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	03/27/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility staff failed to document the amount of meal intake on the resident's medical record for one of four sampled residents (Resident 1). This deficient practice had the potential to result in lack of communication between staff and delay and interrupt the provision of care needed to maintain the resident's highest practicable, physical, mental, and psychosocial well-being.Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 12/31/2024 with diagnoses including sepsis (a life-threatening blood infection) and diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control). During a review of Resident 1's History and Physical (H&P) dated 1/1/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 1/5/2025, the MDS indicated Resident 1 had intact cognition (ability to understand). The MDS indicated Resident 1 required setup assistance from staff with eating. The MDS indicated Resident 1 required supervision from staff with oral hygiene. The MDS indicated Resident 1 required moderate assistance (helper did less than half the effort) from staff with toileting hygiene, showering/bathing, and personal hygiene. The MDS indicated Resident 1 required maximal assistance (helper did more than half the effort) from staff with bed-to-chair transferring. During a concurrent record review and interview with Certified Nurse Assistant 1 (CNA 1) on 3/27/2026 at 11:37 AM, Resident 1's Documentation Survey Report (DSR) for January and February 2025 were reviewed. The DSR indicated the CNAs (in general) documented Resident 1's amount of meal intake for 90 out of 93 meals from 1/1/2025 to 1/31/2025. The DSR indicated the CNAs documented Resident 1's amount of meal intake for 40 out of 45 meals from 2/1/2025 to 2/15/2025. CNA 1 stated the CNAs (in general) should have documented in the resident's medical record after each resident's meal. CNA 1 stated the CNAs needed to document on the resident's medical record if the resident refused to eat. CNA 1 stated it was important to complete the documentation on the resident's medical record before the end of the shift because it was the standard of practice. CNA 1 stated if there was no documentation on the DSR, staff would not know how much the residents ate. CNA 1 stated incomplete medical record documentation would affect the continuity of residents' care. During an interview with the Director of Nursing (DON) on 3/27/2026 at 2:17 PM, the DON stated without documentation, nursing staff would not know if the resident ate or refused the meal. During a review of the CNA's job description dated 10/2020, the job description indicated the CNA should record the resident's food/fluid intake. During a review of the facility's Policy and Procedure (P&P) titled Charting and Documentation, dated 7/2017, the P&P indicated all services provided to the resident should be documented completely in the resident's medical records. The P&P further indicated that documentation should include the date and time the procedure/treatment was provided and the signature and title of the individual documenting.

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