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	09/17/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect one of three sampled residents (Resident 2) from physical abuse (aggressive or violent behavior with the intention to cause physical harm) as indicated in the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program to be free from abuse. As a result, on 8/23/2025 Resident 1 pushed Resident 2 and Resident 2 fell to the floor. Resident 2 was transferred to General Acute Care Hospital (GACH) 1 for an assessment and evaluation due to an unwitnessed fall. Resident 2 sustained an acute (sudden) comminuted (the bone breaks into multiple small fragments) fracture (partial or complete break of the bone) of the right 5th metacarpal (the bone in the hand that connects the little finger to the wrist).Findings: During a review of Resident 2's admission Record (AR), the AR indicated Resident 2 was admitted to the facility on [DATE] with a diagnoses that included schizoaffective disorder (a mental health condition that combines symptoms of schizophrenia [a mental illness that is characterized by disturbances in thought] and a mood disorder, such as depression [serious illness that negatively affects how one feels, thinks and acts] or bipolar disorder [serious mental illness that causes unusual shifts in mood]), and legal blindness (severe visual impairment that meets specific criteria established by law). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 6/19/2025, the MDS indicated Resident 2's cognition (ability to understand and process information) was severely impaired. The MDS indicated Resident 2 needed partial to moderate assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance [the caregiver places one or two hands on the resident's body to help with balance but provides no other assistance to perform the functional mobility task] as resident completes the activity) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and with walking. During a review of Resident 2's Situation, Background, Assessment and Recommendation (SBAR, structured communication framework that helps teams share information about the condition of a resident) Communication Form, dated 8/23/2025, timed at 12:18 pm, the form indicated (on 8/23/2025), at 11:30 am, Resident 2 was having a verbal conversation with Resident 1 when suddenly Resident 2 fell on the floor unwitnessed. The form indicated Resident 2 told staff, He [Resident 1] pushed me, and [I] ended [on] the floor; my back is painful. The form indicated Resident 2's pain was rated 1 out of 10 (pain scale 0 to 10, 0 means no pain and 10 means the worst possible pain felt). The form indicated Medical Doctor (MD) 1 was notified 8/23/2025 at 12 pm, and the facility received a new order for laboratory [blood] work. During a review of Resident 2's Progress Notes (PN), dated 8/23/2025, timed at 2 pm, the PN indicated Resident 2 was transferred to GACH 1's Emergency Department (ED) for an assessment due to an unwitnessed fall. During a review of Resident 2's PN, dated 8/23/2025, timed at 11:40 pm, the PN indicated Resident 2 returned to the facility from GACH 1 with a right-hand 5th metacarpal fracture. During a review of Resident 2's GACH 1's right wrist X-ray (imaging study that takes pictures of bones and soft tissues) results, dated 8/23/2025, timed at 2:28 pm, the X-ray indicated an acute comminuted fracture of the right 5th metacarpal beginning in the distal diaphysis (the main or midsection (shaft) of a long bone) and extending to the distal epiphysis with suspected intra-articular extension [(the rounded end of the bone). The breaking of the long bone leading to the little finger in multiple pieces with a high likelihood of damage to the joint surface]. During a review of Resident 1's AR, the AR indicated Resident 1 was admitted to the facility 6/8/2025 with diagnoses that included type 2 diabetes (a disease that results in elevated levels of glucose in the blood) and essential hypertension (high pressure of blood pushing against the wall of the arteries). During a review of Resident 1's History and Physical (H&P) Examination, dated 6/9/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's SBAR Communication Form, dated 8/23/2025, the form indicated Resident 1 had a disagreement with [Resident 2] and Resident 1 pushed Resident 2. During an interview on 8/28/2025 at 11 am with Resident 1, Resident 1 stated on 8/23/2025 (could not remember the time) Resident 1 had an altercation (a conflict that can range from verbal arguments to physical fights, occurring between two or more individuals receiving care) with Resident 2. Resident 1 stated Resident 2 was sitting across the hall and Resident 1 was walking into Resident 1's room when Resident 2 said something to Resident 1 and Resident 1 told Resident 2 to, shut up and mind his [Resident 2's] own business. Resident 1 stated Resident 2 was walking toward Resident 1 and, I pushed and dropped Resident 2 to the ground, and he [Resident 2] started yelling he [Resident 1] hit me. During an interview on 9/2/2025 at 1 pm with Licensed

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report and a physical abuse (willful infliction of injury, deliberate aggressive or violent behavior with the intention to cause harm) incident to the California Department of Public Health (CDPH, State Agency) for one of three sampled residents (Resident 2) as indicated in the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program.This deficient practice resulted in the delay of notification to the State Agency and had the potential to result in residents residing at the facility to be subjected to further abuse.Cross Reference F600Findings:During a review of Resident 2's admission Record (AR), the AR indicated Resident 2 was admitted to the facility on [DATE] with a diagnoses that included schizoaffective disorder (a mental health condition that combines symptoms of schizophrenia [a mental illness that is characterized by disturbances in thought] and a mood disorder, such as depression [serious illness that negatively affects how one feels, thinks and acts] or bipolar disorder [serious mental illness that causes unusual shifts in mood]), and legal blindness (severe visual impairment that meets specific criteria established by law).During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 6/19/2025, the MDS indicated Resident 2's cognition (ability to understand and process information) was severely impaired and needed partial to moderate assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance [the caregiver places one or two hands on the resident's body to help with balance but provides no other assistance to perform the functional mobility task] as resident completes the activity) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and with walking.During a review of Resident 2's Situation, Background, Assessment and Recommendation (SBAR, structured communication framework that helps teams share information about the condition of a resident) Communication Form, dated 8/23/2025, timed at 12:18 pm, the form indicated (on 8/23/2025), at 11:30 am, Resident 2 was having a verbal conversation with Resident 1 when suddenly Resident 2 fell on the floor unwitnessed. The form indicated Resident 2 told staff, He [Resident 1] pushed me, and [I] ended [on] the floor.During an interview on 9/2/2025 at 2:33 pm with Licensed Vocational Nurse (LVN) 4, LVN 4 stated Resident 1 was standing by his room yelling and laughing at Resident 2 that is what you get you should not be here, yea I pushed him so what, I pushed him. Resident 2 was lying on the floor and stated, help me, I can't get up. LVN 4 stated I notified the Administrator (ADM) and the Director of Nursing (DON) of the incident and stated LVN 3 told LVN 4 not to fill out the abuse reporting form because the ADM and DON told LVN 3, the ADM and the DON would fill out the form [and report to the State Agency]. LVN 4 stated, LVN 4 was a mandated reported and abuse should be reported within 2 hours to the State Agency, the Ombudsman (an official, public advocate, helps to resolve issues between parties through various types of informal mediation), and the police department.During a concurrent interview and record review on 9/3/2025 at 3:30 pm with DON, the facility's P&P titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated April 2021 was reviewed. The P&P indicated, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation: The resident abuse, neglect and exploitation prevention program consist of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: b. other residents, 9. Investigate and report any allegations within time frames required by federal requirements. The DON stated we [the facility] failed to report the incident that occurred on 8/23/2025 within two hours to the State Agency.