensuring call lights were within reach promoted a safer, more dignified, and responsive care environment for all residents. During a review of the facility's policy and procedure (P&P) titled, Call Light/Bell, undated, the P&P indicated it was the policy of the facility to provide the resident a means of communication with nursing staff. The P&P indicated to leave the resident comfortable, place the call device within resident's reach before leaving room, and if the call/light bell is defective, immediately report this information to the unit supervisor.