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	03/27/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review, the facility failed to ensure two of three sampled residents (Resident 104 and Resident 6), were treated with dignity when:a. On 3/24/2026, Certified Nursing Assistant (CNA) 5 did not close Resident 104's drapes (privacy curtain) all around Resident 104's bed while getting ready to clean up Resident 104 and CNA 5 removed Resident 104's bed sheet exposing Resident 104 from the waist down.b. On 3/27/2026, CNA 7 and CNA 8 did not close Resident 6's drapes all around Resident 6's bed while providing peri care (cleaning and caring of the genital and anal areas) to Resident 6 and exposing Resident 6's back, buttocks, and scrotal (dual-chambered sac of skin and muscle that protects the testes and regulates their temperature for optimal sperm production) area.This deficient practice had the potential to cause Resident 104 and Resident 6 to feel humiliated and could negatively impact Resident 104 and Resident 6's psychosocial well-being.Findings:a.During a review of Resident 104's Face Sheet (FS - admission record), the FS indicated Resident 104 was newly admitted to the facility on [DATE] with multiple diagnoses including muscle weakness (generalized) and essential (primary) hypertension (HTN - high blood pressure).During a concurrent observation and interview on 3/24/2026 at 10:38 AM with CNA 5, Resident 104's bed was in between two (2) roommates (unnamed). Resident 104 was lying in bed and CNA 5 was preparing to clean up Resident 104. Resident 104's drapes were partially drawn on both sides of Resident 104's bed. CNA 5 removed Resident 104's bed sheet and Resident 104's diaper was exposed from the waist down and making it visible to others (potential passers-by). CNA 5 stated, CNA 5 should have closed Resident 104's drapes all the way, (around the bed), for privacy before CNA 5 started cleaning up Resident 104.During an interview on 3/27/2026 at 7:45 AM with the Director of Nursing (DON), the DON stated, [when cleaning up a resident] the drapes should be closed all the way around resident's (in general) beds for privacy.b. During a review of Resident 6's admission Record (AR), the AR indicated, Resident 6 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including type 2 diabetes mellitus (DM II - an adult onset disorder characterized by difficulty in blood sugar control and poor wound healing) without complications, and obesity (too much body fat), unspecified.During a review of Resident 6's Care Plan (CP), initiated 12/26/2025, the CP indicated Resident 6 had ADL self-care performance deficit r/t (related to) weakness, impaired mobility (bed bound), pain, and incontinence. The CP's interventions indicated to promote dignity by ensuring privacy.During a review of Resident 6's History and Physical Examination (H&P), dated 12/27/2025, the H&P indicated Resident 6 had the capacity to understand and make decisions.During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool), dated 12/29/2025, the MDS indicated Resident 6's cognitive skills (ability to think and process information) for daily decision making were intact. The MDS indicated Resident 6 was frequently (7 or more episodes) incontinent (loss of bladder control) of urine and frequently (2 or more episodes) incontinent of bowel movement. The MDS indicated Resident 6 was dependent (helper does all of the effort) and required setup or clean-up assistance (helper sets up or cleans up) with activities of daily living (ADLs - activities such as bathing, dressing, toileting and feeding a person performs (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	daily).During an observation on 3/27/2026 at 9:35 AM, Resident 6 was lying in bed, awake, and alert, in a double occupancy room, and waiting for wound care. Resident 6 was positioned on Resident 6's left side while CNA 7 and CNA 8 were cleaning up Resident 6 of bowel incontinence. Resident 6's drapes were partially drawn on both sides of Resident 6's bed and Resident 6's back, buttocks, and scrotal area with external hemorrhoids (swollen, inflamed veins around your anus) were exposed. During an interview on 3/27/2026 at 10:14 AM with CNA 7, CNA 7 stated, Resident 6's drapes should have been drawn, all the way, completely closed for Resident 6's dignity and privacy and to prevent Resident 6 from being exposed if Resident 6's roommate (unnamed) walked in.During a review of the facility's policy and procedure (P&P), titled, Dignity and Privacy, reviewed date 3/2026, the P&P indicated, all residents be treated with kindness, dignity, and respect. The P&P indicated residents should be examined and treated in a manner that maintains the privacy of their bodies. The P&P indicated a closed door or drawn curtain shielded the resident from passers-by. The P&P indicated, privacy of a resident's body should be maintained during toileting, bathing, and other activities of personal hygiene.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary care and services for three of three sampled residents (Residents 7, 56, and 98) when the facility:1. Failed to follow a physician's (health professional who is licensed and trained to practice medicine) order indicating to ear lavage (a medical procedure used to remove excess ear wax [cerumen] or foreign materials from the ear canal with a gentle stream of warm water) for Resident 7 who was hard of hearing.2. Did not complete a fall risk evaluation following Resident 56's third fall on [DATE].3. Failed to follow a physician's order and performed cardiopulmonary resuscitation (CPR -an emergency lifesaving procedure performed when a person's breathing or heartbeat has stopped) to Resident 98 when the order for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life), indicated Do Not Attempt Resuscitation/DNR [Allow Natural Death].These failures resulted in: The potential to result in worsened hearing and further impairing Resident 7's ability to communicate Resident 7's needs leading to negatively affecting Resident 7's his quality of life, the potential to result in Resident 56's safety needs not being addressed and the potential for further falls and serious injury to Resident 56, and a violation of Resident 98's rights and wishes regarding life-sustaining treatment.Findings 1. During a review of Resident 7's Face Sheet (admission record, FS), the FS indicated Resident 7 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation (irregular heartbeats), dysphagia (difficulty swallowing), and generalized muscle weakness. During a review of Resident 7's History and Physical (H&P), dated [DATE], the H&P indicated Resident 7 had the capacity to understand and make decisions. During a review of Resident 7's MDS, dated [DATE], the Minimum Data Set (MDS - a resident assessment tool), indicated Resident 7's cognitive (the ability to think and process information) was intact and required moderate assistance (helper does less than half the effort) with toilet hygiene, upper body dressing, chair to bed and toilet transfers. The MDS's section B: Hearing, Speech and Vision indicated Resident 7 had the ability to hear with minimal difficulty (difficulty in some environments e.g., when people speak softly or setting is noisy). During a review of Resident 7's physician orders (PO), dated [DATE], the PO indicated ear lavage, one time only on [DATE]. During a review of Resident 7's Medication Administration Record (MAR), dated [DATE], the MAR indicated ear lavage one time only, ordered on [DATE]. The MAR indicated the ear lavage on [DATE] was left blank (not signed by a licensed nurse, a signature indicates the treatment was completed) and the lavage was not completed. During an observation and concurrent bedside interview with Resident 7 on [DATE] at 10:30 AM, with the MDS Coordinator (MDS) 1, Resident 7 gestured for the surveyor to come closer to Resident 7's bedside, and stated, Speak louder and put your mask down so I can hear you. I have had trouble hearing from before I got here [the facility]. They [facility] were putting drops in my ear for five days and were supposed to flush [to clean the ear canal by removing excess wax with a gentle stream of warm water] my ear out of wax, but that never happened. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and concurrent record review on [DATE] at 10:52 AM with MDS 1. Resident 7's MAR, dated [DATE], was reviewed. MDS 1 stated Resident 7's physician order for ear lavage was not done on [DATE]. MDS 1 stated it was important for us [the facility] to carry out [implement, to perform] physician orders to provide appropriate care and treatment to Resident 7. MDS 1 state Resident 7 already had difficulty hearing and [not following the order for ear lavage could] effect Resident 7's quality of life. MDS 1 stated [a resident's] hearing was important and MDS 1 would like to have [Resident 7's hearing] last as long as possible. During an interview on [DATE] at 3:07 PM with the Director of Nursing (DON), the DON stated Resident 7's physician's order for ear lavage was not carried out. The DON stated following physician orders was important to ensure resident's (in general) well-being. The DON also stated the facility did not have a policy specifically addressing following physician orders. During a review of the facility's policy and procedure (P&P) titled Physician Orders, reviewed 3/2026, the P&P's policy indicated drugs and treatments shall be administered only upon the written order by a person duly licensed and authorized to prescribe such drugs and treatments. During a review of the facility's P&P titled Hearing-Impaired Resident, revised 3/2026, the P&P's policy indicated to improve communication with hearing impaired individuals. 2. During a review of Resident 56's FS, the FS indicated the facility admitted Resident 56 on [DATE] with diagnoses including malignant neoplasm of unspecified site of unspecified female breast (breast cancer) and secondary malignant neoplasm of brain (brain cancer). During a review of Resident 56's H&P, dated [DATE], the H&P indicated Resident 56 could make needs known but could not make medical decisions. During a review of Resident 56's Care Plan (CP), initiated [DATE], the CP indicated Resident 59 was at risk for falls related to weakness, impaired mobility, impaired gait (manner of walking), and confusion. The CP indicated Resident 56 had three falls on [DATE]. During a review of Resident 56's Situation, Background, Assessment, Recommendation (SBAR-a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form, dated [DATE], timed at 7:09 PM, the SBAR indicated Resident 56 had an unwitnessed fall. During a concurrent interview and record review on [DATE] at 10:57 AM with the DON, Resident 56's Fall Risk Evaluations dated [DATE], timed at 6:39 AM and timed at 10 AM were reviewed. The DON stated the facility did not complete a fall risk evaluation for Resident 56's unwitnessed fall that occurred in the evening (7:09 PM) of [DATE]. The DON stated it was the policy of the facility to complete a fall risk evaluation after each fall. The DON stated it was important to complete a fall risk evaluation to ensure Resident 56's needs were met and proper interventions were initiated. During a review of the facility's P&P titled, Fall Management System, revised [DATE], the P&P's policy indicated, It is the policy of this facility to provide an environment that remains as free of accident hazards as possible. 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. The P&P's procedure indicated, A fall risk evaluation will be completed post fall incident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 98's admission Record (AR), the AR indicated Resident 98 was admitted to the facility on [DATE] with diagnoses including hemiplegia (form of paralysis that causes total or partial loss of movement on one side of the body affecting the arm, leg, and sometimes the face) and hemiparesis (weakness, reduced muscle strength, or numbness on one side of the body) following cerebral infarction (CVA – stroke, loss of blood flow to a part of the brain) affecting right non-dominant side, dementia (a progressive state of decline in mental abilities) in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic (a mental disorder characterized by a disconnection from reality) disturbance, mood disturbance, and anxiety (intense, excessive, and persistent worry and fear about everyday situations). During a review of Resident 98's MDS, dated [DATE], the MDS indicated Resident 98's cognitive skills (ability to think and process information) for daily decision making were severely impaired. The MDS indicated, Resident 98 was dependent (helper does all of the effort) for activities of daily living (ADLs - activities such as bathing, dressing, toileting and feeding a person performs daily). The MDS indicated Resident 98 had a POLST indicating Do not attempt resuscitation/DNR, that was signed by the physician and resident or legally recognized decisionmaker. During a review of Resident 98's Order Summary Report (OSR), active orders as of [DATE], the OSR indicated, an order, dated [DATE], for DNR/Do Not Attempt Resuscitation. During a review of Resident 98's POLST, dated [DATE], signed by Resident Representative (Resident 98's representative, RR) 3, the POLST indicated a copy of a signed POLST form is a legally valid physician order. The POLST indicated if patient [Resident 98] had no pulse and was not breathing, Do Not Attempt Resuscitation/DNR (Allow Natural Death). During a review of Resident 98's Social Services Assessment/Evaluation (SSA), dated [DATE], timed at 12:17 PM, the SSA indicated Resident 98 and RR 3 chose to convey wishes for advanced care planning using a POLST paradigm document. The SSA indicated a POLST was completed indicating, DNR/Do Not Attempt Resuscitation. During a review of Resident 98's H&P, dated [DATE], the H&P indicated Resident 98 did not have the capacity to understand and make decisions. During a review of Resident 98's CP, initiated [DATE], the CP indicated Resident/resident representative requested a physician order for life sustaining treatment (POLST). The CP indicated request (DNR/Do Not Attempt Resuscitation) would be honored until the next review x (for) ninety (90) days. During a review of Resident 98's Progress Notes (PN), dated [DATE], the PN indicated, at 12:30 AM, Resident 98 was noted pale, staff (unnamed) assessed vitals (measure the basic functions of your body that include your body temperature, blood pressure, pulse and respiratory (breathing) rate), no pulse, no respirations, CPR was initiated, 911 (emergency response system) was called, and RR 3 was notified. The PN indicated, paramedics (highly trained emergency medical professionals who provide advanced life-saving care on the scene and during ambulance transport) were called and Resident 98's time of death at 1:10 AM. During a review of Resident 98's MAR, dated 1/2026, the MAR indicated DNR/Do Not Attempt Resuscitation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on [DATE] at 10:22 AM with Licensed Vocational Nurse (LVN) 6, Resident 98's POLST, dated [DATE], and the PN, dated [DATE], were reviewed. LVN 6 stated a POLST was how the resident [in general] wants their care, and Resident 98's POLST indicated DNR. LVN 6 stated, DNR meant staff [in general] do not perform CPR when a resident went into cardiac arrest (heart stops beating suddenly). LVN 6 stated, staff should check the POLST, should be doing it as soon as you see, a resident becomes nonresponsive. LVN 6 stated CPR should not have been initiated on Resident 98 and staff (unidentified) violated Resident 98's wishes and rights and did not follow the physician's order (for life-sustaining treatment) and possibly caused trauma to Resident 98 when staff provided CPR to Resident 98. During a concurrent interview and record review on [DATE] at 10:40 AM with the DON, Resident 98's POLST, dated [DATE], and PN, dated [DATE], were reviewed. The DON stated Resident 98's POLST indicated DNR and a POLST was a resident or family's wishes and a physician's order for life sustaining treatment. The DON stated, DNR meant when staff found a resident with no pulse, staff were not to provide CPR. The DON stated staff did not follow the physician's order for life-sustaining treatment for Resident 98 when staff performed CPR to Resident 98 on [DATE]. During a review of the facility's P&P titled, Physician Orders, reviewed 3/2026, the P&P indicated, drugs and treatments should be administered only upon written order of a person duly licensed and authorized.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure one of one kitchen (Kitchen 1) had safe and proper storage practices in accordance with professional standards for food service safety and the facility's policy and procedure (P&P) by failing to:1. Discard a gallon of expired ClassicGourmet [brand name] classic Caesar dressing on or before the expiration date that was stored inside Refrigerator # 3.2. Label and date a large clear plastic storage bin that had ready to eat corn flakes with raisins inside and supplied from the manufacturer's original bulk container.3. Properly store two (2) rectangular pans of facility baked yellow cake left out for cooling.These deficient practices could result in food borne illness (illness caused by the ingestion of contaminated food or beverage) and serious health complications to the residents consuming the foods and/or affect the quality and palatability of the food items. Findings:During a concurrent observation and interview on 3/24/2026 at 8:25 AM with the Dietary Supervisor (DS) during the initial tour of Kitchen 1, a gallon of expired ClassicGourmet classic Caesar dressing with half contents with a manufacturer's date of Best By: 01 02 26 was inside Refrigerator # 3. The DS stated the facility should have checked (date) and should not have accepted the dressing from the vendor. The DS stated, checking the expiration date of the dressing was important since an expired dressing, will not be good to the residents, who could maybe get stomachache, diarrhea, cramps, throw-up.During a concurrent observation and interview on 3/24/2026 at 8:49 AM with the DS inside the dry goods storage room of Kitchen 1, there was an unlabeled, undated 16-gallon (a unit of volume) clear plastic storage bin with one fourth (1/4) contents of ready to eat corn flakes with raisins on the multiple open shelving racks for dry goods. Additionally, there were 2 uncovered half sheet (18 inches x 13 inches) rectangular pans of facility baked yellow cake stored on top of a clear plastic storage bin of beans. The DS stated, the cornflakes were from the original container (manufacturer's bulk bag) and should have been labeled with open date and a use by date immediately so the facility knew when to use the corn flakes because we could be using expired, old products. The DS stated the baked yellow cakes were not covered because the yellow cakes were being cooled off.During an interview on 3/27/2026 at 1 PM with the DS, the DS stated, [the facility] did not have a designated area in Kitchen 1 for cooling facility baked goods and it was important to properly store and cool baked goods to prevent burns to staff.During an interview on 3/27/2026 at 3:18 PM with the Registered Dietician (RD), the RD stated the facility baked yellow cakes could have been stored inside the dry goods storage room but had to be stored in a cart and not on top of the plastic bin of beans in the open shelving rack. The DS stated, storing the baked yellow cakes properly was important so the cakes would not be exposed to physical contamination like dust, droppings.During a review of the facility's undated P&P titled, Labeling and Dating of Foods, the P&P indicated, all food items in the storeroom, refrigerator, and freezer need to be labeled and dated based on established procedures for either food safety or product rotation (FIFO - First In - First Out). The P&P indicated, the individual opening or preparing a food should be responsible for date marking at the time of processing and/or storage.During a review of the facility's undated P&P titled, Dry Goods Storage Guidelines, the P&P indicated, the storage length was to be followed unless you [facility] had manufacturer's recommendations indicating otherwise. The P&P indicated, opened, refrigerated salad dressing had one (1) month of storage and opened cereals, ready to eat had two (2) months of storage.During a review of the facility's P&P titled, Foods Brought by Family or Visitor, reviewed date 3/2026, the P&P indicated, foods to be served via the kitchen would be handled according to food and nutrition professional food safety standards.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. Based on interview and record review, the facility failed to provide specialized rehabilitative services (therapy services that help a resident improve or regain physical, mental, or functional abilities) for one of one sampled resident (Resident 56) when:1. Resident 56's physical therapy (PT-a treatment focused on improving or restoring physical movement and function) evaluation was not completed.2. Resident 56's occupational therapy (OT-a treatment focused on improving the performance of activities required in daily life) evaluation was not completed.This failure had the potential to result in Resident 56's rehabilitative needs not being addressed, leading to a significant physical decline posing a serious risk to the resident's overall health and safety.Findings:During a review of Resident 56's Face Sheet (admission record, FS), the FS indicated the facility admitted Resident 56 on 3/12/2026 with diagnoses including malignant neoplasm of unspecified site of unspecified female breast (breast cancer) and secondary malignant neoplasm of brain (brain cancer).During a review of Resident 56's History and Physical (H&P), dated 3/15/2026, the H&P indicated Resident 56 could make needs known but could not make medical decisions.During a review of Resident 56's Order Summary Report (OSR), dated 3/12/2026, the OSR indicated Resident 56 had the following physician orders:OT to evaluate and treatment as indicated, ordered 3/12/2026.PT to evaluate and treatment as indicated, ordered 3/12/2026.During an interview on 3/27/2026 at 10:34 AM with Resident Representative (RR) 1, RR 1 stated RR 1 was concerned because Resident 56 did not receive PT while at the facility.During a concurrent record review and interview on 3/27/2026 at 2:18 PM with the Director of Rehabilitation (DOR) services, Resident 56's Net Health electronic medical record (a healthcare software technology specializing in rehabilitation therapy) was reviewed. The DOR stated Resident 56 had an order for PT and OT evaluation but there was no documentation in Resident 56's Net Health record indicating the evaluations were completed. The DOR stated if PT and OT evaluations were not documented it meant they were not done. The DOR emphasized that completing PT and OT evaluations for Residentˆ56 was essential to support Residentˆ56's return to prior functional capacity.During a review of the facility's Policy and Procedure (P&P) titled, Rehabilitation Policy & Procedures - Evaluation & Plan of Care, revised 8/1/2019, the P&P's purpose indicated, Therapy services must be directly and specifically related to an active written treatment plan that is based upon an initial evaluation performed by a clinician. The P&P's policy indicated, for each new patient admitted to therapy services, the evaluating clinician will establish a Plan of Care (POC) upon completion of the evaluation process. The evaluation process should be initiated within 72 hours of the date of the physician's order.

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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** Based on observation, interview, and record review, the facility failed to implement infection prevention and control practices by failing to ensure four of four sampled residents' (Resident 72, 80, 16 and 70) personal care item was labeled and stored properly.This deficient practice had the potential to result in cross contamination (the process by which microorganisms are unintentionally transferred from one area/object to another with a harmful effect) and/or the development and transmission of disease (an illness or sickness) and infections for Resident 72, 80, 16 and 70).Findings:During a review of Resident 72's Face Sheet (FS - admission record), the FS indicated Resident 72 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including cerebral infarction (CVA - stroke, loss of blood flow to a part of the brain), unspecified, and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction.During a review of Resident 72's History and Physical Examination (H&P), dated 7/26/2025, the H&P indicated Resident 72 could make needs known but could not make medical decisions.During a review of Resident 72's Minimum Data Set (MDS - a resident assessment tool), dated 1/28/2026, the MDS indicated Resident 72's cognitive skills (ability to think and process information) for daily decision making were moderately impaired (decisions poor; cues/supervision required). The MDS indicated Resident 72 required substantial/maximal assistance (helper does more than half the effort) to supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with toileting hygiene, shower/bathe, and personal hygiene.During a review of Resident 80's FS, the FS indicated Resident 80 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including cerebral infarction, unspecified, and hemiplegia and hemiparesis following cerebral infarction affecting the right non-dominant side.During a review of Resident 80's H&P, dated 2/11/2026, the H&P indicated Resident 80 had the capacity to understand and make decisions.During a review of Resident 80's MDS, dated [DATE], the MDS indicated Resident 80's cognitive skills for daily decision making were moderately impaired.During a review of Resident 16's FS, the FS indicated Resident 16 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, and cerebral infarction, unspecified.During a review of Resident 16's H&P, dated 10/23/2025, the H&P indicated Resident 16 did not have the capacity to understand and make decisions.During a review of Resident 16's MDS, dated [DATE], the MDS indicated Resident 16's cognitive skills for daily decision making were intact (decisions consistent/reasonable). The MDS indicated Resident 16 was dependent (helper does all of the effort) and required substantial/maximal activity with toileting hygiene, shower/bathe, and personal hygiene.During a review of Resident 70's FS, the FS indicated Resident 70 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), unspecified, and anemia (a condition where the body does not have enough healthy red blood cells), unspecified.During a review of Resident 70's H&P, dated 7/12/2025, the H&P indicated Resident 70 had the capacity to understand and make decisions.During a review of Resident 70's MDS, dated [DATE], the MDS indicated Resident 70's cognitive skills were intact. During an observation on 3/24/2026 at 9:42 AM, Resident 72, 80, 16 and 70's shared room had an Enhanced Barrier Precaution (EBP - an infection control intervention designed to reduce transmission of multidrug resistant organisms (MDROs) in nursing homes) signage posted by the room door and there was a black colored trimmed 3-drawer personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) cart outside of the room.During a concurrent observation and interview on 3/24/2026 at 9:58 AM with (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Certified Nursing Assistant (CNA) 3 inside Resident 72, 80, 16, and 70's shared restroom there was an unlabeled eight (8) fluid oz (ounce - a unit of weight and volume) Essentials Cleanse Shampoo & Body Wash stored on the sink. CNA 3 stated, the shampoo & body wash was a cleanser and should have been labeled with a resident's (in general) name and kept at the resident's bedside so staff (in general) knew, who it belongs to and any patient could just use it, to prevent cross contamination, and for infection control.During an interview on 3/26/2026 at 7:40 AM with Infection Preventionist (IP) 1, IP 1 stated, Resident 72, 80, 16, and 70's shared room was on EBP, and the room had one (1) restroom. IP 1 stated, leaving the unlabeled body wash and shampoo in the restroom could result in cross contamination, we have 4 residents sharing the restroom. The IP stated, resident's personal care items should be labeled with the resident's name and left at the resident's drawer or closet to prevent other residents from using the item, for protection, and infection control.During a review of the facility's policy and procedure (P&P) titled, Personal Care Items, reviewed 3/2026, the P&P indicated, it was the facility's policy to ensure proper hygiene, safety, and accountability regarding personal care items provided to or brought in by individuals. The P&P indicated, items must be stored in designated personal storage areas and must be labeled with residents' name.During a review of the facility's P&P titled, IPCP Standard and Transmission-Based Precautions, revision/review date 3/2026, the P&P indicated, it was the facility's policy to implement infection control measures to prevent the spread of communicable diseases and conditions.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to notify the ombudsman (an advocate for residents of nursing home, board and care centers, and assisted living facilities) of one of one sampled resident's (Resident 9) transfer to an acute hospital (GACH).This deficient practice had the potential to result in the ombudsman not being able to advocate for Resident 9 and could potentially lead to illegal or inappropriate discharge (resident dumping) or loss of bed-hold (keeping a resident's bed available while the resident is temporarily absent/hospitalized) rights for Resident 9. Findings:During a review of Resident 9's Face Sheet (admission record, FS), the FS indicated the facility admitted Resident 9 on 8/20/2024, with diagnoses that included chronic obstructive pulmonary disease (COPD - type of obstructive lung disease characterized by long-term poor airflow) and generalized weakness.During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool), dated 2/23/2026, the MDS indicated Resident 9 had intact cognition (ability to think and make decisions) and Resident 9 was independent with bed mobility (rolling left and right, sit to lying, lying to sitting, sit to stand).During a review of Resident 9's Physician's Order (PO), dated 3/11/2026, the PO indicated Resident 9 was transferred to the GACH due to possible stroke (medical emergency occurring when blood flow to part of the brain is interrupted or a blood vessel burst causing brain cells to die from lack of oxygen) or sepsis (a life-threatening blood infection).During an interview on 3/27/2026 at 10:33 AM with the Social Services Director (SSD), the SSD stated Resident 9 was transferred from the physician's office to the GACH, the SSD stated the facility needed to notify the Ombudsman of the transfer because Resident 9 was a resident at the facility. The SSD stated the importance of notifying the Ombudsman of [resident] transfers was for the safety of the resident.During a review of the facility's policy and procedure(P&P) titled Discharge Planning Process dated 3/2026, the P&P did not indicate the process for ombudsman notification for resident transfer to the GACH.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately assess one of three sampled residents (Resident 7's) hearing. Resident 7's Minimum Data Sheet (MDS, a resident assessment and care-screening tool) indicated minimal difficulty, when it was observed Resident 7 had moderate difficulty in hearing.This deficient practice had the potential to result in Resident 7 not receiving appropriate care or treatment services to effectively communicate with others.Cross reference with F656Findings:During a review of Resident 7's Face Sheet (admission record, FS), the FS indicated Resident 7 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation (irregular heartbeats), dysphagia (difficulty swallowing), and generalized muscle weakness.During a review of Resident 7's History and Physical (H&P), dated 3/18/2025, the H&P indicated Resident 7 had the capacity to understand and make decisions.During a review of Resident 7's MDS, dated [DATE], the MDS indicated Resident 7's cognitive (the ability to think and process information) was intact and required moderate assistance (helper does less than half the effort) with toilet hygiene, upper body dressing, chair to bed and toilet transfers. The MDS's section B: Hearing, Speech and Vision indicated Resident 7 had the ability to hear with minimal difficulty (difficulty in some environments e.g., when people speak softly or setting is noisy).During an observation and concurrent bedside interview with Resident 7 on 3/26/2026 at 10:30 AM, with the MDS Coordinator (MDS) 1, Resident 7 gestured for the surveyor to come closer to Resident 7's bedside, and stated, Speak louder and put your mask down so I can hear you. I have had trouble hearing from before I got here [the facility]. They [facility] were putting drops in my ear for five days and were supposed to flush [to clean the ear canal by removing excess wax with a gentle stream of warm water] my ear out, but that never happened.During an interview on 3/27/2026 at 3:09 PM with the Director of Nursing (DON), the DON stated accuracy of resident assessment was important to make sure we [the facility] took care of residents appropriately.During an interview and concurrent record review on 3/26/2026 at 10:52 AM, with MDS 1, Resident 7's MDS dated [DATE] was reviewed with MDS 1, MDS 1 stated Resident 7's ability to hear should reflect Resident 7's moderate difficulty (speaker has to increase volume and speak distinctly) in hearing. MDS 1 stated Resident 7's MDS assessment should be accurate. MDS 1 stated Resident 7 could not hear us and the facility risked missing important information provided to the resident or missing information provided from the resident to us (the facility).During a review of the facility's policy and procedure (P&P) titled, Resident Assessment and Associated Processes, revised 3/2026, the P&P indicated it is the policy of the facility that residents will be assessed. The P&P indicated the assessment will be comprehensive, accurate and will be conducted initially and periodically as [NAME] of an ongoing process through which each resident's preferences and goals of care, functional and health status, and strengths and needs will be identified.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop an individualized person-centered care plan (CP) for one of one sampled resident (Resident 7) that addressed Resident 7's moderate difficulty (speaker has to increase volume and speak distinctly) hearing.This failure had the potential to result in unmet individual needs for Resident 7 and the potential to affect Resident 7's physical and psychosocial well-being.Cross reference with F636Findings:During a review of Resident 7's Face Sheet (admission record, FS), the FS indicated Resident 7 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation (irregular heartbeats), dysphagia (difficulty swallowing), and generalized muscle weakness.During a review of Resident 7's History and Physical (H&P), dated 3/18/2025, the H&P indicated Resident 7 had the capacity to understand and make decisions.During a review of Resident 7's MDS, dated [DATE], the MDS indicated Resident 7's cognitive (the ability to think and process information) was intact and required moderate assistance (helper does less than half the effort) with toilet hygiene, upper body dressing, chair to bed and toilet transfers. The MDS's section B: Hearing, Speech and Vision indicated Resident 7 had the ability to hear with minimal difficulty (difficulty in some environments e.g., when people speak softly or setting is noisy).During an observation and concurrent bedside interview, at Resident 7's bedside, on 3/26/2026 at 10:30 AM, with MDS Coordinator (MDS) 1, Resident 7 gestured for the surveyor to come closer and stated, Speak louder and put your mask down so I can hear you. I have had trouble hearing from before I got here [to the facility].During an interview and concurrent record review on 3/26/2026 at 10:52 AM, with MDS 1, MDS 1 stated Resident 7 did not have a CP that addressed Resident 7's hearing [difficulty]. MDS 1 stated [creating] CPs was important to provide appropriate care to the residents (in general).During an interview on 3/27/2026 at 3:11 PM with the Director of Nursing (DON), the DON stated CPs were important because they provided plan of care direction and helped ensuring resident (in general) care was appropriate.During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, revised 3/2026, the P&P indicated it is the policy of the facility that the interdisciplinary team (IDT) develops a comprehensive person-centered CP for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The P&P indicated the facility IDT will develop and implement a comprehensive person-centered, culturally competent CP for each resident within 7 days of completion of the resident MDS and will include resident's needs identified in the comprehensive assessment, the resident's goals and desired outcomes.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure a licensed nursing staff informed one of four sampled residents (Resident 79) of the type of medication being administered during medication administration on 3/26/2026 and as indicated in the facility's Policy and Procedure (P&P), titled Med Pass. This deficient practice had the potential to result in medication errors due to Resident 79 not being encouraged to participate during Resident 79's medication administration. Findings:During a review of Resident 79's Face Sheet (admission record, FS), the FS indicated the facility admitted Resident 79 on 3/20/2024 with diagnoses that included type 2 diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine), parkinsonism (disease that affects the nerve cells in the brain that produces symptoms that include muscle rigidity, tremors, and changes in speech and gait).During a review of Resident 79's History and Physical (H&P), the H&P indicated Resident 79 had the capacity to understand and make decisions.During an observation on 3/26/2026 at 8:29 AM, Licensed Vocational Nurse (LVN) 1 prepared Resident 79's 9 AM scheduled oral (by mouth) medications. LVN 1 placed seven (7) oral medications into a small clear cup and brought the cup with medications to Resident 79's room. LVN 1 informed Resident 79 LVN 1 would administer 9 AM medications, LVN 1 did not inform Resident 79 the types of medications being administered.During an interview on 3/26/2026 at 2:50 PM, LVN 1 stated residents (in general) needed to be informed of the types of medications residents were administered.During an interview on 3/27/2026 at 3:09 PM with the Director of Nursing (DON), the DON stated it was standard nursing practice to inform residents what [type of] medications were administered because it was a patient's right to know. The DON stated if a resident was alert, awake, and oriented, the resident could notify the nurse if there was an error with the medications being administered.During a review of the facility's undated P&P, titled Med Pass, the P&P's policy indicated medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. The P&P's procedure indicated to explain to the residents the type of medication being administered.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 95), who spoke a dialect from China, was provided a communication tool or resources to effectively ensure Resident 95 communicated Resident 95's needs.This deficient practice had the potential to result in Resident 95's care needs not effectively conveyed to the facility staff, which could lead to a decline in the resident's physical and psychosocial well-being.Findings:During a review of a Face Sheet (admission record, FS), the FS indicated Resident 95 was re-admitted to the facility on [DATE] with diagnosis that included traumatic subdural hemorrhage (dangerous collection of blood between the brain surface and its outer covering, caused when tiny bridging veins tear, usually due to head trauma), and abnormalities of gait (manner of walking) and mobility (ability to actively move joints through their full range of motion).During a review of Resident 95's history and physical (H&P), dated 2/20/2026, the H&P indicated Resident 95 was alert and oriented to person only.During a review of Resident 95's Social Services Assessment (SSA), dated 3/5/2026, the SSA indicated Resident 95's primary language was Mandarin and Resident 95 was a Mandarin speaker.During a review of Resident 95's Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 3/7/2026, the MDS indicated the resident's preferred and primary language was Mandarin (a Chinese dialect) and Resident 95 had adequate (no difficulty) hearing. The MDS indicated Resident 95 needed maximal assistance (helper does more than half the effort) with oral and toilet hygiene, sit to stand and chair to bed transfers.During an observation and an attempted interview with Resident 9, in Resident 9's room, on 3/24/2026 at 12:19 AM, Resident 95 smiled, nodded head, and did not respond to questions when asked in English.During a telephone interview with Resident 95's Family Member (FM) 1 and FM 2 on 3/24/2026 at 12:19 PM, FM 1 stated Resident 95 communicated in Mandarin. FM 2 stated Resident 95 did not speak English.During an observation with Licensed Vocational Nurse (LVN) 5 on 3/24/2026 at 12:29 PM, LVN 5 performed blood sugar checking for Resident 95 and administered insulin (a medication used to control sugar in the blood). LVN 5 did not speak Mandarin and communicated with Resident 95 through gestures. LVN 5 did not attempt to use a communication tool.During an interview with LVN 5 on 3/24/2026 at 12:29 PM, LVN 5 stated Resident 95 only spoke Chinese (Mandarin). LVN 5 stated a communication board should have been used to communicate thoroughly with Resident 95. LVN 5 stated communication boards were important so we can all be on the same page and [be able to] inform Resident 95 of the treatments we are giving the resident.During an interview with the Director of Nursing (DON) on 3/27/2026 at 3:06 PM, the DON stated communication tools were important to properly communicate with the residents (in general) and ensure their needs were met.During a review of the facility's policy and procedure (P&P) titled Quality of Life-Non-English & Aphasic Residents, Communication for, dated 3/2026, the P&P indicated it is the policy of this facility that all residents who are cognitively intact will be able to communicate their needs to facility staff, other residents, and other persons as desired by the resident. The P&P indicated the facility will also provide interpreter services for non-English speaking residents. The P&P indicated social services determines the language or tool needed for interpreter services and will supply residents and/or family members with the use of a communication board that has universally known drawings, whenever desired. The P&P indicated all attempts will be made to write in the resident's native tongue, the name of each pictured item, using available staff, family members, and community resources as appropriate.During a review of the facility's policy P&P titled Accommodation of Needs, reviewed 3/2026, the P&P indicated it was the policy of the facility to provide accommodation of reasonable needs to the resident while in the facility.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 42), who was unable to carry out activities of daily living (ADL - routine tasks activities such as bathing, dressing, and toileting, a person performs daily to care for themselves) was properly groomed.This deficient practice had the potential to impact Resident 42's overall health and could affect Resident 42's psychosocial well-being.Findings:During a review of Resident 42's Face Sheet (admission record, FS), the FS indicated Resident 42 was admitted to the facility on [DATE] with diagnoses that included heart failure, essential hypertension (high blood pressure), and abnormalities of gait (manner of walking).During a review of Resident 42's Care Plan (CP), initiated 3/8/2026, the CP's focus indicated Resident 42 had an ADL self-care performance deficit. The CP's interventions indicated Resident 42's personal hygiene routine included: preferred to being shaved, and getting hands washed.During a review of Resident 42's Minimum Data Set (MDS - a resident assessment tool), dated 3/13/2026, the MDS indicated Resident 42's cognitive skills (ability to think and process information) for daily decision making were moderately impaired. The MDS indicated Resident 42 needed moderate (helper does less than half the effort) to maximal assistance (helper does more than half the effort) with ADLs.During a review of Resident 42's History and Physical Examination (H&P), dated 3/17/2026, the H&P indicated Resident 42 could make needs know but could not make medical decisions.During an observation and concurrent interview on 3/24/2026 at 10:05 AM with Resident 42, at Resident 42's bedside, Resident 42 had unshaven facial hair, all fingernails were long and had dark brown blacking paste under them.During an observation and concurrent interview, at Resident 42's bedside on 3/24/2026 at 10:12 AM with Licensed Vocational Nurse (LVN) 6 and Resident 42. Resident 42 stated, I often ask to be shaved, but it is not always done. I don't like having a beard. Resident 42 stated look at my nails, they are so long. no one cuts them. Look at my arms and forehead, there are scratch marks from my nails. LVN 6 stated [Resident 42's fingernails] are not clean. LVN 6 stated Resident 42's hair and beard needed to be shaved. LVN 6 stated the resident's fingernails were long and had dirt underneath them. LVN 6 stated having long fingernails was not acceptable because [long nails] could result in scratches to Resident 42 and could lead to cuts and an infection.During an interview with the Director of Nursing (DON) on 3/27/2026 at 3:07 PM, the DON stated ADL's were important to ensure residents (in general) remained clean and with good hygiene. The DON stated long fingernails were not acceptable because it was a sign of poor hygiene and could lead to infections.During a review of the facility's policy and procedure (P&P) titled ADL, reviewed 3/2026, the P&P indicated it was the policy of the facility that residents were given the appropriate treatment and services to maintain or improve his/her abilities. The P&P's procedures indicated residents who are unable to carry out ADLs will receive necessary services to maintain: grooming, personal hygiene, and oral hygiene.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure a low air loss (LAL, mattress that operates using a blower-based pump that was designed to circulate a constant flow of air) mattress was set at intermittent pressure mode (alternating pressure, continuous, automatic inflation and deflation of air cells in a cyclical pattern) for one of four sampled residents (Resident 43).This deficient practice had the potential for Resident 43 to develop new pressure injuries (PI, lesion/wound caused by unrelieved pressure usually over a bony prominence that results in damage of underlying tissue) or delayed healing to Resident 43's existing PI.Findings:During a review of Resident 43's Face Sheet (admission record, FS), the FS indicated the facility admitted Resident 43 on 3/2/2026 with diagnoses that included unstageable PI (pressure ulcer with slough [yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture] or eschar [dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like] on the wound bed) of the sacral region (bone at the base of the spine) and generalized muscle weakness.During a review of Resident 43's Braden Scale (a tool for predicting PI risk evaluation), dated 3/2/2026, the BS indicated a score of 15 indicating a mild risk for the development of PIs.During a review of Resident 43's History and Physical (H&P), dated 3/3/2026, the H&P indicated Resident 43 had unstageable PI on the right sacrum measuring 4.5 centimeters (cm unit of measurement) in length by 5 cm in width.During a review of Resident 43's Minimum Data Set (MDS - a standardized resident assessment tool), dated 3/6/2026, the MDS indicated Resident 43 had intact cognitive (the ability to think and process information) and required maximal assistance with all bed mobility. During a review of Resident 43's Order Recap Report (ORR), dated 3/1/2026 to 3/31/2026, the ORR included a physician's order, dated 3/9/2026, indicating a LAL mattress for wound healing every shift, setting by weight or comfort for unstageable PI for Resident 43.During an interview on 3/24/2026 at 10:47 AM, Resident 43 stated Resident 43 had a PI.During an observation on 3/26/2026 at 3:40 PM, Resident 43's LAL mattress was set on static mode (holds all air cells at the same inflation level, providing a stable, firm, and evenly distributed support surface for the resident).During a concurrent record review and interview on 3/27/2026 at 10:37 AM, with Registered Nurse (RN) 2, Resident 43's ORR, dated 3/1/2026 to 3/31/2026, was reviewed. The OSR indicated a LAL mattress was ordered for Resident 43 based on weight or comfort. RN 2 stated the mattress setting was set based on Resident 43's weight or based on Resident 43's comfort.During a concurrent observation and interview on 3/27/2026 at 10:40 AM, Resident 43's LAL was set on static mode. RN 2 stated LAL mattresses were ordered for residents (in general) who had PIs. RN 2 stated Resident 43's LAL mattress setting needed to be set to intermittent pressure and not set on static mode to promote healing of Resident 43's PI. RN 2 stated static mode on the LAL mattress was only used during position changes or when providing care such as diaper changes or baths because static mode kept the pressure on the mattress firm.During an interview on 3/27/2026 at 3:17 PM with the Director of Nursing (DON), the DON stated Resident 43's LAL mattress needed to be set on alternating pressure and not on static mode to promote healing of Resident 43's PI.During a review of the undated Alternating Pressure with LAL Manufacturer's Manual (MM), the MM indicated there were 4 therapy settings for the LAL mattress: autofirm, alternating, static, and seat function. The MM indicated alternating function was for normal alternating function and static function does not alternate and keeps the mattress firm and always inflated.During a review of the facility's Policy and Procedure (P&P) titled Skin and Wound Monitoring Management revised 3/2026, the P&P's policy indicated a resident having PIs receives necessary treatment and services to promote healing. The P&P's purpose indicated for the facility to provide care and services to promote the healing of PIs that are present (including prevention of infection to the extent possible); and to prevent the development of additional, avoidable PI. The P&P indicated to use pressure relieving/reducing and redistributing devices (including but not limited to low air loss mattresses, wedges, pillows, etc).

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	03/27/2026

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 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** Based on observation, interview, and record review, the facility failed to supervise two of two sampled residents (Resident 82 and Resident 106) while smoking in the patio's designated smoking area.This failure had the potential to result in injury, accidental burns, and fire hazards to the resident.Findings:During a review of Resident 82's Face Sheet (FS), the FS indicated Resident 82 was admitted to the facility on [DATE] with diagnoses including but not limited to effusion of right knee (abnormal fluid in the knee), muscle weakness, and schizoaffective bipolar disorder (a mental illness that can affect thoughts, mood, and behavior).During a review of Resident 82's History and Physical (H&P), dated 3/14/2026, the H&P indicated Resident 82 had the capacity to understand and make decisions.During a review of Resident 82's Minimum Data Set (MDS - a resident assessment tool), dated 3/12/2026, the MDS indicated Resident 82 smoked one to two times a day.During a review of Resident 82's Care Plan (CP), dated 3/12/2026, the CP indicated Resident 82 had potential risk of injury related to smoking. The CP did not indicate whether or not Resident 82 required supervision while smoking.During a review of Resident 106's Face Sheet (FS), the FS indicated Resident 106 was admitted to the facility on [DATE] with diagnoses including but not limited to acute pancreatitis (an inflammation of the pancreas), muscle weakness, difficulty walking, and nicotine dependence (a chronic need to use tobacco).During a review of Resident 106's History and Physical (H&P), dated 3/22/2026, the H&P indicated Resident 106 had the capacity to understand and make decisions.During a review of Resident 106's MDS dated [DATE], the MDS indicated Resident 106 smoked four to six times a day.During a review of Resident 106's Care Plan (CP), dated 3/21/2026 and 3/27/2026, the CP indicated Resident 106 had potential risk of injury related to smoking, risk for impaired cognitive function or impaired thought processes, required assistance with ambulation and mobility, and potential for behavioral problems related to psychosis. The CP did not indicate whether or not Resident 106 require supervision while smoking.During an observation on 3/27/2026 at 8:39 AM in the facility's patio smoking area, Resident 82 was smoking unsupervised.During an interview on 3/27/2026 at 9:03 AM with Human Resources Manager (HRM), HRM stated the smoking supplies are held in the HR office during day shift and then handed over to the evening and night shift Charge Nurse. HRM stated HRM supervises residents who smoke, but if MDS smoking assessment indicates a resident is awake, alert, and oriented to smoke independently, sometimes, the resident is left unsupervised to finish smoking. HRM stated the Activities Director (AD) has an open view of the patio from the activity room and the AD can also supervise residents who are in the patio's smoking area.During an observation on 3/27/2026 at 1:16 PM in the facility's patio smoking area, Resident 82 and Resident 106 were smoking unsupervised.During a concurrent interview and record review on 3/27/2026 at 1:18 PM with Infection Preventionist Nurse (IPN), the facility's policy and procedure (P&P) titled, Smoking Policy, revised July 2025 was reviewed. The P&P indicated the facility has designated smoking areas and a smoking schedule with assigned staff to supervise. The IPN nurse stated the residents should not be left unsupervised while they are smoking because it could be dangerous.During a concurrent observation and interview on 3/27/2026 at 1:20 PM with Director of Nursing (DON) in the facility's patio smoking area, Resident 82 and Resident 106 were smoking unsupervised. DON stated the P&P indicated smoking should be supervised with a staff member present in the smoking area. DON stated the residents should not have been left unsupervised because the residents could burn or hurt themselves.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure call lights (a device used by a resident to signal the need for assistance) were within reach for two of two sampled residents (Resident 10 and Resident 41).This deficient practice had the potential to result in unmet needs for Resident 10 and Resident 41 due to the residents being unable to call for assistance from staff or alert staff during an emergency.Findings: a. During a review of Resident 10's Face Sheet (admission record, FS), the FS indicated the facility admitted Resident 10 on 9/10/2024 with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning) and metabolic encephalopathy (disease that affects the function or structure of the brain). During a review of Resident 10's Minimum Data Set (MDS – a standardized resident assessment tool), dated 3/3/2026, the MDS indicated Resident10's cognitive (the ability to think and process information) skills for daily decision making were moderately impaired. The MDS indicated Resident 10 had impairment on one upper extremity (arm). During a concurrent observation and interview on 3/24/2026 at 9:55 AM with Registered Nurse (RN) 2, Resident 10 was lying in bed and facing the left side. There was a touchpad call light located on Resident 10's right side near the resident's right ear. Resident 10's right hand was contracted (a permanent tightening and shortening of muscles, tendons, skin, or nearby soft tissues that causes joints to become rigid and stiff, severely restricting normal movement) and turned inward toward the wrist. Resident 10 was saying oh my God, the bottom of my feet hurt. RN 2 stated it would be hard for Resident 10 to find the call light since it was placed behind Resident 10. RN 2 stated the call light needed to be placed close to Resident 10's left hand because Resident 10 was able to use the left hand and able to ask for assistance [from staff]. b. During a review of an admission Record (AR), the AR indicated Resident 41 was re-admitted to the facility on [DATE] with diagnosis that included hemiplegia and hemiparesis (complete loss of muscle function on one side of the body) following cerebral infraction (a condition that cuts of oxygen to the brain) affecting the right side, and need for assistance with personal care. During a review of a Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 1/22/2026, indicated Resident 41 was cognitively intact and was dependent (helper does all effort) with bed mobility (moves to and from lying position, turns side-to-side and body position). The MDS indicated Resident 41 was fully dependent (full staff performance) with transfers (how resident moves to and from bed, chair, wheelchair) and toilet use. During a concurrent observation and interview on 3/24/2026 at 11:12 AM with Resident 41, at Resident 41's bedside, Resident 41 was lying in bed, a touch-pad call light (a specialized, highly sensitive patient safety device designed to help, individuals with limited mobility, call for assistance) was observed close to Resident 41's right shoulder. Resident 41 stated can you please call the nurse; I cannot reach the call light. I can't use my right arm. I can't even go across my body with my left arm. How am I supposed to reach that [call light]? During a concurrent observation and interview with Licensed Vocational Nurse 1 (LVN 1), on (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/24/2026 at 11:22 AM, at Resident 41's bedside, LVN 1 stated Resident 41 can minimally move his left arm but cannot grab a call light. LVN 1 stated the resident's touch pad call light was located on the right side of Resident 41's body and Resident 41 could not reach it. LVN 1 stated it was important for the call light to be within reach so the residents could ask for assistance [from staff]. During an interview with the Director of Nursing (DON) on 3/27/2026 at 3:04 PM, the DON stated call lights should be within reach for the residents (in general) to communicate their needs to staff. During a review of the facility's policy and procedure (P&P) titled Call Light, reviewed 3/2026, the P&P's policy indicated to provide the resident a means of communication with nursing staff. The P&P's procedure indicated to listen to the resident's request/need, leave the resident comfortable and place the call device within the resident's reach before leaving the room. The P&P indicated to provide a touchpad call light for residents with limited mobility of fingers but functional upper extremities.