

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555854	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2025
NAME OF PROVIDER OR SUPPLIER Mesa Glen Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 638 E Colorado Avenue Glendora, CA 91740	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to promptly identify signs and symptoms (S/S, ways the body lets a person know that a person is sick) of a urinary tract infection (UTI- an infection in the bladder/urinary tract) for one (1) of three (3) sampled residents (Resident 1) when the facility did not monitor Resident 1's vital signs (VS, measurements of the body's basic functions, such as heart rate, breathing rate, blood pressure, and temperature) every shift according to Resident 1's care plan (CP) for UTI, dated 1/23/2025. This failure resulted in Resident 1 being transferred to General Acute Hospital (GACH) 1 and being admitted to GACH 1 with UTI and sepsis (a life-threatening blood infection). During a review of Resident 1's admission Record (AR), the AR indicated facility admitted Resident 1 on 12/23/2024 with diagnoses including encephalopathy (any disease or disorder that affects the function or structure of the brain), dementia (a general term for a decline in mental ability severe enough to interfere with daily life), and anxiety (a group of mental health conditions characterized by excessive fear and worry that can significantly interfere with daily life). The AR indicated resident 1 did not have a diagnosis of UTI. During a review of Resident 1's History and Physical Examination (H&P, physician's clinical evaluation and examination of the resident), dated 12/20/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 3/25/2025, the MDS indicated Resident 1's cognitive skills (ability to make daily decisions) was severely impaired did not have the capacity to understand and make decisions. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) from staff for personal hygiene. The MDS indicated Resident 1 was incontinent (lacking voluntary control over urination and/or bowel movement). During a review of Resident 1's care plan (CP) for UTI, dated 1/23/2025, the CP indicated Resident 1 had a UTI and was at risk for further complications from UTI. The CP interventions included monitoring Resident 1's vital signs (measurements of the body's basic functions, such as heart rate, breathing rate, blood pressure, and temperature) every shift. During a review of Resident 1's Physician's Order (PO), dated 6/4/2025, the PO indicated to transfer Resident 1 to GACH 1 via 911 (emergency services). During a review of the Public Incident Report (PIR), dated 6/4/2025, the PIR indicated the paramedics (healthcare professionals who provide emergency medical care) arrived at the facility and assessed Resident 1 on 6/4/2025 at 8:49 pm. The PIR indicated Resident 1 had severe shortness of breath with an oxygen saturation level (O2 sat- a measurement of how much oxygen the blood is carrying as a percentage) of 75 and the paramedics' primary impression was sepsis. During a review of Resident 1's Change in Condition (CIC) note, dated 6/4/2025 and timed at 9:14 pm, the CIC indicated Resident 1 had labored breathing, with a temperature of 103.3, and an oxygen saturation level of 66. The CIC indicated the paramedics arrived and Resident 1 was transferred to GACH 1 via 911. During a review of Resident 1's History of Present Illness (HPI, physician's clinical evaluation and examination of the resident and the resident's current medical condition) from GACH 1, dated 6/4/2025 and timed 9:15 pm, the HPI indicated Resident 1 was admitted to the GACH Emergency Department (ED) from the facility in severe distress, unresponsive, and with rapid shallow breathing. The HPI indicated Resident 1 had UTI and Sepsis. During a review of Resident 1's Progress Note (PN), dated 6/5/2025 and timed at 6:50 pm, the PN indicated Licensed Vocational Nurse (LVN) 1 followed up with Registered Nurse (RN) 1 from GACH 1. RN 1 stated Resident 1 was admitted to GACH 1 on hospice (compassionate care for people who are near the end of life) per Resident 1's daughter's request. During a concurrent interview and record review on 7/2/2025, at 4:58 pm, with the Director of Nursing (DON), the DON stated Resident 1's vital signs were not monitored every day. The DON stated Resident 1's VS were only monitored once a week. Resident 1's clinical record was reviewed with the DON and the clinical records indicated Resident 1's VS were last checked on 5/28/2025 prior to 6/4/2025. During an interview on 7/17/2025, at 12:27 pm, with the DON, the DON stated, the care plan, dated 1/23/2025, indicated to monitor Resident 1's VS every shift. The DON stated it was important to monitor VS to notice the signs and symptoms of decline in Resident 1 who had previously had a urinary tract infection (UTI). DON stated staff should have followed the care plan and did not. DON stated the policy for the Care Plans was not followed. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated March 2022, 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</p>		