

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 08/13/2025
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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (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 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide one of one sampled resident (Resident 1) with behavioral health care and services for the treatment of Resident 1's emotional, mental, and drug abuse (a disease that affects a person's brain and behavior and leads to an inability to control the use of a legal or illegal drug or medication) by failing to: Identify goals and nursing interventions when Resident 1 had cannabis (marijuana, a mind-altering drug) abuse, anxiety (nervousness), and depression (persistent sadness and a lack of interest or pleasure in previously rewarding or enjoyable activities) would leave the facility on out on pass (OOP, temporary permission of a resident to leave the facility in a specified time) unsupervised, without OOP orders from Resident 1's Physician (MD 1). This deficient practice resulted in Resident 1 continuing to go OOP unsupervised and without MD 1's orders and had the potential to result in serious injury or harm to Resident 1. Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses of chronic obstructive pulmonary disease (COPD- is a group of lung diseases that cause long-term breathing problems), major depressive disorder (a serious mental health condition characterized by persistent sadness, hopelessness, and a significant loss of interest or pleasure in activities that lasts for at least two weeks and impairs daily functioning), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) and peripheral vascular disease (PVD- a condition where blood vessels outside the heart and brain narrow, block, or spasm, reducing blood flow and potentially causing tissue damage in the limbs or organs). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 3/27/2025, the MDS indicated Resident 1's cognitive status (the mental process of thinking and understanding) was intact. The MDS indicated Resident 1 was independent with eating, oral and personal hygiene, toileting and bathing. During a review of Resident 1's Interdisciplinary Team Conference Record (IDT- a collaborative gathering of various healthcare professionals- including nurses, therapists, social workers, dietary staff, and life enrichment coordinators- to discuss a resident's care plan, coordinate efforts, and address any changes or challenges in their health) dated 7/7/2025, the IDT notes indicated the purpose of the conference was to discuss the smoking policy. There was no documented evidence found in Resident 1's care plans that a person-centered care plan was developed and implemented from this behavioral meeting between Resident 1 and the facility's IDT including the Social Services Director (SSD 1). Resident 1's Care Plans did not include person centered care plans that were developed for Resident 1's behavioral health care needs specific to behaviors assessed for substance abuse/alcohol abuse, that included psychiatrist/psychologist consult, voluntary checking of personal belongings every quarter and as necessary. During a review of Resident 1's Health Note Status (HNS) dated 5/8/2025 at 7:06 PM, the HNS indicated The resident went out on pass to Grocery Store 1 at 12:30 PM. At approximately 6:30 PM, multiple employees witnessed the resident coming out of the Smoke Shop 1 with red cup and beer in her hand smoking a vape and drinking the beer. During a review of Resident 1's HNS dated 5/13/2025 at 9:56 PM, the HNS indicated, Urine drug screen results sent to MD for his review, positive for tetrahydrocannabinol (THC- the principal ingredient in marijuana), opioids (a class of drug used to reduce moderate to severe pain), and benzos (a class of drug that relieves anxiety and relaxes muscles). During an interview and record review with the Director of Nursing (DON) on 8/13/2025 at 7:55 AM, a review of the facilities Sign Out document indicated Resident 1 signed out on 5/5/2025 at 10:45 AM, and 5/7/2025 at 12:25PM. A review of Resident 1's OOP orders indicated Resident 1 did not have OOP orders for 5/5/2025 or 5/7/2025. The DON stated there is no documentation or an order for Resident 1 OOP for the dates of 5/5/25 at 10:45am or 5/7/25 at 12:25pm. The DON stated there should have been a doctor's order if Resident 1 left the facility. During an interview with Minimum Data Set Assistant (MDSA- an assistant that helps to collect, organize, and submit resident data for long-term care facilities, ensuring compliance with federal and state regulations for resident assessment and care planning) on 8/13/2025 at 8:30 AM, the MDSA stated documents including residents care plans are reviewed quarterly or annually as needed. Per the MDSA, it is the license nurse's responsibility to update or discontinue a residents care plan. The MDSA stated she was not sure if there should be a care plan regarding Resident 1's actions of using illegal drugs and drinking beer. Per the MDSA, if Resident 1 was seen using illegal drugs and drinking beer, there should be a care plan in place, so staff are aware, and interventions are in place. During an interview with the Social</p>		