STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555416	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendora Canyon Transitional Care Unit	401 W. Ada Ave. Glendora, CA 91741

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 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** 46687 Based on observation, interview, and record review, the facility failed to follow its policy and procedure (P&P) titled, Fingernails/Toenails, Care of, for one of nine sampled residents (Resident 4) and failed to follow Resident 4's untitled care plan by failing to: Ensure assigned Licensed Vocational Nurses (LVNs) notified the Social Services Director (SSD) that Resident 4 needed to be referred and seen by a podiatrist (medical doctor who help with problems that effect the lower legs and feet) for cleaning and trimming of Resident 4's long and overgrown toenails. This failure had the potential to cause injuries and infection to Resident 4. Findings: During a review of Resident 4's Admission Record (AR), the AR indicated, Resident 4 was admitted to the facility on [DATE], with diagnoses that included gout (occurs when urate crystals [high levels of uric acid- waste product created when the body breaks down chemicals- in the blood] accumulate in the joints causing inflammation and intense pain), infection of amputation (removal of body part) stump (remaining healthy part of limb) of right lower extremity (right lower leg), and peripheral vascular disease (PVD- a systemic disorder that involves the narrowing of peripheral blood vessels). During a review of Resident 4's Minimum Data Set (MDS- a standardized resident assessment and care screening tool) dated 6/20/2024, the MDS indicated, Resident 4 was dependent (helper did all the effort or the assistance of 2 or more helpers was required for the resident to complete the activity) with toileting hygiene, showering/bathing self, lower body dressing, and putting on/taking off footwear. The MDS indicated, Resident 4 required substantial/maximal assistance (helper did more than half the effort, helper lifted or held trunk or limbs and provided more than half effort) with rolling left to right (in bed), sitting to lying, lying to sitting on side of bed, sitting to standing, chair/bed-to-chair transfers, and toileting transfers. The MDS indicated Resident 4 required partial/moderate assistance (helper did less than half the effort and lifted or held trunk or limbs but provided less than half the effort) with upper body dressing. The MDS indicated, Resident 4 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completed the activity and may be provided throughout the activity or intermittently) with eating and oral hygiene. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 4's untitled care plan (CP) initiated 6/16/2024, the CP indicated, Resident 4 had diabetes mellitus (DM- a condition that happens when the blood sugar [glucose] is too high). The CP indicated, Resident 4 would have no complications related to DM through the review date of 9/15/2024. The CP interventions indicated for staff to inspect Resident 4's feet daily for open areas, sores, pressure areas, blisters, edema (swelling), or redness, and to refer Resident 4 to podiatrist/foot care nurse to monitor and document foot care needs and to cut long (toe) nails. During a concurrent observation and interview on 8/16/2024 at 12:05 pm with Resident 4, Resident 4's left toenails were observed. Resident 4's left toenails were long, overgrown, and were yellow in color. Resident 4 stated Resident 4 did not know when Resident 4's toenails were last trimmed. Resident 4 stated Resident 4 did not like her toenails long because Resident 4 was worried Resident 4 would develop an infection in her left foot like what happened to Resident 4's right foot. During a concurrent observation and interview on 8/16/2024 at 12:14 pm with LVN 7, Resident 4's left toenails were observed. LVN 7 stated Resident 4's left toenails were long and overgrown. LVN 7 stated Resident 4's toenails needed to be kept clean and trimmed to prevent wounds and infections. LVN 7 stated LVN 7 would inform the SSD to schedule an appointment with the podiatrist to trim Resident 4's left toenails. During an interview on 8/20/2024 at 3:33 pm with the Director of Nursing (DON), the DON stated toenails needed to be kept clean and trimmed so residents (in general) were protected from infection and injury. The DON stated Certified Nurse Assistants (CNAs) needed to inspect residents' toenails and inform the LVN and SSD when a resident's toenails needed to be trimmed. The DON stated the podiatrist came every two months and as needed. During a review of the facility's P&P titled, Fingernails/Toenails, Care of, revised 2/2018, the P&P indicated, the purpose of the procedure was to clean the nail bed, keep nails trimmed, and to prevent infections. The P&P indicated, trimmed and smooth nails prevented the resident from accidentally scratching and injuring his or her skin. The P&P indicated, nail care included daily cleaning and regular trimming. The P&P indicated, unless otherwise permitted, not to trim the nails of diabetic residents or residents with circulatory impairments.

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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 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** 46687 Based on interview and record review, the facility failed to provide adequate supervision according to the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents, for one of nine sampled residents (Resident 1) by failing to: Ensure Licensed Vocational Nurse (LVN) 1 and LVN 2 obtained an order for a sitter (one-to-one supervision) after Resident 1 sustained a fall (move downward, typically rapidly and freely without control, from a higher to a lower level), was assessed to be confused, and needed a sitter on 8/15/2024. This failure placed Resident 1 at risk for further falls and injuries. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated, Resident 1 was admitted to the facility on [DATE], with diagnoses that included generalized muscle weakness (weakness of muscles caused by lack of exercise, ageing, injury, or disease), type II diabetes mellitus (DM2- A condition that happens because of a problem in the way the body regulates and uses sugar as fuel), and encephalopathy (disease of the brain that alters brain function or structure). During a review of Resident 1's untitled CP, initiated 7/13/2024, the CP indicated, Resident 1 was at risk for falls secondary to cardiac (heart) medication, cognitive (ability to think, remember, and reason) impairment, history of falls prior to admission in last two to six months, impaired balance, poor safety awareness, and use of anti-hypertensive (elevated blood pressure) medication. The CP interventions indicated to provide a pressure pad alarm (sensor pad device placed under a resident's bottom containing sensors that trigger an alarm when it detects a change in pressure. Used as early alert that a resident is trying to get out of bed), for staff to remind Resident 4 to use call light and ask for assistance when needed, encourage Resident 4 to assume a standing position slowly, and remind Resident 4 to walk slowly and rest adequately. During a review of Resident 4's Minimum Data Set (MDS- a standardized resident assessment and care screening tool), dated 7/17/2024, the MDS indicated, Resident 1 had moderately impaired cognition. The MDS indicated, Resident 1 required setup or clean-up assistance (helper sets up or cleans up while the resident completes the activity and helper assists only prior to or following the activity) with eating. The MDS indicated, Resident 1 required partial/moderate assistance (helper does less than half the effort and lifts or holds trunk or limbs, but provides less than half the effort) with lower body dressing, personal hygiene, rolling left to right (in bed), sitting to lying, lying to sitting on side of bed, sitting to standing, chair/bed-to-chair transfers, and walking 10 feet (unit of measurement). The MDS indicated, Resident 1 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half effort) with toileting hygiene and showering/bathing self, putting on/taking off footwear. During a review of Resident 4's Fall Risk Assessment (FRA) dated 7/30/2024, the FRA indicated, Resident 1 was at high risk for falls. (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 4's Situation-Background-Assessment-Recommendation (SBAR- a written communication tool that helps provide essential, concise information, usually during crucial situations) Communication Form dated 8/15/2024, timed at 4:22 pm, the SBAR Communication Form indicated, Resident 4 had an unwitnessed fall on 8/15/2024, untimed. The SBAR indicated, Resident 4 was confused and needed a sitter. The SBAR indicated, Resident 4 was having hallucinations (false perception of objects or events involving the senses: sign, sound, smell, touch and/or taste). The SBAR indicated, LVN 1 completed the SBAR. During a review of Resident 4's Progress Notes (PN) dated 8/15/2024, timed at 6:30 pm, the PN indicated, (on 8/15/2024), at around 4:40 pm, Resident 4 had slid from Resident 4's bed to the floor. The PN indicated, Resident 4 had no head injury, was alert and oriented to person, place, and time, and was able to make needs known. The PN indicated, the Medical Doctor/Primary Physician (MD) 1 was notified and ordered bed alarm and floor mat. The PN indicated, no documentation that MD 1 was notified about Resident 1 being confused and needing a sitter. During an interview on 8/16/2024 at 3:42 pm with LVN 2, LVN 2 stated on 8/15/2024 at approximately 4 pm, LVN 2 assessed Resident 1 after Resident had an unwitnessed fall. LVN 2 stated Resident 1 was trying to move Resident 1's fan closer to Resident 1. LVN 2 stated LVN 2 did not complete an SBAR or update Resident 1's CP because LVN 2 was not the nurse who found Resident 1 after the fall. During a telephone interview on 8/16/2024 at 4:12 pm with LVN 1, LVN 1 stated Certified Nurse Assistant (CNA) 5 informed LVN 1 that CNA 5 found Resident 1 on the floor of Resident 1's room (on 8/15/2024, at 4:40 pm). LVN 1 stated Resident 1 seemed confused at that time. During a telephone interview on 8/16/2024 at 4:39 pm with Registered Nurse Supervisor (RNS) 3, RNS 3 stated when RNS 3 checked on Resident 1 throughout RNS 3's shift on 8/15/2024, Resident 1 was confused. RNS 3 stated RNS 3 was not made aware that Resident 1 needed a sitter. RNS 3 stated that information was not endorsed to RNS 3 during shift-change report (huddle). RNS 3 stated had RNS 3 known Resident 1 needed a sitter, RNS 3 would have obtained an order from Resident 1's physician for a sitter. During a concurrent interview and record review on 8/20/2024 at 11:08 am with LVN 1, Resident 1's SBAR dated 8/15/2024, timed at 4:22 pm, was reviewed. LVN 1 stated LVN 1 did not recall documenting Resident 1 was confused and needed a sitter. LVN 1 stated LVN 1 was unsure how the process worked for getting a sitter for a resident (in general). LVN 1 stated LVN 1 believed a physician's order was needed. LVN 1 stated (in general), when a resident needed a sitter and did not get one, the resident could continue to have more falls and become injured. During an interview on 8/20/2024 at 11:51 am with MD 1, MD 1 stated MD 1 assessed Resident 1 the morning of 8/15/2024. MD 1 stated Resident 1 was alert and oriented to person, place, and time at the time of MD 1's assessment. MD 1 stated the facility nurse (unidentified) called MD 1 in the afternoon of 8/15/2024, and informed MD 1 that Resident 1 had a fall. MD 1 stated the facility nurse (unidentified) did not inform MD 1 that Resident 1 was confused and needed a sitter. MD 1 stated if Resident 1 needed a sitter, MD 1 would have placed an order for a sitter because it was a safety issue for Resident 1. MD 1 stated having a sitter for Resident 1 could prevent future falls and injuries. (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 8/20/2024 at 3:33 pm with the Director of Nursing (DON), the DON stated LVN 1 and LVN 2 needed to obtain a physician's order for a sitter for Resident 1 on 8/15/2024 after Resident 1 fell . The DON stated if it was documented in Resident 1's SBAR that Resident 1 needed a sitter, then it should have been implemented. The DON stated getting a sitter and even moving Resident 1's bed closer to the nursing station could potentially prevent further falls and injury. During a review of the facility's P&P titled, Safety and Supervision of Residents, revised 7/2017, the P&P indicated, the facility strived to make the environment as free from accident hazards as possible, and that resident safety and supervision and assistance to prevent accidents were facility-wide priorities. The P&P indicated, employees would be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. The P&P indicated, the care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. The P&P indicated, resident supervision was a core component of the systems approach to safety, and that the frequency of supervision was determined by the individual resident's assessed needs and identified hazards in the environment.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687 Based on observation, interview, and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 7 reassessed the pain level of one of nine sampled residents (Resident 4) after 30 minutes to one hour of receiving acetaminophen (pain medication used to relieve mild or chronic pain and to reduce fever) for complaint of mild pain on 8/16/2024 at 9:44 am as indicated in the facility's policy and procedure (P&P) titled, Pain- Clinical Protocol. This deficient practice resulted in unrelieved pain for Resident 4 and placed Resident 4 at risk for psychosocial (mental, emotional, social, and spiritual effects) harm. Findings: During a review of Resident 4's Admission Record (AR), the AR indicated, Resident 4 was admitted to the facility on [DATE], with diagnoses that included gout (occurs when urate crystals [high levels of uric acid- waste product created when the body breaks down chemicals- in the blood] accumulate in the joints causing inflammation and intense pain), infection of amputation (removal of body part) stump (remaining healthy part of limb) of right lower extremity (right lower leg), and peripheral vascular disease (PVD- a systemic disorder that involves the narrowing of peripheral blood vessels). During a review of Resident 4's Minimum Data Set (MDS- a standardized resident assessment and care screening tool) dated 6/20/2024, the MDS indicated, Resident 4 was dependent (helper did all the effort or the assistance of 2 or more helpers was required for the resident to complete the activity) with toileting hygiene, showering/bathing self, lower body dressing, and putting on/taking off footwear. The MDS indicated, Resident 4 required substantial/maximal assistance (helper did more than half the effort, helper lifted or held trunk or limbs and provided more than half effort) with rolling left to right (in bed), sitting to lying, lying to sitting on side of bed, sitting to standing, chair/bed-to-chair transfers, and toileting transfers. The MDS indicated Resident 4 required partial/moderate assistance (helper did less than half the effort and lifted or held trunk or limbs but provided less than half the effort) with upper body dressing. The MDS indicated, Resident 4 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completed the activity and may be provided throughout the activity or intermittently) with eating and oral hygiene. During a review of Resident 4's untitled care plan (CP) initiated 7/11/2024, the CP indicated, Resident 4 had acute pain related to amputation. The CP goals indicated Resident 4 would verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date of 9/15/2024. The CP interventions indicated for staff to administer analgesia (absence of pain) as per orders and give a half hour before treatments or care, administer pain relief measures, and monitor and record effectiveness, and assess effects of pain on Resident 4. During a review of Resident 4's Order Summary Report (OSR) dated 8/16/2024, the OSR indicated the following physician orders: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Hydrocodone-Acetaminophen 5-325 milligrams (mg- unit of measurement), give one (1) tablet by mouth every six hours as needed for moderate to severe pain (pain level of 4 to 10 [0 being no pain and 10 being the worst pain possible]), order dated 6/18/2024. 2. Acetaminophen tablet 325 mg, give two (2) tablets by mouth every four hours as needed for mild pain (pain level of 1 to 3), not to exceed three (3) grams (g- unit of measurement) in 24 hours, order dated 8/2/2024. A review of Resident 4's Medication Administration Record (MAR) for August 2024, the MAR indicated Resident 4 complained of 3 out of 10 pain on 8/16/2024 at 9:44 am (location and description of pain not indicated). During a concurrent observation and interview on 8/16/2024 at 12:05 pm with Resident 4, Resident 4's pain level and right lower leg and foot were observed. Resident 4 stated Resident 4's right foot hurt. Resident 4 stated Resident 4 got Tylenol (brand name for acetaminophen) a while ago (unable to specify time). Resident 4 stated no one came to see if the pain medication was effective for Resident 4. Resident 4 stated Resident 4 was experiencing 9 out of 10 pain in the right lower leg and foot. Resident 4 stated Resident 4, felt horrible and did not like that. Resident 4 stated Resident 4 could not think with 9 out of 10 pain. During a concurrent interview and record review on 8/16/2024 at 12:10 pm with LVN 7, Resident 4's MAR dated 8/1/2024 to 8/31/2024 was reviewed. LVN 7 stated Resident 4 received a dose of acetaminophen at 9:44 am that morning (8/16/2024). LVN 7 stated LVN 7 was supposed to reevaluate Resident 4's pain level within one hour after administering acetaminophen to see if the medication was effective in treating Resident 4's pain. LVN 7 stated LVN 7 did not reassess Resident 4's pain medication effectiveness within one hour of giving the acetaminophen. LVN 7 stated if LVN 7 did not reassess Resident 4's pain, Resident 4's pain could get worse. LVN 7 stated acetaminophen was used to treat mild pain. LVN 7 stated Resident 4 had an order for hydrocodone as needed for severe pain. During a concurrent observation and interview on 8/16/2024 at 12:14 pm, LVN 7 assessed Resident 4's pain level. Resident 4 stated Resident 4 had 9 out of 10 pain to the right lower leg and foot. Resident 4 stated Resident 4, felt really bad. During an interview on 8/20/2024 at 3:33 pm with the Director of Nursing (DON), the DON stated part of the process for giving pain medication was for the licensed nurse to reassess the effectiveness of the medication within one hour of administration. The DON stated this process was used to check if the pain medication worked for a resident (in general). The DON stated it was possible that if pain medication was not effective a resident (in general) could require more pain medication. The DON stated an increase in pain from 3 out of 10 to 10 out of 10 was considered a significant change in pain level for Resident 4. The DON stated if pain medication was not reevaluated for effectiveness, then the resident could be in more pain and could negatively affect them mentally and physically. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Pain- Clinical Protocol, revised 3/2018, the P&P indicated, the physician and staff would identify individuals who had pain or were at risk for having pain. The P&P indicated, the nursing staff would assess each individual for pain whenever there was a significant change in condition, and when there was a new onset of pain, or worsening of existing pain. The P&P indicated, the staff would reassess the resident's pain and related consequences at regular intervals and at least each shift for acute pain or significant changes in levels of chronic pain.