

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 residents were called by their legal (official name recognized by government on documents), proper and preferred names for three of three sampled residents (Residents 14, 96, and 132). These failures had the potential for Residents 14, 96, and 132 to lose their dignity and individuality. Findings: a. During a review of Resident 132's admission Record (AR), the AR indicated Resident 132 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (a type of ischemic stroke caused by a blockage in blood vessels supplying the brain), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypertension (HTN-high blood pressure). During a review of Resident 132's Order Summary Report (OSR) dated 1/6/2026, the OSR indicated Resident 132 had an order for 1:1 feeder with all meals every shift. During a review of Resident 132's Minimum Data Set (MDS- a resident assessment tool) dated 1/10/2026, the MDS indicated Resident 132 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 132 required substantial/maximal assistance (helper did more than half the effort) with eating and dependent (helper did all the effort) with oral hygiene, toileting, shower, upper and lower body dressing. During a concurrent observation and interview on 1/13/2026 at 12:35 pm with Certified Nurse Assistant 2 (CNA 2) in the hallway, CNA 2 was passing lunch meal tray to Resident 132. CNA 2 stated Resident 132 was a feeder. During an interview on 1/14/2025 at 11:47 pm with the Infection Prevention Nurse (IPN), the IPN stated all residents should be treated with dignity and respect and referred to by their own legal, proper and preferred names or nicknames. During an interview on 1/15/2026 at 4:08 pm with the Assistant Director of Nursing (ADON), the ADON stated residents should not be labeled as feeder because it would affect the resident's dignity. b. During a review of Resident 96's AR, the AR indicated Resident 96 was admitted to the facility on [DATE] with diagnoses including urinary tract infection (UTI- infection that affects part of the urinary tract), malignant neoplasm (group of diseases involving abnormal cell growth with the potential to invade or spread to other parts of the body) of prostate, and acute kidney failure (a sudden decline in kidney function). (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: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 96's MDS dated [DATE], the MDS indicated Resident 96 had severely impaired cognition. The MDS indicated Resident 96 was dependent (helper does all of the effort) with oral hygiene, toileting, shower, upper and lower body dressing and putting on/taking off footwear. During a review of Resident 96's OSR dated 12/11/2025, the OSR indicated Resident 96 had an order for 1:1 feeder with all meals every shift. During an interview on 1/14/2026 at 11:18 am with Registered Nurse 1 (RN 1), RN 1 stated, I know the resident, he (Resident 96), is a feeder, someone helped him with meals. RN 1 stated, Resident 96 should not have been addressed as a feeder for resident's dignity. c. During a review of Resident 14's AR, the AR indicated Resident 14 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities) and dementia (a progressive state of decline in mental abilities). During a review of Resident 14's untitled Care Plan (CP) revised on 9/28/2025, the CP indicated Resident 14 was on hospice (compassionate care for people who are near the end of life) services with routine level of care related to Alzheimer's disease diagnosis, with a goal to maintain Resident 14's dignity and autonomy at the highest level. During a review of Resident 14's MDS dated [DATE], the MDS indicated Resident 14 was rarely or never understood, rarely or never made decisions regarding tasks of daily life and was dependent during eating (helper does all of the effort). During a review of Resident 14's OSR dated 11/19/2025, the OSR indicated Resident 14 had an active order for a regular diet, pureed texture (smooth, pudding like consistency), mildly thick consistency, and needed assistance with meals. During an interview on 1/16/2026 at 9:13 am with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated Resident 14 was a feeder. LVN 3 stated Resident 14 had severe Alzheimer's disease and couldn't feed self. LVN 3 stated, a feeder was someone who needed assistance with feeding and all residents who needed help feeding were feeders. During an interview on 1/16/2026 at 10:41 am with the Director of Nursing (DON), the DON stated residents should be called by their last name or how they preferred to be addressed. The DON stated, in order to provide respect and dignity to the resident they should not be called/labeled as feeder. During a review of the facility's policy and procedure (P&P) titled, Quality of Life-Dignity, revised 2/2020, the P&P indicated, each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth, and self-esteem. The P&P indicated, staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs. The P&P indicated, staff were expected to treat cognitively impaired residents with dignity and sensitivity.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure:a. The call lights were accessible for residents in four of four private shower areas.b. The call light was accessible for one of one visually impaired resident (Resident 92).These deficient practices had the potential to result in a delay in meeting the residents' needs for assistance and could lead to falls and accidents. Findings: a. During a concurrent observation and interview with the Director of Nursing (DON) on 1/15/2026 at 10:21 AM, in Room A's private shower area, the emergency call light cord was located outside the shower area. The DON stated the call light cord was not reachable for the residents during shower. The DON stated this placed the residents at risk of injury and delayed help/assistance. The DON stated all staff were responsible for ensuring the call light cords are within resident's reach and easily accessible at all times to maintain safety, including the shower room. During a concurrent observation and interview with the Maintenance Supervisor (MS) on 1/15/2026 at 2:12 PM, in Room A's private shower area, the emergency call light cord was located outside the shower area. The MS stated the shower emergency call light cord was not accessible for residents in Room A. The MS stated the emergency call light cord should be within three feet (units of length used to measure distance) of the shower head so that residents could reach and use in case of emergency. The MS stated the emergency call light cord should be hanging two to six inches from the floor. The MS stated if the call light was not within reach, this placed the residents at risk for fall and injury. The MS stated there were a total of four residents' rooms with private shower area, and none of the emergency call light cords were reachable for residents in the shower. During a review of the facility's Policy and Procedure (P&P) titled, Call System, Resident, dated 9/2022, the P&P indicated the emergency pull cord in shower areas must be within three feet of the shower head. The P&P further indicated that a pull cord must hang to within two to six inches of the floor to ensure a resident could reach it if they had fallen. b. During a review of Resident 92's admission Record (AR), the AR indicated Resident 92 was admitted to the facility on [DATE] with diagnoses including glaucoma (an eye condition that damages the optic nerve), legal blindness (severe vision loss) and history of falling (moving from a higher to a lower level, rapidly and without control). During a review of Resident 92's Minimum Data Set (MDS- a resident assessment tool) dated 1/5/2026, the MDS indicated Resident 92 had severely impaired vision and severely impaired cognition (ability to understand and process information). The MDS indicated Resident 92 required partial/moderate assistance (helper did less than half the effort) with eating, oral hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 92 required substantial/maximal assistance (helper did more than half the effort) with toileting, shower and upper body dressing. During a review of Resident 92's untitled Care Plan (CP) dated 1/5/2026, the CP indicated Resident 92 had severely impaired vision. The CP interventions included providing the resident with assistance with activities of daily living (ADLs) and a goal for Resident 92 to remain physically safe. During a concurrent observation and interview on 1/13/2026 at 9:17 am with Certified Nurse Assistant 3 (CNA 3) inside Resident 92's room, Resident 92 was trying to get out of bed. Resident 92's call light was wrapped around the bed siderails. Resident 92 stated Resident 92 did not know (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	where Resident 92's call light was and could not see the call light. CNA 3 stated Resident 92 was blind. CNA 3 stated it was important for Resident 92 to know where Resident 92's call light was, to be able to call for help and assistance. During a concurrent interview and record review on 1/14/2026 at 1:27 pm with the Infection Prevention Nurse (IPN), Resident 92's MDS dated [DATE] was reviewed. The IPN stated Resident 92 had severely impaired vision. The IPN stated Resident 92 should have Resident 92's call light in Resident 92's possession and be accessible to Resident 92 all the time to be able to call for assistance and prevent the resident from falling and accidents. During an interview on 1/15/2026 at 4:12 pm with the Assistant Director of Nursing (ADON), the ADON stated legally blind, or visually impaired residents should have an appropriate call light intended for the resident's special needs like the sensor or pad call light to alert staff and assist the resident's needs promptly. During a review of the facility's Policy and Procedure (P&P) titled, Call System, Resident, revised September 2022, the P&P indicated, If the resident has a disability that prevents him/her from making sure of the call system, an alternative means of communication that is usable for the resident is provided and documented in the care plan.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility failed to develop and implement specific and resident-centered care plans (CP) for four of four sampled residents (Residents 3, 48, 49, and 95). These deficient practices had the potential for Residents 3, 48, 49 to not receive appropriate care, treatment, and/or services related to their needs and the potential to result in burns or injuries to Resident 95 during smoking breaks. Findings: a. During a review of Resident 3's admission Record (AR), the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities) and psychosis (a severe mental condition in which thought, and emotions were affected that contact was lost with reality). During a review of Resident 3's History and Physical (H&P) dated 12/7/2025, the H&P indicated Resident 3 lacked decision-making capacity. During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool) dated 12/10/2025, the MDS indicated Resident 3 had severely impaired cognition (ability to understand). The MDS indicated Resident 3 required moderate assistance (helper did less than half the effort) from staff with eating and oral hygiene. The MDS indicated Resident 3 required maximal assistance (helper did more than half the effort) from staff with toileting hygiene, showering/bathing, and bed-to-chair transferring. During a review of Resident 3's Order Summary Report (OSR) with active orders as of 1/15/2026, the OSR indicated a physician's order for licensed staff to administer memantine HCL (medication to treat dementia) twice a day starting on 12/6/2025. The OSR further indicated a physician's order for licensed staff to administer rivastigmine (medication to treat dementia) twice a day starting on 12/6/2025. During an interview with Licensed Vocational Nurse 2 (LVN 2) on 1/15/2026 at 10:48 AM, LVN 2 stated residents' CP (in general) should be specific and updated to ensure quality of care. LVN 2 stated the resident's CP should include the medication name to be specific. During a concurrent record review and interview with Registered Nurse 1(RN 1) on 1/15/2026 at 11:13 AM, all of Resident 3's CP were reviewed. RN 1 stated there were no specific CP to address memantine HCL nor rivastigmine use. RN 1 stated Resident 3's CP should be specific and resident-centered and the licensed nurse should initiate the CP upon admission. RN 1 stated memantine HCL and rivastigmine should have been included in Resident 3's CP because they were part of Resident 3's care. RN 1 stated it would affect nursing care without a specific CP. b. During a review of Resident 49's AR, the AR indicated Resident 49 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia and psychosis. During a review of Resident 49's MDS dated [DATE], the MDS indicated Resident 49 had moderately impaired cognition. The MDS indicated Resident 49 required setup assistance from staff for eating, oral hygiene, and walking. The MDS indicated Resident 49 required supervision from staff with toileting hygiene, personal hygiene, and bed-to-chair transferring. The MDS indicated Resident 49 (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	required moderate assistance from staff for showering/bathing. During a review of Resident 49's OSR, with active orders as of 1/15/2026, the OSR indicated a physician's order for licensed staff to administer donepezil (medication to treat dementia) twice a day starting on 3/6/2025. The OSR further indicated a physician's order for licensed staff to administer memantine HCL twice a day starting on 7/4/2025. During a concurrent record review and interview with RN 1 on 1/15/2026 at 11:43 AM, all of Resident 49's CP were reviewed. RN 1 stated there were no specific CP to address donepezil nor memantine HCL use. RN 1 stated donepezil nor memantine HCL should have been included in the CP because they were part of Resident 49's care. During an interview with the Director of Nursing (DON) on 1/16/2026 at 1:36 PM, the DON stated it was beneficial to staff and residents to specify the medication names in the CP. The DON stated the specific CP would guide staff on how to care for the residents with dementia and psychosis. The DON stated the CP should individualize care to monitor the specific side effects of the medication. c. During a review of Resident 48's AR, the AR indicated Resident 48 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including pressure ulcer stage 4 (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) and needs assistance with personal care. During a review of Resident 48's MDS dated [DATE], the MDS indicated Resident 48 had intact cognition. The MDS indicated Resident 48 required setup assistance from staff for eating. The MDS indicated Resident 48 required partial assistance from staff for oral hygiene and personal hygiene. The MDS indicated Resident 48 was dependent (helper did all the effort) on staff with toileting hygiene, showering/bathing, and bed-to-chair transferring. The MDS indicated Resident 48 had pressure reducing device for bed. During a review of Resident 48's H&P dated 1/7/2026, the H&P indicated Resident 48 had the capacity to understand and make decisions. During a review of Resident 48's OSR with active orders as of 1/15/2026, the OSR indicated a physician's order for licensed staff to set the low air loss mattress (LALM, mattress that provided airflow to reduce pressure) according to Resident 48's weight or per Resident 48's comfort every shift starting on 1/4/2026. During a concurrent observation and interview with LVN 2 on 1/15/2026 at 10:30 AM in Resident 48's room, Resident 48 was observed lying in bed. LVN 2 stated Resident 48 was lying on a LALM. LVN 2 stated the LALM prevented pressure ulcers and should have a CP. During a concurrent record review and interview with LVN 2 on 1/15/2026 at 10:30 AM, all of Resident 48's CP were reviewed. LVN 2 stated there was no specific CP for the use of the LALM. LVN 2 stated the licensed nurse should have developed a specific CP Resident 48's use of the LALM upon receiving the order. LVN 2 stated LALM use was an important intervention for wound management. LVN 2 stated staff would not be able to follow the plan of care without the specific CP which could potentially cause complications with Resident 48's wound. During a review of the facility's Policy and Procedure (P&P) titled Care Plans, Comprehensive (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Person-Centered, revised on 3/2024, the P&P indicated a comprehensive, person-centered care plan that meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident. The P&P indicated that the comprehensive, person-centered CP should describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The P&P further indicated that the comprehensive, person-centered CP should reflect currently recognized standards of practice for problem areas and conditions. d. During a review of Resident 95's admission Record (AR), the AR indicated Resident 95 was admitted to the facility on [DATE] with diagnoses including blindness in both eyes, psychosis (a severe mental condition in which thought, and emotions are affected that contact is lost with reality), schizophrenia (a mental illness that is characterized by disturbances in thought), parkinsonism (disease that affects the nerve cells in the brain that produces symptoms that include muscle rigidity, tremors, and changes in speech and gait), and a need for assistance with personal care. During a review of Resident 95's History & Physical (H&P) dated 12/8/2025, the H&P indicated Resident 95 had the capacity to understand and make decisions. During a review of Resident 95's Minimum Data Set (MDS, a resident assessment tool) dated 12/11/2025, the MDS indicated Resident 95 had moderately impaired cognition (ability to understand). The MDS indicated Resident 95 needed substantial/maximal assistance (helper does more than half the effort) while eating (ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident) and used tobacco. During a review of Resident 95's Smoking Assessment (SA) dated 12/15/2025, the SA recommendations indicated Resident 95 needed supervision while smoking and measures were required (such as smoking apron, cigarette extension). During a review of Resident 95's Care Plan (CP) dated 12/15/2025, the CP indicated Resident 95 was a smoker who needed supervision. The CP indicated interventions to explain the risk and benefits of smoking protector/apron and explain consequences of non-compliance, such as cigarette related burns and other injuries. The CP indicated the resident required SUPERVISION while smoking and had a goal for Resident 95 to not smoke without supervision. During an observation on 1/15/2026 at 2:08 pm, Resident 95 was not wearing a smoking apron and was seated in a wheelchair with his back to the doors, smoking a cigarette outside of the facility. The Activities Assistant (AA) was sitting inside the double doors of the facility looking downward at a phone. During an interview on 1/15/2026 at 2:50 pm with the AA, the AA stated Resident 95 was partially blind and requested someone take Resident 95 on smoke break. The AA stated, the AA was instructed to supervise residents by lighting their cigarettes and observing them from inside through a window since the AA disliked the smoke. The AA stated, the AA periodically kept an eye on the residents and stayed inside the doors during supervision. The AA stated direct supervision required being next to or very close to the resident, which the AA did not do for Resident 95. The AA stated, the AA would not be able to prevent Resident 95 from being burned by cigarette ashes. The AA stated, Resident 95 required a smoking apron and concurred it was important to discuss the risks and benefits of wearing the apron with the resident. The AA stated, Resident 95 would not refuse to wear the smoking apron if it was offered, but smoking aprons were unavailable so the AA did not offer it to Resident 95. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/16/2026 at 11:00 am with the Assistant Director of Nursing (ADON), the ADON stated Resident 95 was a smoker and due to his blindness in both eyes Resident 95 needed supervision and would benefit from a smoking apron to prevent any burns. The ADON stated following the CP was important to guide staff what to do and determine the best interventions for the resident. During an interview on 1/16/2026 at 11:20 am with the Director of Nursing (DON), the DON stated Resident 95 was a smoker who needed supervision and the smoking apron was a necessary shield from cigarette ashes. The DON stated whoever takes Resident 95 to smoke should offer Resident 95 a smoking apron. The DON stated following the CP was vital for patient safety, to prevent fires and accidents from occurring. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, last revised 3/2024, the P&P indicated, a comprehensive, person-centered care plan included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs were developed and implemented for each resident. The P&P indicated, each resident's comprehensive person-centered care plan was consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to receive the services and/or items included in the plan of care. During a review of the facility's P&P titled, Smoking Policy-Residents, revised 12/2024, the P&P indicated, it was the policy of the facility to establish and maintain safe resident smoking practices. The P&P indicated, any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the low air loss mattress (LALM - a specialty bed that alternates pressure to help heal and prevent pressure ulcers/injuries (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) was set accurately for two of three sampled residents (Residents 48 and 117). These failures had the potential to worsen and impede healing of both residents' wounds and cause further skin injuries. Findings: a. During a review of Resident 117's admission Record (AR), the AR indicated Resident 117 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (one-sided muscle weakness) after a stroke affecting the left side and hypertension (HTN-high blood pressure). During a review of Resident 117's Order Summary Report (OSR), the OSR indicated active orders for: 1.LALM, every shift, ordered on 5/28/2024. 2.Set LALM according to resident's weight or per resident's comfort, every shift, ordered on 7/26/2023. During a review of Resident 117's History & Physical (H&P) dated 10/9/2025, the H&P indicated the resident did not have the capacity to understand and make decisions with a fluctuating mental status. During a review of Resident 117's Braden Scale (BS - assessment tool used to assess a resident's risk of developing a pressure ulcer/sore) for Predicting Pressure Sore Risk dated 11/6/2025, the BS indicated Resident 117 was At Risk for developing a pressure ulcer. During a review of Resident 117's Minimum Data Set (MDS, a resident assessment tool) dated 11/9/2025, the MDS indicated Resident 117 had moderately impaired cognition (ability to understand), had an open lesion, and a pressure reducing device for the resident's bed as a skin and ulcer/injury treatment. During a review of Resident 117's Current Weights and Vitals, dated 1/1/2026, Resident 117's weight was 148 pounds (lbs.- unit of measurement to measure body mass) During a review of Resident 117's Treatment Administration Record (TAR) dated 1/1/2026 through 1/31/2026, the TAR indicated Resident 117 was receiving continuous treatment for a mid-back cancer lesion (tissue damage) and a left anterior (near the front) lower leg arterial ulcer (painful, slow healing open sore) for 30 days. During a concurrent observation and interview on 1/13/2026 at 9:11 am with Resident 117 in Resident 117's room, Resident 117's was lying in bed with LALM weight setting at 400 pounds with a white sticker labeled 200-300. Resident 117 stated Resident 117 was not comfortable on Resident 117's bed. During a concurrent observation and interview on 1/13/2026 at 9:14 am with Minimum Data Set Nurse (MDSN) in Resident 117's room, Resident 117's LALM weight setting was set to 400 lbs. The MDSN (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated Resident 117's LALM should not be set to 400 lbs., but should be on 200-300 lbs. The MDSN stated Resident 117 needed assistance to turn in bed and the LALM was used for pressure relieving as Resident 117 had fragile skin and had a history of pressure ulcers and a left leg arterial ulcer. During an interview on 1/16/2026 at 10:52 am with the Assistant Director of Nursing (ADON), the ADON stated Resident 117 had confusion and forgetfulness and was receiving treatments for a mid-back wound. The ADON stated the LALM should have been set between 100-200 lbs. for Resident 117 or based on the resident's comfort. The ADON stated 400 lbs. was an inappropriate setting. The ADON stated, if 400 lbs. was the resident's preferred setting, nursing staff would call the physician for an order while documenting the discussion with the physician in a progress note. The ADON stated if the LALM was set too firm, there was a possibility it could slow wound healing. During a review of Proactive medical products: Operator's Manual Item for Protekt Aire 4000DX/5000Dx, (undated), the LALM manual indicated the system was designed for prevention, treatment and management of pressure ulcers. The manual indicated to press the up or down buttons to select the correct patient weight. The manual indicated users could adjust air mattress to a desired firmness according to patient's weight or the suggestion for a health care professional. During a review of the facility's policy and procedure (P&P) titled, Specialty Mattress-Pressure Relieving Devices, revised 1/2024, the P&P indicated, the purpose of this procedure was to provide guidelines for the appropriate pressure-relieving devices or LALM for residents at high risk of skin breakdown or further skin breakdown. The P&P also indicated any individual at risk for developing pressure ulcers shall be placed on a redistribution support surface as ordered by the attending physician. The P&P further indicated, to follow the LAL manufacturer's user instructions and adjust the comfort settings or weight setting when indicated. b. During a review of Resident 48's AR, the AR indicated Resident 48 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including pressure ulcer stage 4 (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) and obesity (excessive fat accumulation in the body). During a review of Resident 48's MDS dated [DATE], the MDS indicated Resident 48 had intact cognition. The MDS indicated Resident 48 required setup assistance from staff for eating. The MDS indicated Resident 48 required moderate assistance (helper did less than half the effort) from staff for oral hygiene and personal hygiene. The MDS indicated Resident 48 was dependent (helper did all the effort) on staff with toileting hygiene, showering/bathing, and bed-to-chair transferring. The MDS further indicated Resident 48 had one or more unhealed pressure ulcer and a pressure reducing device for bed. During a review of Resident 48's History and Physical (H&P) dated 1/7/2026, the H&P indicated Resident 48 had the capacity to understand and make decisions. During a review of Resident 48's Pressure Ulcer Assessment ([NAME]) dated 1/12/2026, the [NAME] indicated Resident 48 had left buttock pressure ulcer stage 4 and required low air loss mattress (LALM) for preventative measures. During a review of Resident 48's untitled Care Plan (CP) revised on 1/13/2026, the CP indicated Resident 48 had left buttock pressure ulcer stage 4 and the CP goal indicated Resident 48 would not develop any further skin breakdown (skin was damaged or started to wear away). (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 48's OSR with active orders as of 1/15/2026, the OSR indicated a physician's order for licensed staff to set the LALM according to Resident 48's weight or Resident 48's comfort every shift starting on 1/4/2026. During a review of Resident 48's Monthly Weight Report (MWR) dated 1/15/2026, the MWR indicated Resident 48 weighed 266 lbs. During an observation on 1/14/2026 at 9:59 am in Resident 48's room, Resident 48 was lying on a LALM. The LALM weight setting was set at 350 lbs. During a concurrent observation and interview with Resident 48 on 1/15/2026 at 9:30 am, in Resident 48's room, Resident 48 was lying on a LALM. The LALM was set for a resident who weighed 350 lbs. Resident 48 stated Resident 48 was not comfortable lying on the LALM because there were uneven air pockets on Resident 48's back. During a concurrent observation and interview with Treatment Nurse 1 (TN 1) on 1/15/2026 at 1:50 pm, in Resident 48's room, Resident 48 was lying on a LALM. TN 1 stated Resident 48's LALM was set for a resident who weighed 350 lbs. TN 1 stated the purpose of the LALM was for wound healing and comfort. TN 1 stated the LALM was set up per resident's weight or comfort according to the physician order. During a concurrent record review and interview with TN 1 on 1/15/2026 at 1:50 pm, the undated Operation Manual (OM) for the LALM was reviewed. TN 1 stated the OM indicated to set the LALM according to the resident's weight. TN 1 stated it was not beneficial to Resident 48's left buttock pressure ulcer stage 4 if the LALM was set too high because the LALM was firm. TN 1 stated the licensed nurse should have explained the risks and benefits of the higher LALM setting to the residents. TN 1 stated the licensed nurse should have set up the LALM according to Resident 48's weight at 266 lbs. During a concurrent record review and interview with the Director of Nursing (DON) on 1/16/2026 at 11:10 AM, the facility's P&P titled Specialty Mattress - Pressure Relieving Devices, revised on 1/2024, the P&P indicated staff were to follow the LALM manufacturer's user instructions for setup. The DON stated the license nurse should verify the LALM order with the physician. The DON stated the licensed nurse should have set up the LALM per Resident 48's weight.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **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 residents with indwelling catheter (a catheter inserted into the bladder to drain urine) and suprapubic catheter (a soft tube inserted directly into the bladder through a small incision in the lower belly [just above the pubic bone] to drain urine into a bag) for two of four sampled residents (Residents 132 and 33) by failing to: a. Ensure Resident 132's foley catheter (FC - a common type of indwelling catheter, a soft, plastic or rubber tube that is inserted into the bladder to drain urine) was secured to the resident's thigh. b. Ensure Resident 33's suprapubic catheter site was monitored for signs and symptoms of skin breakdown as indicated in residents plan of care and facility's policy and procedure (P&P) titled Suprapubic Catheter Care, Urinary. These failures had the potential to result in catheter-related complications for Residents 33 and 132. Findings: a. During a review of Resident 132's admission Record (AR), the AR indicated Resident 132 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (a type of ischemic stroke caused by a blockage in blood vessels supplying the brain), diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension (HTN - high blood pressure). During a review of Resident 132's Order Summary Report (OSR) dated 1/5/2026, the OSR indicated Resident 132 had an order for indwelling foley catheter connect to straight drainage for neurogenic bladder (inability to control urination). During a review of Resident 132's untitled Care Plan (CP) dated 1/5/2026, the CP indicated Resident 132 had a foley catheter. The CP goal indicated Resident 132 remained free from catheter- related trauma. During a review of Resident 132's Minimum Data Set (MDS - a resident assessment tool) dated 1/10/2026, the MDS indicated Resident 132 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 132 required substantial/maximal assistance (helper did more than half the effort) with eating and dependent (helper did all the effort) with oral hygiene, toileting, shower, upper and lower body dressing. The MDS indicated Resident 132 had an indwelling catheter (a catheter inserted into the bladder to drain urine). During a concurrent observation and interview on 1/13/2026 at 9:26 am with the Infection Prevention Nurse (IPN) inside Resident 132's room, Resident 132 was lying in bed with a foley catheter. The IPN stated the foley catheter was not secured to Resident 132's thigh. The IPN stated foley catheter tubing should be secured on the resident's thigh to prevent accidental pulling during bed mobility and cause trauma and injury to the resident. During an interview on 1/15/2026 at 4:08 pm with the Assistant Director of Nursing (ADON), the ADON stated foley catheter should be kept secured on the resident's thigh to prevent dislodgement, irritation and injury at the insertion site. During a review of the facility's Policy and Procedure (P&P) titled, Catheter Care, Urinary, revised September 2024, the P&P indicated, Ensure that the catheter remains secured with a leg strap/stabilization device to reduce friction and movement at the insertion site. Catheter tubing (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should be strapped to the resident's inner thigh. b. During a review of Resident 33's AR, the AR indicated Resident 33 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including neuromuscular dysfunction of the bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems) and heart failure (condition when the heart is unable to pump sufficiently to maintain blood flow to meet the body's needs). During a review of Resident 33's OSR dated 1/14/2025, the OSR indicated for licensed staff to irrigate the suprapubic catheter size 18 with distilled water every day shift, for suprapubic catheter treatment related to neuromuscular dysfunction of the bladder. During a review of Resident 33's OSR dated 1/14/2025, the OSR indicated for licensed staff to cleanse suprapubic catheter site with NS, pat dry and apply T-Drain dressing secure with paper tape one time a day. During a review of Resident 33's CP titled Alteration in Bowel and Bladder as manifested by presence of suprapubic catheter due to Neurogenic Bladder and Bowel incontinence, revised 9/12/2025, the CP indicated for nursing staff to monitor Resident 33 for signs and symptoms of skin breakdown. During a review of Resident 33's MDS dated [DATE], the MDS indicated Resident 33 had intact cognition. The MDS indicated Resident 33 required partial/moderate assistance (helper did less than half the effort) with shower, lower body dressing and putting on/taking off footwear. During a concurrent observation inside Resident 33's room and interview on 1/13/2026 at 9:50 am with the Assistant Director of Nursing (ADON), Resident 33 was in bed with suprapubic catheter in placed. The suprapubic catheter site had scattered redness around the area. The ADON stated, there were scattered redness on Resident 33's abdomen. During an interview in 1/14/2026 at 9:38 am with the facility's Treatment Nurse (TN), the TN stated there was an excoriation (loss of skin surface) around the suprapubic catheter site on the abdominal area of Resident 33. The TN stated signs and symptoms of infection and skin breakdown should have been monitored by the TN. The TN stated residents with suprapubic catheter were at high risk for skin irritation. During an interview on 1/16/2025 at 10:56 am with the facility's Director of Nursing (DON), the DON stated residents with suprapubic catheters were at high risk for skin breakdown. The DON stated the suprapubic catheter site, and skin should have been monitored every shift for any changes such as redness, drainage and temperature to prevent infection and skin breakdown. During a review of the facility's P&P titled, Suprapubic Catheter Care, Urinary, revised 10/2020, the P&P indicated, The purpose of this procedure is to prevent skin irritation around the stoma site and to prevent infection of the resident's urinary tract. The following information should be recorded in the resident's medical record: Results of skin assessment around the stoma site. Notify the physician of any abnormalities in the skin assessment or the character of urine.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **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 residents receiving oxygen therapy (treatment that provides supplemental, or extra oxygen) in accordance with professional standards of practice for five of the five sampled residents (Residents 33, 68, 76, 131 and 117) by failing to: a. Ensure Resident 33's nasal cannula tubing (flexible plastic tubing used to deliver oxygen through the nostrils and the tubing is fitted over the patient's ears) was stored appropriately when not in use, there was a physician's order for the use of oxygen at two liters per minute through nasal cannula and there was a cautionary sign posted on Resident 33's door indicating oxygen was in use. b. Ensure Resident 68's inhalation tubing set was dated, stored appropriately when not in use and Resident 68 had a care plan developed for the use of breathing treatment. c. Place an Oxygen in Use sign on the outside of the room entrance door of Resident 76. d. Ensure the respiratory tubing and mask used for breathing treatment for Resident 131 was labeled and changed. e. Place an Oxygen in Use sign on the outside of the room entrance door and in the room while Resident 117 had ongoing oxygen therapy. These failures placed the residents at risk of complications related to the use of oxygen. Findings: a. During a review of Resident 33's admission Record (AR), the AR indicated Resident 33 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including neuromuscular dysfunction of the bladder (lack of bladder control) and heart failure (condition when the heart is unable to pump sufficiently to maintain blood flow to meet the body's needs). During a review of Resident 33's Minimum Data Set (MDS, a resident assessment tool) dated 11/15/2025, the MDS indicated Resident 33 had intact cognition (ability to understand and process information). The MDS indicated Resident 33 required partial/moderate assistance (helper did less than half the effort) with shower, lower body dressing and putting on/taking off footwear. During a concurrent observation and interview on 1/13/2026 at 9:48 am, together with the Assistant Director of Nursing (ADON), Resident 33 was lying in bed, asleep with ongoing oxygen at 2 liters per minute (LPM) via nasal cannula. The ADON stated Resident 33's nasal cannula tubing dated 12/29/2025 was hanging on the left side rail of the bed and a plastic bag dated 12/29/2025 was hanging on the oxygen concentrator. The ADON stated Resident 33 was able to remove Resident 33's oxygen and hang the cannula on the bed rails. During a concurrent observation and interview on 1/13/2026 at 9:51 am, together with the ADON, the ADON stated oxygen nasal cannula tubing and bag needed to be changed every Sunday of the week for infection control and once the nasal cannula tubing was not in use, it should be placed inside the plastic bag to prevent contamination of the nasal cannula tubing. The ADON stated there was no cautionary sign (Oxygen in Use) posted outside Resident 33's room indicating oxygen was currently in use and/or smoking was prohibited. The ADON stated there should be an oxygen sign to remind staff, residents and visitors not to smoke inside the room to prevent fire and combustion (process of burning things). During a concurrent observation and interview on 1/14/2025 at 10:56 am, Resident 33 was awake lying in bed. Resident 33 stated I used it (referring to oxygen) sometimes, but I don't need it. During a concurrent interview and record review on 1/15/2026 at 1:32 pm with the ADON of Resident 33's medical records (PointClickCare - PCC, a cloud-based software), the ADON stated there was no (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician's (doctors) order for Resident 33's oxygen administration of 2 LPM via nasal cannula. The ADON stated there should be a doctor's order for oxygen administration use for Resident 33 to ensure Resident 33 received safe and accurate oxygen therapy. During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration, dated 12/2024, the P&P indicated, Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Nasal cannula, mask and humidifier bottle (when indicated) shall be labeled with date and replaced every 7 days or as needed. Oxygen tubing (cannula/mask) shall be stored in a designated plastic bag when not in use. Place an 'Oxygen in Use' sign on the outside of the room entrance door. b. During a review of Resident 68's AR, the AR indicated Resident 68 was admitted to the facility on [DATE] with diagnoses including fracture (a complete or partial break in a bone) of the right hip, right above the knee amputation (AKA - surgical removal of the portion of the leg above the knee), and history of falling (moving from a higher to a lower level, rapidly and without control). During a review of Resident 68's MDS dated [DATE], the MDS indicated Resident 68 had intact cognition. The MDS indicated Resident 68 required setup or clean-up assistance (helper sets up or cleans up; resident completes the activity) with eating, required partial/moderate assistance (helper did less than half the effort) with oral hygiene and dependent (helper did all the effort) with toileting, shower, upper and lower body dressing. During a review of Resident 68's Order Summary Report (OSR), dated 1/7/2026, the OSR indicated Resident 68 had an order for DuoNeb Solution (a medication used to treat respiratory conditions) via inhalation every six (6) hours for shortness of breath (SOB) for seven (7) days and every two (2) hours as needed for SOB or wheezing (a high-pitched sound made when breathing is restricted/obstructed in the lungs). During a concurrent observation and interview on 1/13/2026 at 10:30 am with Certified Nurse Assistant 1 (CNA 1) inside Resident 68's room, CNA 1 stated Resident 68 had an inhalation tubing set on top of the bedside table. CNA 1 stated the inhalation tubing set did not have a label when it was changed, and the tubing set was not being used. During a concurrent interview and record review on 1/13/2026 at 10:40 am with the Infection Prevention Nurse (IPN), Resident 68's OSR, dated 1/7/2026 and care plans were reviewed. The IPN stated Resident 68 had an order for inhalation breathing treatments. The IPN stated there was no care plan developed for Resident 68 on the use of inhalation breathing treatments. The IPN stated a care plan should be developed to ensure staff provided care and interventions specific for the resident. The IPN stated inhalation tubing sets were changed every week and labeled with the date it was changed and placed in a clear plastic bag intended for respiratory supplies when not in use for infection control. During an interview on 1/15/2026 at 4:02 pm with the Assistant Director of Nursing (ADON), the ADON stated oxygen and inhalation tubing sets should be labeled with the date it was changed. The ADON stated oxygen and inhalation tubing sets should be kept inside the clear plastic bag when not in use to keep it clean and prevent cross-contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another). The ADON stated care plan should be developed based on the residents' diagnosis, assessment, orders, treatment and medication to communicate among staff the interventions specific to the resident. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. During a review of Resident 76's AR, the AR indicated Resident 76 was admitted to the facility on [DATE] with diagnoses including fracture of the right arm, dementia (a progressive state of decline in mental abilities), and history of falling. During a review of Resident 76's MDS dated [DATE], the MDS indicated Resident 76 had severely impaired cognition. The MDS indicated Resident 76 required partial/moderate assistance with eating and substantial/maximal assistance (helper did more than half the effort) with oral hygiene, toileting, shower, upper and lower body dressing, and personal hygiene. During a review of Resident 76's OSR dated 1/7/2026, the OSR indicated Resident 76 had an order for oxygen at 2 liters (L)/minute (min) via nasal cannula as needed for shortness of breath. During a concurrent observation and interview on 1/13/2026 at 9:06 am with Licensed Vocational Nurse 1 (LVN 1) inside Resident 76's room, Resident 76 was in bed, lying on Resident 76's back with ongoing oxygen set at 2L/min. LVN 1 stated there was no precautionary sign posted outside Resident 76's room indicating oxygen was in use and smoking was prohibited. During an interview and record review on 1/13/2026 at 10:40 am with the IPN, Resident 76's OSR, dated 1/7/2026, was reviewed. The IPN stated Resident 76 had an order for oxygen at 2L/min through nasal cannula. The IPN stated residents on oxygen therapy should have a No smoking, Oxygen in Use sign posted outside the residents' room to remind residents and visitors not to smoke inside the room because oxygen was a fire hazard. During an interview on 1/15/2026 at 4:03 pm with the Assistant Director of Nursing (ADON), the ADON stated all residents on oxygen therapy should have a no smoking sign posted outside the residents' door to alert everybody not to smoke to avoid fire and for the safety of everybody in the facility. During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration, revised December 2024, the P&P indicated, Review the resident's care plan to assess any special needs of the resident. Oxygen tubing (cannula, mask) shall be stored in a designated plastic bag when not in use. Place an Oxygen in Use sign on the outside of the room entrance door. Place an Oxygen in Use sign in a designated place on or over the resident's bed. Instruct the resident, his/her family, visitors and roommate if any) of the oxygen safety precautions. d. During a review of Resident 117's AR, the AR indicated Resident 117 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (one-sided muscle weakness) after a stroke affecting the left side and hypertension (HTN-high blood pressure). During a review of Resident 117's Care Plan (CP) dated 11/30/2023, the CP indicated Resident 117 used a handheld nebulizer (HHN- device that converts liquid medication into a fine mist for inhalation directly into the lungs) related to the diagnosis of shortness of breath, congestion, and wheezing. The CP intervention/task included changing the HHN and putting it in a new bag weekly, initialing and dating the HHN and bag. During a review of Resident 117's OSR dated 11/6/2024, the OSR indicated Resident 117 had an active order for Ipratropium-Albuterol Solution (medication used to open airways and relax airway muscles to improve breathing) 0.5-2.5 (3) milligrams(mg)/milliliters (ml) to inhale orally every four hours as needed for shortness of breath, congestion, and wheezing via nebulizer. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 117's H&P dated 10/9/2025, the H&P indicated Resident 117 did not have the capacity to understand and make decisions with a fluctuating mental status. During a review of Resident 117's MDS dated [DATE], the MDS indicated Resident 117 had moderately impaired cognition. During a concurrent observation and interview on 1/13/2026 at 9:22 am with the Minimum Data Set Nurse (MDSN) in Resident 117's room, Resident 117's tubing and mask were connected to the nebulizer and were unlabeled on the nightstand in a bag that was dated 11/24/2025 with the resident's name and room number. The MDSN stated, the tubing and mask should be dated, the tubing and the bag should be changed every week and as needed to prevent the resident from developing any infection. The MDSN stated Resident 117 had a cough and was currently getting nebulizer treatments. During an interview on 1/16/2026 at 10:47 am with the Assistant Director of Nursing (ADON), the ADON stated the tubing and mask used for breathing treatment needed to be changed once a week and as needed if contaminated or dirty, it will be changed sooner. The ADON stated the CP interventions should be followed and if it was not done, it would place the resident at risk of getting an infection. During a review of the facility's policy and procedure (P&P) titled, Cleaning, Changing and Disinfection of Resident-Care Items and Equipment, last revised October 2018, the P&P indicated, resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected or changed according to current Centers for Disease Control and Prevention (CDC-national public health agency of the United States) recommendations for disinfection and the Occupational Safety and Health Administration (OSHA-government agency of the United States that ensures safe and healthy working conditions) Bloodborne Pathogens Standard. The P&P indicated, oxygen tubing, nebulizer tubing and mask are replaced once a week or as needed. e. During a review of Resident 131's AR, the AR indicated Resident 131 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including pneumonia (an infection [when germs entered the body and caused illness] in the lungs) and respiratory failure with hypoxia (lungs could not get enough oxygen into the blood). During a review of Resident 131's Physician Order (PO), dated 1/8/2026, the PO indicated oxygen at three liters (L, a unit for measuring the volume of a liquid) per minute (LPM) via nasal cannula continuously every shift for pneumonia. During a review of Resident 131's Physician Progress Note (PPN) dated 1/9/2026, the PPN indicated Resident 131 required supplemental oxygen for respiratory failure with hypoxia. During a review of Resident 131's MDS dated [DATE], the MDS indicated Resident 131 had intact cognition. The MDS indicated Resident 131 was independent with eating. The MDS indicated Resident 131 required moderate assistance (helper did less than half the effort) from staff with oral hygiene, toileting hygiene, showering/bathing, and bed-to-chair transferring. The MDS further indicated Resident 131 was on continuous oxygen. During a review of Resident 131's Medication Administration Record (MAR) for 1/2026, the MAR indicated Resident 131 received oxygen at three LPM via NC continuously every shift from 1/8/2026 evening shift to 1/13/2026 morning shift. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 1/13/2026 at 10:59 AM in Resident 131's room, Resident 131 was receiving oxygen at three LMP via NC. A non-in-used oxygen tank was observed in Resident 131's room. There was no Oxygen in Use sign observed in the room. There was no Oxygen in Use sign on the room entrance door. During an observation 1/13/2026 at 12:51 PM outside Resident 131's room, there was no Oxygen in Use sign on the room entrance door. Resident 131 was observed sitting on a wheelchair with oxygen concentrator (a machine that took in air and gave extra oxygen to the resident) at bedside. A non-in-used oxygen tank was observed in Resident 131's room. There was no Oxygen in Use sign observed in the room. During a concurrent interview and pictures review with Treatment Nurse 1 (TN 1) on 1/15/2026 at 2:03 PM, the pictures dated 1/13/2026 at 10:59 AM and 12:52 PM were reviewed. The pictures indicated there was no Oxygen in Use sign outside Resident 131's room where the oxygen concentrator and oxygen tank were stored. The TN stated it was important to have the Oxygen in Use sign outside the room because of explosion risks. TN 1 stated the licensed nurse should put up the Oxygen in Use sign for everyone's safety. During an interview with the Director of Nursing (DON) on 1/16/2026 at 11:11 AM, the DON stated there should have a Oxygen in Use sign outside the door where the oxygen concentrator and oxygen tank were stored, even though the oxygen was not in used. The DON stated the Oxygen in Use sign alerted everyone not to light cigarette or smoke in the room for safety. The DON stated the Oxygen in Use sign should have been posted outside the room as soon as the oxygen was in the room. During a review of facility's P&P titled, Oxygen Administration, revised on 12/2024, the P&P indicated staff were to provide safe oxygen administration. The P&P indicated staff were to place an Oxygen in Use sign on the outside of the room entrance door and in a designated place on or over the resident's bed.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to attempt the use of appropriate alternatives to bedrails (a bar that runs along the side of a bed) or siderails (adjustable metal or rigid plastic bars attached to bed) and did not meet the residents' needs before its installation for two of two sampled residents (Residents 76 and 94). These failures placed Residents 76 and 94 at risk for entrapment (an event in which residents were caught, trapped, or entangled in the tight spaces around the bed) and injury from the use of bedrails or side rails. Findings: a. During a review of Resident 76's admission Record (AR), the AR indicated Resident 76 was admitted to the facility on [DATE] with diagnoses including fracture (a complete or partial break in a bone) of right arm, dementia (a progressive state of decline in mental abilities) , and history of falling (moving from a higher to a lower level, rapidly and without control). During a review of Resident 76's Minimum Data Set (MDS, a resident assessment tool) dated 12/23/2025, the MDS indicated Resident 76 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 76 required partial/moderate assistance (helper did less than half the effort) with eating and substantial/maximal assistance (helper did more than half the effort) with oral hygiene, toileting, shower, upper and lower body dressing, and personal hygiene. During a review of Resident 76's Order Summary Report (OSR), dated 12/25/2025, the OSR indicated Resident 76 had an order for bilateral (both sides) 1/4 partial side rails up to use as mobility aid to improve functional ability when in bed every shift. During a concurrent observation and interview on 1/13/2026 at 9:06 am with Licensed Vocational Nurse 1 (LVN 1) inside Resident 76's room, Resident 76 was in bed, lying on Resident 76's back, with 1/4 siderails up on both sides of the bed. LVN 1 stated Resident 76 had a fracture from a fall and was wearing a sling on the right shoulder. LVN 1 stated Resident 76 could not hold on to the side rails using Resident 76's right arm. During a concurrent interview and record review on 1/14/2026 at 11:07 am with the Infection Prevention Nurse (IPN), Resident 76's medical record (chart) and initial siderail use assessment dated [DATE] were reviewed. The IPN stated there was no record and documentation indicating appropriate alternatives were attempted and did not meet Resident 76's needs prior to the application of bilateral 1/4 siderails. The IPN stated the use of less invasive appropriate alternatives should have been attempted first and did not meet the need of the resident prior to the installation of side rails to prevent injury to Resident 76. b. During a review of Resident 94's AR, the AR indicated Resident 94 was admitted to the facility on [DATE] with diagnoses including epilepsy (a chronic brain disorder causing recurring seizures due to abnormal electrical activity in nerve cells), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and history of falling. During a review of Resident 94's OSR, dated 11/24/2025, the OSR indicated Resident 94 had an order for bilateral 1/4 partial side rails up to aid in functional ability when in bed every shift. During a review of Resident 94's MDS dated [DATE], the MDS indicated Resident 94 had severely impaired cognition. The MDS indicated Resident 94 required partial/moderate assistance with eating, oral hygiene and upper body dressing and dependent (helper did all the effort) with toileting, shower, and personal hygiene. During a concurrent observation and interview on 1/13/2026 at 9:14 am with Certified Nurse Assistant 3 (CNA 3) inside Resident 94's room, Resident 94 was in bed, lying on Resident 94's back, with 1/4 siderails up on both sides of the bed. CNA 3 stated Resident 94 was confused. During a concurrent interview and record review on 1/14/2026 at 11:17 am with the Infection Prevention Nurse (IPN), Resident 94's chart and initial siderail use assessment dated [DATE] were reviewed. The IPN stated there was no record and documentation indicating appropriate alternatives were attempted and did not meet Resident 94's needs prior to the application of bilateral 1/4 siderails. The IPN stated the use of less invasive (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	appropriate alternatives should have been attempted first and did not meet the needs of the resident prior to the installation of side rails to prevent injury to Resident 94. During an interview on 1/15/2026 at 4:04 pm with the Assistant Director of Nursing (ADON), the ADON stated, least restrictive appropriate alternatives should have been attempted and did not meet the residents' needs prior to the installation and use of side rails to prevent risk of entrapment and injury to Residents 76 and 94. During a review of the facility's Policy and Procedure (P&P) titled, Bed Rails, Bed Safety, revised February 2020, the P&P indicated, Siderails may be used if assessment and consultation with the Attending Physician has determined that they are needed to help manage a medical symptom or condition, or help the resident reposition or move in bed and transfer, and no other reasonable alternatives can be identified.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 safe and sanitary food preparation for one of one facility kitchen. This deficient practice has the potential to result in pathogen (germ) exposure to residents and places them at risk for developing foodborne illness. Findings: During an observation in the kitchen in the presence of the Director of Nutritional Service (DNS) on 1/14/2026 at 11:30 AM, the following were observed: 1. DA 2 did not wear gloves when DA 2 was preparing residents' beverages. 2. DA 2 did not wash hands or wear gloves before pouring the prune juice into the residents' beverage cups after walking to the dry storage area for a new carton of prune juice. 3. DA 2 did not wash hands or wear gloves after touching the refrigerator door and before covering the residents' beverage cups with plastic food wrap. During an interview with DA 2 on 1/14/2026 at 11:35 AM, DA 2 stated DA 2 should wear gloves while handling residents' food for infection control. DA 2 stated it was important to wear gloves to keep food and kitchen clean and prevent food borne illnesses. DA 2 stated beverages such as milk and prune juice were ready-to-drink. DA 2 stated DA 2 should change glove if DA 2 touched a different surface. During an interview with the DNS on 1/14/2026 at 11:36 AM, the DNS stated dietary staff should wear gloves when handling ready-to-eat items. During a concurrent record review and interview with the Infection Prevention Nurse (IPN) on 1/15/2026 at 3:31 PM, the facility's Policy and Procedure (P&P) titled Glove Use Policy dated 2023 was reviewed. The IPN stated the facility P&P indicated staff should wear disposable gloves when preparing and serving any ready-to-eat food. The IPN stated kitchen staff should wear gloves when preparing food and drinks in accordance with the facility P&P. The IPN stated DA 2's hands were considered not clean after touching the prune juice carton and the refrigerator. The IPN stated kitchen staff should wear gloves to prevent food borne illnesses.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility licensed nurses failed to document the intravenous (IV, directly into a vein) antibiotic (a medicine that killed bacteria) medication administrations on the Medication Administrative Record (MAR) for two of two sampled residents (Residents 42 and 48). These deficient practices had the potential to result in lack of communication between staff and delay and interruption of care needed to maintain the residents' highest practicable, physical, mental, and psychosocial well-being. Findings: a. During a review of Resident 42's admission Record (AR), the AR indicated Resident 42 was admitted to the facility on [DATE] with diagnoses including sepsis (a life-threatening blood infection [when germs entered the body and caused illness]) and bacteremia (the presence of bacteria in the blood). During a review of Resident 42's History and Physical (H&P) dated 12/25/2025, the H&P indicated Resident 42 could not make decisions. During a review of Resident 42's untitled Care Plan (CP) for bacteremia revised on 12/25/2025, the CP indicated for licensed nursing staff to administer antibiotic medication as ordered. During a review of Resident 42's Minimum Data Set (MDS, a resident assessment tool) dated 12/29/2025, the MDS indicated Resident 42 had moderate cognitive (ability to understand) impairment. The MDS indicated Resident 42 was independent with eating. The MDS indicated Resident 42 required setup assistance from staff with oral hygiene. The MDS indicated Resident 42 required moderate assistance (helper did less than half the effort) from staff with toileting hygiene, showering/ bathing, and bed-to-chair transfer. During a review of Resident 42's Order Summary Report (OSR) with active orders as of 12/30/2025, the OSR indicated a physician's order (PO) for licensed staff to administer IV ampicillin (antibiotic medication) every six hours for bacteremia, starting on 12/24/2025. During a concurrent record review and interview with Registered Nurse 1 (RN1) on 1/15/2025 at 10:52 AM, Resident 42's MAR for 12/2025 was reviewed. The MAR indicated Resident 42 received 21 out of 23 doses of the IV ampicillin from 12/25/2025 to 12/30/2025. RN 1 stated the MAR did not indicate the IV ampicillin administrations were documented at 6 AM on 12/28/2025 and 12/30/2025. RN 1 stated the RN should document the IV medication administration on the MAR. RN 1 stated it was important to document to prove the action was done. During a concurrent record review and interview with RN 1 on 1/15/2025 at 10:52 AM, Resident 42's Nursing Progress Notes (NPN) dated 12/27/2025 to 12/30/2025 were reviewed. RN 1 stated there were no IV ampicillin administrations documented in the NPN at 6AM for Resident 42 on 12/28/2025 and 12/30/2025. b. During a review of Resident 48's AR, the AR indicated Resident 48 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including osteomyelitis (an infection in a bone). During a review of Resident 48's MDS dated [DATE], the MDS indicated Resident 48 had intact cognition. The MDS indicated Resident 48 required setup assistance from staff for eating. The MDS indicated Resident 48 required moderate assistance from staff for oral hygiene and personal hygiene. The MDS indicated Resident 48 was dependent (helper did all the effort) on staff with toileting hygiene, showering/bathing, and bed-to-chair transferring. During a review of Resident 48's H&P dated 1/7/2026, the H&P indicated Resident 48 had the capacity to understand and make decisions. During a review of Resident 48's untitled CP for potential for complications due to IV antibiotics for osteomyelitis, revised on 1/13/2026, the CP indicated for licensed nursing staff to administer medication as ordered and document the progress of the therapy. During a review of Resident 48's OSR with active orders as of 1/15/2026, the OSR indicated a physician's order for licensed staff to administer IV piperacillin sod-tazobactam (antibiotic medication) every six hours for osteomyelitis, starting on 1/7/2026. During a concurrent record review and interview with RN 1 on 1/15/2025 at 10:52 AM, Resident 48's MAR for 1/2026 was reviewed. The MAR indicated Resident 48 received 31 out of 32 doses of the IV piperacillin sod-tazobactam from 1/7/2026 to 1/15/2026. RN 1 stated the MAR did not indicate the IV piperacillin (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	sod-tazobactam administration was documented at 5 AM on 1/13/2026. RN 1 stated the nurse might have forgotten to sign the MAR. During a concurrent record review and interview with RN 1 on 1/15/2025 at 10:52 AM, Resident 48's NPN dated 1/13/2026 was reviewed. RN 1 stated there was no IV piperacillin sod-tazobactam administration documented in the NPN on 1/13/2026 at 5 AM. During an interview with the Assistant Director of Nursing (ADON) on 1/16/2026 at 10:01 AM, the ADON stated the licensed nurse should have documented on the MAR after the medication administration to prove it was done. The ADON stated the risk was that the nurse could give an extra dose or the resident could miss a dose. The ADON stated this could affect the effectiveness of the medication. During an interview with the Director of Nursing (DON) on 1/16/2026 at 11:10 AM, the DON stated the licensed nurse should ensure the MAR was completed before leaving the facility. During a review of the facility's policy and procedure (P&P) titled Administering Medication, revised 1/2024, the P&P indicated the individual administering the medication should initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones. The P&P further indicated that the individual administering the medication should records in the resident's medical record the following:a. The date and time the medication was administered.b. The dosage.c. The route of administration.d. The injection site (if applicable).e. Any complaints or symptoms for which the drug was administered.f. Any results achieved and when those results were observed.g. The signature and title of the person administering the drug.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 and follow infection prevention procedures to prevent the transmission of infectious organisms for two of five sampled residents (Residents 33 and 132) by failing to: a. Wear required personal protective equipment (PPE, equipment that protects people from injury or illness) while providing care to Resident 33 who was placed on Enhanced Barrier Precaution (EBP, precautions that involve using a glove and gown during high-contact resident care activity for residents who are colonized or infected with an multidrug-resistant organisms [MDRO, bacteria that is resistant to many types of antibiotics] and those at a higher risk of developing a MDRO, such as, residents with wounds or indwelling medical devices). b. Ensure an EBP signage was posted outside the room of Resident 132 with foley catheter (FC, a common type of indwelling catheter, a soft, plastic or rubber tube that is inserted into the bladder to drain urine). These deficient practices had the potential to transmit infectious microorganisms and increase the risk of infection for Residents 33 and 132 and staff that could result in a widespread infection in the facility. Findings: a. During a review of Resident 33's AR, the AR indicated Resident 33 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including neuromuscular dysfunction of the bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems) and heart failure (condition when the heart is unable to pump sufficiently to maintain blood flow to meet the body's needs). During a review of Resident 33's Order Summary Report (OSR) dated 5/30/2025, the OSR indicated to place Resident 33 on EBP due to presence of foley catheter (thin, sterile tube inserted into the bladder to drain urine). During a review of Resident 33's Care Plan (CP) titled Enhanced Barrier Precautions initiated on 10/14/2025, the CP indicated Resident 33 had an indwelling catheter (foley catheter). The CP indicated for nursing staff to initiate EBP and staff will perform hand hygiene, wear PPE (gown and gloves) before and after high contact care activities. During a review of Resident 33's Minimum Data Set (MDS, a resident assessment tool) dated 11/15/2025, the MDS indicated Resident 33 had intact cognition (ability to understand and process information). The MDS indicated Resident 33 required partial/moderate assistance (helper did less than half the effort) with shower, lower body dressing and putting on/taking off footwear. During an observation on 1/13/2026 at 9:48 am, Resident 33 was asleep lying in bed in Resident 33's room. During an observation on 1/13/2026 at 9:50 am, Resident 33 was lying in bed. Assistant Director of Nursing (ADON) did not wear gown and clothes while touching Resident 33's bed and bedding while assessing Resident 33's suprapubic catheter (a soft tube inserted directly into the bladder through a small incision in the lower belly [just above the pubic bone] to drain urine into a bag) site. During an interview on 1/13/2026 at 9:59 am, the ADON stated I forgot to wear a gown. The ADON stated protective gown should have been worn to prevent the spread of infection to the residents. During an interview on 1/14/2026 at 11:36 am with the Infection Preventionist Nurse (IPN, a (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	healthcare professional who specializes in preventing the spread of infections in healthcare settings), the IPN stated staff needed to wear gown, gloves and mask prior to touching Resident 33 who was on EBP to avoid the spread of infection from staff to other residents. The IPN stated staff needed to wear required PPE because residents (in general) were high risk for infection especially with indwelling devices. During an interview on 1/16/2026 at 10:56 am with the Director of Nursing (DON), the DON stated staff should wear proper PPE such as gown and gloves before touching a resident with indwelling device such as a catheter to protect the residents and to prevent the spread of infection. During a review of the facility's Policy and Procedure (P&P) titled, Standard Precautions, Enhanced Barrier Precautions and Transmission Based Precautions, revised 5/20/2025, the P&P indicated, EBP &ndash; primarily is the use of gowns and gloves for specific high contact care activities based on the residents characteristics that are associated with a high risk if MDRO colonization and transmission. Presence of indwelling medical devices (e.g., urinary catheter, feeding tube . Gowns and gloves will be used while performing the following high-contact tasks associated with the greatest risk for MDRO contamination of health care personnel hands, clothes and the environment: device care, for example urinary catheter, feeding tube and other indwelling devices. b. During a review of Resident 132's admission Record (AR), the AR indicated Resident 132 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (a type of ischemic stroke caused by a blockage in blood vessels supplying the brain), diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension (HTN - high blood pressure). During a review of Resident 132's Order Summary Report (OSR) dated 1/5/2026, the OSR indicated Resident 132 had an order for indwelling foley catheter connect to straight drainage for neurogenic bladder (inability to control urination). During a review of Resident 132's Minimum Data Set (MDS - a resident assessment tool) dated 1/10/2026, the MDS indicated Resident 132 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 132 required substantial/maximal assistance (helper did more than half the effort) with eating and dependent (helper did all the effort) with oral hygiene, toileting, shower, upper and lower body dressing. The MDS indicated Resident 132 had an indwelling catheter (a catheter inserted into the bladder to drain urine). During a concurrent observation and interview on 1/13/2026 at 9:26 am with the IPN inside Resident 132's room, Resident 132 was lying in bed with a foley catheter. The IPN stated there was no EBP signage posted outside Resident 132's room. The IPN stated all residents with indwelling medical devices like FC were at high risk for infection and should be placed on EBP. During an interview on 1/15/2026 at 4:08 pm with the Assistant Director of Nursing (ADON), the ADON stated all residents with indwelling medical devices should have a signage posted outside the resident's room to alert the staff to wear recommended PPE to prevent infection and cross contamination. During a review of the facility's Policy and Procedure (P&P) titled, Standard Precautions, Enhanced Barrier Precautions and Transmission Based Precautions, revised 5/20/2025, the P&P indicated, EBP &ndash; primarily is the use of gowns and gloves for specific high contact care activities based on the (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents characteristics that are associated with a high risk if MDRO colonization and transmission. Presence of indwelling medical devices (e.g., urinary catheter, feeding tube . Gowns and gloves will be used while performing the following high-contact tasks associated with the greatest risk for MDRO contamination of health care personnel hands, clothes and the environment: device care, for example urinary catheter, feeding tube and other indwelling devices.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to ensure the kitchen dry storage area was free of fruit flies on 1/13/2026 and 1/14/2026 for one of one kitchen dry storage area. This deficient practice had the potential to result in pathogen (germ) exposure to residents and placed the residents at risk for developing foodborne illnesses. Findings: During initial observation of the facility kitchen and interview with Dietary Aide 1 (DA1) on 1/13/2026 at 10:49 AM, in the kitchen dry storage area, multiple fruit flies were observed flying around the open banana and white onion storage containers. DA 1 stated it was not acceptable to have fruit flies in the kitchen for infection control. DA 1 stated fruit flies could lay eggs on food. DA 1 stated everyone in the kitchen was responsible for keeping the area clean. During a concurrent observation and interview with the Director of Nutritional Services (DNS) on 1/14/2026 at 11:35 AM, in the kitchen dry storage area, multiple fruit flies were observed flying around the closed banana and white onion storage containers. The DNS stated it was not acceptable to have fruit flies in the kitchen because they were insects and pests and could contaminate the food. During a concurrent record review and interview with the Infection Prevention Nurse (IPN) on 1/15/2026 at 3:31 PM, the facility's Policy and Procedure (P&P) titled Pest Control for Fruit Flies, dated 5/2020 was reviewed. The facility P&P indicated The facility maintains an on-going pest control program to ensure that the building is kept free of insects. The IPN stated the facility should be free of pests and insects. The IPN stated the fruit flies could land on food and transmit germs to the food. The IPN stated it would place the residents at risk of infections with signs and symptoms of diarrhea and abdominal pain.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement its policy and procedure (P&P) on Informed Consent for Physical Restraint, for the use of bed pad alarm (a pad with sensors that will alarm when a resident stands up unassisted to help prevent falls by alerting staff) for one of one sampled resident (Resident 76). This failure violated Resident 76's rights and placed Resident 76 at risk for psychological distress from hearing the alarm sound. Findings: During a review of Resident 76's admission Record (AR), the AR indicated Resident 76 was admitted to the facility on [DATE] with diagnoses including fracture (a complete or partial break in a bone) of right arm, dementia (a progressive state of decline in mental abilities) , and history of falling (moving from a higher to a lower level, rapidly and without control). During a review of Resident 76's Order Summary Report (OSR) dated 12/18/2025, the OSR indicated Resident 76 had an order for bed alarm. During a review of Resident 76's Minimum Data Set (MDS, a resident assessment tool) dated 12/23/2025, the MDS indicated Resident 76 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 76 required partial/moderate assistance (helper did less than half the effort) with eating and substantial/maximal assistance (helper did more than half the effort) with oral hygiene, toileting, shower, upper and lower body dressing, and personal hygiene. During a concurrent observation and interview on 1/13/2026 at 9:06 am with Licensed Vocational Nurse 1 (LVN 1) inside Resident 76's room, Resident 76 was in bed, lying on Resident 76's back with pad alarm on the bed. LVN 1 stated Resident 76 had a history of falling. During a concurrent interview and record review on 1/14/2026 at 1:47 pm with Infection Prevention Nurse (IPN), Resident 76's medical record (chart) and electronic health record (EHR) were reviewed. The IPN stated there was no record and documentation indicating Resident 76 or Resident 76's family member or responsible party signed a consent prior to the application of bed pad alarm. The IPN stated a consent should be obtained to ensure the resident or the resident's responsible party was informed and the purpose of the use of bed pad alarm was explained for the safety of the resident. During the interview on 1/15/2026 at 4:06 pm with the Assistant Director of Nursing (ADON), the ADON stated bed pad alarm was a mobility alarm that could restrict the residents' mobility while in bed, the alarm sound could cause anxiety and should be consented before its application. During a review of the facility's policy and procedures (P&P) titled, Use of Physical Restraints, revised August 2024, the P&P indicated, Mobility alarms may be considered as physical restraints if typical ability is restricted such as: alarm sound may prevent the resident from changing positions, stand/walk, staff giving reminders not to move/ambulate without assistance. During a review of the facility's P&P titled, Informed Consent for Physical Restraint, revised September 2025, the P&P indicated, Physical restraint/device will be applied after informed consent is obtained by the physician/licensed practitioner and verified by a licensed nurse.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Advance Directive (AD, a written instruction, recognized under State law relating to the provision of health care when the individual is incapacitated [lacking the ability to meet essential requirements for physical health, safety, or self-care]) for one of eight sampled residents (Resident 10) was readily accessible in accordance with the facility's Policy and Procedure (P&P) titled Advance Healthcare Directives/POLST. This failure had the potential for facility staff to provide medical treatment and services against Resident 10's will. Findings: During a review of Resident 10's admission Record (AR), the AR indicated Resident 10 was admitted to the facility on [DATE] with diagnoses including 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), dysphagia (difficulty in swallowing) and encounter for attention to gastrostomy (GT creation of an artificial external opening into the stomach for nutritional support). During a review of Resident 10's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 12/23/2025, the MDS indicated Resident 10 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 10 was dependent (helper does all of the effort) from staff for oral hygiene, toileting hygiene, shower, upper/lower body dressing, putting on/taking off footwear and personal hygiene. During an interview and concurrent record review on 1/14/2026 at 9:55 am, with the Infection Prevention Nurse (IPN) of Resident 10's medical records (chart and PointClickCare [PCC, a cloud-based software]), the IPN stated there was no AD in Resident 10's chart and PCC. The IPN stated the IPN could not find the existing AD of Resident 10 in the chart nor PCC. The IPN stated, Resident 10's AD needed to be accessible in the chart or PCC for staff to identify the resident's medical wants and wishes in case of an emergency or change of condition. During an interview and record review on 1/14/2026 at 10:01 am with the Social Service Director (SSD), SSD stated, there was no AD completed upon admission for Resident 10. The SSD stated, Resident 10's AD should be accessible in residents' chart or PCC to determine the resident's wishes in case of an emergency. During an interview on 1/16/2026 at 10:44 am, with the facility's Director of Nursing (DON), the DON stated, the resident's AD needed to be readily accessible by staff in Resident 10's chart or PCC in case of emergency. The DON stated, AD was a legal document and indicated the resident's medical wishes and wants. During a review of the facility's P&P titled, Advance Healthcare Directives/POLST revised 12/2019, the P&P indicated At the time of admission, admission Staff or designee will inquire about the existence of a Advance Healthcare Directive. A copy of the Advance Healthcare Directive is maintained as part of the resident's medical record.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to revise a plan of care for one of one sampled resident (Resident 96), as indicated in the facility's policy Care Plans, Comprehensive Person-Centered. This deficient practice had the potential for Resident 96 to not receive appropriate care, treatment and/or services. Findings: During a review of Resident 96's admission Record (AR), the AR indicated Resident 96 was admitted to the facility on [DATE] with diagnoses including urinary tract infection (UTI- infection that affects part of the urinary tract), malignant neoplasm (group of diseases involving abnormal cell growth with the potential to invade or spread to other parts of the body) of the prostate, and acute kidney failure (a sudden decline in kidney function). During a review of Resident 96's untitled Care Plan (CP) initiated on 12/6/2025, the CP indicated Resident 96 required contact isolation precautions related to Extended Spectrum Beta-Lactamase (ESBL- bacteria that is not easily killed by antibiotics) UTI. The CP indicated for nursing staff to explain to the resident the reasons for the isolation precaution and techniques, and implement appropriate isolation techniques by staff, resident and visitors. During a review of Resident 96's Minimum Data Set (MDS, a resident assessment tool) dated 12/10/2025, the MDS indicated Resident 96 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 96 was dependent (helper does all of the effort) with oral hygiene, toileting, shower, upper and lower body dressing and putting on/taking off footwear. During an observation on 1/13/2026 at 9:26 am, Resident 96 was awake, lying in bed in Resident 96's room. During an interview and concurrent record review on 1/13/2026 at 2:01pm, with the Infection Prevention Nurse (IPN- a healthcare professional who specializes in preventing the spread of infections in healthcare settings), of Resident 96's medical records (PointClickCare - PCC, a cloud-based software), the IPN stated Resident 96 was no longer on contact isolation for ESBL of the urine. The IPN stated contact isolation for Resident 96 was discontinued 10 days after Resident 96 started the antibiotics and Resident 96 did not show any signs and symptoms of infection. The IPN stated Resident 96's care plan for contact isolation needed to be revised to be specific to the resident's care and treatment. During an interview on 1/16/2025 at 10:52 am, with the facility's Director of Nursing (DON), the DON stated the resident's care plan needed to be revised or updated to determine appropriate care and treatment currently needed by the resident. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 3/2024, the P&P indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: request revisions to the plan of care.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 ensure policies and procedures (P&P) on Smoking were implemented for one of one sampled resident (Resident 95) when Resident 95 did not receive direct supervision and was not offered a smoking apron during smoking break. This failure had the potential to place Resident 95 at risk for burns and accidents during smoking break. Findings: During a review of Resident 95's admission Record (AR), the AR indicated Resident 95 was admitted to the facility on [DATE] with diagnoses including blindness in both eyes, psychosis (a severe mental condition in which thought, and emotions are affected that contact is lost with reality), schizophrenia (a mental illness that is characterized by disturbances in thought), parkinsonism (disease that affects the nerve cells in the brain that produces symptoms that include muscle rigidity, tremors, and changes in speech and gait), and a need for assistance with personal care. During a review of Resident 95's History & Physical (H&P) dated 12/8/2025, the H&P indicated Resident 95 had the capacity to understand and make decisions. During a review of Resident 95's Minimum Data Set (MDS, a resident assessment tool) dated 12/11/2025, the MDS indicated Resident 95 had moderately impaired cognition (ability to understand). The MDS indicated Resident 95 needed substantial/maximal assistance (helper does more than half the effort) while eating (ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident) and used tobacco. During a review of Resident 95's Smoking Assessment (SA) dated 12/15/2025, the SA recommendations indicated Resident 95 needed supervision while smoking and measures were required (such as smoking apron, cigarette extension). During an observation on 1/15/2026 at 2:08 pm, Resident 95 was not wearing a smoking apron and was seated in a wheelchair with his back to the doors, smoking a cigarette outside of the facility. The Activities Assistant (AA) was sitting inside the double doors of the facility looking downward at a phone. During an interview on 1/15/2026 at 2:50 pm with the AA, the AA stated Resident 95 was partially blind and requested someone take Resident 95 on smoke break. The AA stated, the AA was instructed to supervise residents by lighting their cigarettes and observing them from inside through a window since the AA disliked the smoke. The AA stated, the AA periodically kept an eye on the residents and stayed inside the doors during supervision. The AA stated direct supervision required being next to or very close to the resident, which the AA did not do for Resident 95. The AA stated, the AA would not be able to prevent Resident 95 from being burned by cigarette ashes. The AA stated, Resident 95 required a smoking apron and concurred it was important to discuss the risks and benefits of wearing the apron with the resident. The AA stated, Resident 95 would not refuse to wear the smoking apron if it was offered, but smoking aprons were unavailable so the AA did not offer it to Resident 95. During an interview on 1/16/2026 at 11:20 am with the Director of Nursing (DON), the DON stated Resident 95 was a smoker who needed supervision and the smoking apron was a necessary shield from cigarette ashes. The DON stated, for safety reasons, Resident 95 needed someone to assist Resident 95. The DON stated Resident 95 was at risk for accidents, burns, causing accidents or hurting others. The DON stated direct supervision was when the staff was directly next to the resident and the supervising staff should be outside with the resident during smoking time. During a review of the facility's P&P titled, Smoking Policy-Residents, revised 12/2024, the P&P indicated, it was the policy of the facility to establish and maintain safe resident smoking practices. The P&P indicated, any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Glendora Canyon Transitional Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **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 gastrostomy tube (GT, a tube inserted through the abdomen that delivers nutrition/medication directly into the stomach) site as ordered by the physician and as indicated in the plan of care for one of one sampled resident (Resident 10). This failure had the potential for complications related to tube feedings for Resident 10. Findings: During a review of Resident 10's admission Record (AR), the AR indicated Resident 10 was admitted to the facility on [DATE] with diagnoses including 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), dysphagia (difficulty in swallowing) and encounter for attention to gastrostomy (creation of an artificial external opening into the stomach for nutritional support). During a review of Resident 10's History and Physical (H&P) dated 6/21/2025, the H&P indicated Resident 10 did not have the capacity to understand and make decisions. During a review of Resident 10's Order Summary Report (OSR) dated 6/20/2025, the OSR indicated Resident 10 had a treatment order for licensed staff to clean the GT site with normal saline (NS, a saltwater solution), pat dry and apply dry dressing daily and inspect the site for signs and symptoms of infection, drainage, swelling or irritation. During a review of Resident 10's untitled Care Plan (CP) initiated on 7/25/2025, the CP indicated Resident 10 required enteral feeding via GT. The CP indicated for licensed nursing staff to provide enteral feeding as ordered. During a review of Resident 10's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 12/23/2025, the MDS indicated Resident 10 was dependent (helper does all of the effort) from staff for oral hygiene, toileting hygiene, shower, upper/lower body dressing, putting on/taking off footwear and personal hygiene. During a concurrent observation inside Resident 10's room and interview on 1/13/2026 at 10:21 am with facility's Assistant Director of Nursing (ADON), Resident 10 was awake, lying in bed. The ADON stated there was no GT dressing on Resident 10's GT site. The ADON stated there should be dry dressing in placed as ordered by the doctor. During an interview on 1/14/2026 at 9:35 am with the Treatment Nurse (TN), the TN stated Resident 10's GT site should have dry dressing to protect the resident's skin from irritation. During an interview on 1/16/2026 at 1:46 pm with the facility's Director of Nursing (DON), the DON stated the purpose of the dry dressing was to prevent infection and to maintain cleanliness of the GT site. The DON stated the GT dressing should be changed and applied daily by the licensed nurse as ordered by the doctor. During a review of the facility's policy and procedures (P&P) titled, Enteral Feedings - Safety Precautions, revised 5/2020, the P&P indicated, Preventing Skin Breakdown: Keep the skin around exit site clean, dry and lubricated (as necessary).		