

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 09/05/2025
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observation, interview and record review, the facility failed to treat two of four sampled residents (Residents 8 and 14) with dignity by failing to:</p> <p>a. Ensure Staff did not stand over Resident 8 while assisting the resident to eat.</p> <p>b. Ensure Activity Assistant (AA) 1 did not refer to Resident 14 as a Feeder. These failures had the potential to result in Residents 8 and 14 to feel disrespected which could result in impairing Residents 8 and 14's sense of wellbeing and feelings of self-esteem. (Cross Reference F580, F689, and F755). Findings:</p> <p>a. During a review of Resident 14's admission Record (AR), the AR indicated the facility admitted Resident 14 on 7/31/2024 with diagnoses including adult failure to thrive (a decline in older adults that manifests as a downward spiral of health and ability), hypertensive (high blood pressure) heart disease with heart failure (condition in which the heart cannot pump enough blood to all parts of the body), and dementia (a group of thinking and social symptoms that interferes with daily functioning).</p> <p>During a review of Resident 14's "Minimum Data Set (MDS, a resident assessment tool)," dated 7/28/2025, the "MDS" indicated Resident 14 was severely impaired in cognitive skills (ability to make daily decisions). The "MDS" indicated Resident 14 was dependent (helper does all the effort) on staff for bathing, and toileting and personal hygiene. The "MDS" indicated Resident 14 required substantial/maximal assistance (helper does more than half the effort) assistance from staff for oral hygiene and dressing.</p> <p>During a concurrent observation and interview on 8/29/2025, at 12:58 PM with AA 1, Resident 14 was sitting at a table in the small dining room. AA 1 stated, "(Resident 14) is here because he is a feeder".</p> <p>b. During a review of Resident 8's admission Record (AR), the AR indicated Resident 8 was admitted to facility on 8/5/2025 with diagnoses including Huntington's disease (an inherited condition that affects cells in the brain and affects a person's movements, thinking ability and mental health), hypertensive heart disease (heart problems that occur because of high blood pressure that is present over a long time), dysphagia (difficulty swallowing), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily activities).</p> <p>During a review of Resident 8's History and Physical (H&P), dated 8/7/2025, the H&P indicated the resident had the capacity to understand and make decisions.</p> <p>(continued on next page)</p>

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: 555854	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2025
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated 8/11/2025, the MDS indicated Resident 8 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated resident required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with eating, oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, sitting to lying and lying to sitting on the side of bed.</p> <p>During an observation on 8/29/2025 at 12:18 PM in Resident 8's room, a staff was observed standing at Resident 8's bedside and assisting the resident to eat.</p> <p>During an interview on 8/29/2025 at 12:31 PM with Resident 8, Resident 8 stated that Resident 8 would feel staff were maintaining Resident 8's dignity if the staff had been sitting at the same level as the resident while assisting to eat.</p> <p>During an interview on 8/29/2025 at 12:38 PM with Certified Nurse Assistant (CNA) 2, CNA 2 confirmed CNA 2 was standing at Resident 8's bedside while assisting the resident to eat. CNA 2 stated that she should sit at the same level as the resident to maintain the resident's dignity when assisting the resident to eat.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, "Dignity," revised February 2021, the P&P indicated, "Residents are treated with dignity and respect at all times." The P&P indicated that "When assisting with care, residents are supported in exercising their rights. For example, Residents are: e. provided with a dignified dining experience."</p> <p>During a review of the facility's P&P titled, "Assistance with Meals," revised March 2022, the P&P indicated, "Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example:</p> <ul style="list-style-type: none"> a. Not standing over residents while assisting them with meals; b. Keeping interactions with other staff to a minimum while assisting residents with meals; c. Avoiding the use of labels when referring to residents (e.g., feeders); and d. Avoiding the use of bibs or clothing protectors instead of napkins, unless requested by the resident 		

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 09/05/2025
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their Change in a Resident's Condition or Status policy and procedure to notify one of three sampled residents (Resident 7's) doctor of Resident 7's weight loss on 7/1/2025. These failures had the potential to result in Resident 7 to not receive treatment to address Resident 7's weight loss which could negatively affect Resident 7's health and wellbeing. (Cross Reference F550, F689, and F755) Findings: During a review of Resident 7's admission Record (AR), the AR indicated Resident 7 was admitted to the facility on [DATE] with diagnoses including multiple fractures (broken bone) of ribs, hypertensive heart disease (heart problems that occur because of high blood pressure that is present over a long time), urinary tract infection (UTI- an infection in the bladder/urinary tract), and protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function). During a review of Resident 7's Progress Notes (PN), dated 7/9/2025, the PN indicated the resident had experienced a significant unintentional weight loss of 17 LBs (11.8%) over the past 30 days. According to the PN the resident's weight decreased from 144 LBS on 6/9/2025 to 127 LBs on 7/7/2025. During a review of Resident 7's History and Physical (H&P), dated 7/16/2025, the H&P indicated that the resident had capacity to make medical decisions. During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool), dated 7/22/2025, the MDS indicated Resident 7 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 7 required substantial to maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene, shower/bathe self, and lower body dressing. The MDS indicated the resident required partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with upper body dressing. During a review of the facility's Weight Summary Report (WSR), dated 8/29/2025, the WSR indicated Resident 7 weighed 144 pounds (LB, a unit of measurement) 90 days prior. The WSR indicated Resident 7's weight was 118 LBs for week 8/22/2025. The MSR indicated Resident 1 had a more than ten percent (10%) weight loss in less than 180 days on 7/1/2025. During a concurrent interview and record review on 9/2/2025 at 4:10 PM with Registered Nurse (RN) 1 and the Director of Nursing (DON), Resident 7's Change in Condition Evaluation (CICE), for June, July, and August 2025 were reviewed. The DON confirmed there was no CICE for a significant unintentional weight loss to notify the resident's doctor in June, July, and August 2025. The DON stated the facility should create a CICE for the resident's significant weight loss. During a review of the facility's Policy and Procedure (P&P) titled, Change in a Resident's Condition or Status, revised February 2021, the P&P indicated that the nurse will notify the resident's attending physician or on call physician when there has been a significant change in the resident's physical/emotional/mental condition. During a review of the facility's P&P titled, Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol, revised September 2017, the P&P indicated, the staff will report to the physician significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake. During a review of the facility's P&P titled, Weighing and Measuring the Resident, revised March 2011, the P&P indicated, report significant weight loss/weight gain to the nurse supervisor. The P&P indicated that the threshold for significant unplanned and undesired with loss/gain will be based on the following criteria: a. 1 month - 5% weight loss is significant; greater than 5% is severe. b. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months - 10% weight loss is significant; greater than 10% is severe.</p>		

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 09/05/2025
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)		
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>Based on observation, interview and record review, the facility failed to honor the privacy (a resident's right to be free from observation including the resident's private space) and confidentiality (safeguarding the content of information including video, audio, or other computer stored information from unauthorized disclosure) of one of one sampled resident (Resident 13) when a video recording (Video 1) of Resident 13's room was posted to TikTok (a social media app where people create and share short videos). This failure resulted in the violation of Resident 13's right to privacy and confidentiality and had the potential to result in Resident 13 experiencing emotional distress and feelings of decreased self-worth. Findings: During a review of Resident 13's admission Record (AR), the AR indicated the facility originally admitted Resident 13 on 3/4/2025 and readmitted Resident 13 on 6/27/2025 with diagnoses including hereditary (a disease passed down from a person's parents) and idiopathic (a disease of unknown cause) neuropathy (nerve damage or disease leading to pain, numbness, tingling, or muscle weakness) and dementia (the loss of the ability to think, remember, and reason that affect daily life and activities). During a review of Resident 13's History and Physical (H&P), dated 7/24/2025, the H&P indicated Resident 13 had fluctuating (changing in an unstable or unpredictable way) capacity to understand and make decisions. During an observation on 8/29/2025 at 12:20 PM Video 1, dated 7/7/2025, was observed on TikTok. Video 1 recorded Certified Nursing Assistant (CNA) 1 sitting in a resident's room with a resident's personal property and pictures in the background. Additionally, Video 1 recorded a view into four other (unidentified) resident rooms. During an interview on 8/29/2025 at 1:34 PM with CNA 1, CNA 1 stated Video 1 was a recording of CNA 1 sitting in Resident 13's room and was recorded by LVN 1. During an interview on 8/29/2025 at 1:58 PM with the Director of Nursing (DON), the DON stated Video 1 was recorded at the facility. The DON stated recording TikTok videos was not allowed at the facility because it violated the residents' rights to privacy and confidentiality. During a review of the facility's Policy and Procedure (P&P) titled, Resident Rights, dated 2001, revised February 2021, the P&P policy statement indicated, Employees shall treat all residents with kindness, respect, and dignity. The P&P policy interpretation and implementation indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to privacy and confidentiality. During a review of the facility's P&P titled, Confidentiality of Information and Personal Privacy, dated 2001, revised October 2021, the P&P policy statement indicated, Our facility will protect and safeguard resident confidentiality and personal privacy. The P&P policy interpretation and implementation indicated, Release of resident information, including video, audio, or computer stored information, will be handled in accordance with resident rights and privacy policies. During a review of the facility's employee handbook titled, California Employee Handbook, dated 2024-2025, the handbook's social media guidelines indicated, These guidelines apply to all Facility employees who participate in any form of personal social networking including, but not limited to Facebook, Twitter, Instagram, TikTok, Snap Chat, LinkedIn, Yelp or any other social networking sites. Except when expressly authorized in writing for use for business purposes, social media activities are not permitted at work or while on Facility time.</p>		

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 09/05/2025
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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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 09/05/2025
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	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of four Residents, Resident 22, was provided an accurate comprehensive admission assessment. This deficient practice resulted in delayed interventions for pain from a red and swollen right hand and forearm and services accommodating to Resident 22's cognitive state and blindness. Findings: During a review of Resident 22's admission Record (AR), the AR indicated that Resident 22 was admitted to the facility on [DATE], with multiple diagnoses including Unspecified dementia and legal Blindness. During a review of Resident 22's Care Plan Report (CP), dated 8/25/2025, the CP indicated that Resident 1 was to have a wanderguard placed on the left wrist for safety, with an initiated date one day after admission on [DATE]. During a review of Resident 22's N ADV Clinical admission Note (NACAN), dated 8/25/2025, the NACAN indicated Resident 4 is confused, and did not require any special care and had no safety concerns. During a review of Resident 22's Baseline Care Plan (BCP), dated 8/25/2025, the BCP indicated that Resident 22 was vision impaired; required setup or clean-up assistance for eating, and had the ability to use food utensils to bring food and/or liquid to the mouth once the meal is placed before the resident; no presence of pain; eats in the dining room; and a fracture to metacarpals. During a review of Resident 22's New Progress Notes (NPN), dated 8/25/2025, the NPN indicated that Resident 22 did not have a fracture related to a fall in the 6 months prior to admission/entry or reentry; No safety concerns; and None recorded for indicators of pain. During a review of Resident 22's Order Summary Report (OSR), dated 8/26/2025, the OSR indicated to wrap right forearm with hard half splint with ACE wrap daily for immobilization purposes every day shift. During a review of Resident 22's SBAR Communication Form (SBAR), dated 8/26/2025, the SBAR indicated that, Patient (Resident 22) noted to wander and is legally blind. Noted to benefit from wander guard placement and is assessed to be an elopement risk. MD made aware and is ok to wander guard placement. During a review of Resident 22's Care Plan Report (CPR), dated 8/26/2025, the CPR did not indicate a care plan for Resident 22's right red and swollen metacarpals. During a review of Resident 22's hard chart on 9/5/2025 at 10:25 a.m., the hard chart had no documentation or records of a right arm injury. During a review of the Medication Administration Record (MAR), dated September 2025, the MAR indicated Resident 22 did not receive a pain assessment or a dose of pain medication until 9/5/2025. During a concurrent interview and record review on 9/4/2025 at 11:25 p.m., with LVN 2, a review of the N 5 B Progress Notes (N5B), dated 8/25/2025, the N5B indicated that Resident 22 had no visual impairment, no pain or hurting at any time in the last 5 days, and had no safety or comfort concerns. LVN 2 stated the visual, pain evaluation, and safety/comfort concerns for Resident 22 was inaccurate. LVN 2 stated if Resident 22 needed assistance, Resident 22 would not know the location of the call light and Resident 22 might get up on his own and not know how to navigate the new environment. During a concurrent observation and interview with LVN 2 and Resident 22, on 9/4/2025 at 12:55 p.m., Resident 22's right arm and hand were slightly red and swollen. The knuckle joint at the right pointer finger, was also red and swollen. Resident 22 was asked to lift their right arm and left arm. Resident 22 lifted the right arm slowly but was able to lift the left arm quickly when requested. During an interview on 9/5/2025 at 9:55 a.m., with the Activities Director (AD), the AD stated they are part of the initial IDT meeting, and they did not talk with Resident 22 because they were asked to document during the IDT meeting. AD also stated there was no documentation of activities provided to Resident 22. During a concurrent interview and record review on 9/5/2025 at 11:13 a.m. with DON and LVN 3, LVN 3 stated they did not perform a vision assessment nor an assessment of Resident 22's right extremity, and did not follow the physician order to, Wrap right forearm with hard half splint with ACE wrap daily for immobilization purposes every day shift. During a review of the facility's P&P titled, Pain: Assessment and Management dated October 2022, the P&P indicated the following under Steps in the Procedure: 1. Recognizing Pain, #4 indicated Ask the resident if he/she is experiencing pain. 2. Assessing Pain #1 indicated Assess the resident at admission and during ongoing assessments to help identify the resident who is experiencing pain or for who pain may be anticipated during specific procedures, care, or treatment; and #4 indicated, Assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level. During a review of the facility's P&P titled, admission Criteria, dated March 2019, the P&P indicated the following: 1. The objectives of our admission criteria policy are to: (b) admit residents who can be cared for adequately by the facility. 2. Examples of nursing/medical needs that can be met adequately include: (a) medication</p>		

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 09/05/2025
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the environment remained free of accident hazards and/or provided adequate supervision for three of 11 sampled residents (Residents 6, 9, and 15) by failing to: a. Ensure Resident 15's assigned 1:1 sitter (S1) (1:1 Sitter, facility staff who provides constant, one-to-one observation for a resident who is at risk of falls, self-harm, or other dangers due to a medical or cognitive condition) S1 was not looking at S1's personal phone for four minutes instead of watching Resident 15. S1 was sitting inside the facility while Resident 15 was sitting outside in the facility patio. b. Ensure to have an interdisciplinary team meeting (IDT- brings together professionals from various disciplines to develop a shared, comprehensive understanding and plan for a patient's needs, ensuring coordinated care across different areas like physical, emotional, social, and clinical aspects) post fall for two of eleven sampled residents (Resident 6 and Resident 9) in accordance with the facility's Safety and Supervision of Residents policy and procedure (P&P). This failure resulted in Residents 6 and 9 experiencing repeated falls and had the potential to result in Residents 6, 9, and 15 to injure themselves and/or other residents while in the care of the facility. Findings:</p> <p>a. During a review of Resident 15's admission Record (AR), the AR indicated the facility admitted Resident 15 on 5/2/2025 with metabolic encephalopathy (brain disease that alters brain function or structure), acute respiratory failure (when the lungs can't get enough oxygen into the blood), and lack of coordination.</p> <p>During a review of Resident 15's care plan titled, "Patient Lost Balance," dated 6/2/2025, the care plan indicated Resident 15 had a 1:1 sitter assigned to Resident 15 because Resident 15 "bumped" into another resident (unidentified).</p> <p>During a review of Resident 15's "Minimum Data Set (MDS, a resident assessment tool)," dated 8/6/2025, the "MDS" indicated Resident 15 was severely impaired in cognitive skills (ability to make daily decisions). The "MDS" indicated Resident 15 required substantial to maximal assistance (helper does more than half the effort) from staff for lower body dressing, bathing, and personal and toileting hygiene.</p> <p>During an observation on 8/29/2025 at 1:37 PM, S1 was sitting in a chair in the [NAME] Room facing next to a sliding glass door facing the outside patio. The sliding glass door was closed. S1 was looking down at S1's personal phone for four minutes. After four minutes on S1's phone, S1 stood up and went outside through the sliding glass doors.</p> <p>During a concurrent observation and interview on 8/29/2025 at 1:42 PM with S1, Resident 15 was observed sitting in a patio chair near the center of the patio. S1 stated S1 was assigned to be Resident 15's 1:1 sitter. S1 stated Resident 15 required a 1:1 sitter because Resident 15 had aggressive behaviors. S1 confirmed S1 had been on S1's phone. S1 stated S1 was reading emails on the phone. S1 stated S1 should not be on the phone but should be watching Resident 15.</p> <p>(continued on next page)</p>		

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 09/05/2025
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 8/29/2025 at 3 PM with the DON, the DON stated personal phone use by staff was not allowed and that staff should rather be focused on taking care of residents. The DON stated Resident 15 required a 1:1 sitter because Resident 15 had a history of angry outburst. The DON stated if the 1:1 sitter (in general) was on the phone then the 1:1 sitter (in general) was not paying attention to Resident 15.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, "Safety and Supervision of Residents," revised July 2017, the P&P indicated, "Resident safety and supervision and assistance to prevent accidents are facility-wide priorities." The P&P indicated, "The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision."</p> <p>b. During a review of Resident 6's admission Record (AR), the AR indicated Resident 6 was originally admitted to facility on 7/15/2024 and readmitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a change in how the brain works due to an underlying condition. It can cause confusion, memory loss and loss of consciousness), dementia (a group of thinking and social symptoms that interferes with daily functioning), and urinary tract infection (UTI- an infection in the bladder/urinary tract), arthritis (is the swelling and tenderness of one or more joints), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior).</p> <p>During a review of Resident 6's Change in Condition Evaluation (CICE) dated 7/19/2025, the CICE indicated Resident 6 had an unwitnessed fall and the staff notified the physician on 7/18/2025 at 2:45 AM.</p> <p>During a review of Resident 6's CICE dated 7/22/2025, the CICE indicated Resident 6 had an unwitnessed fall on 7/22/2025 and notified the physician on 7/22/2025 at 11:30 PM.</p> <p>During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 7/29/2025, the MDS indicated Resident 6 was severely impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 6 required substantial to maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with oral hygiene, toileting hygiene, shower/bathe self, and lower body dressing. The MDS indicated the resident required partial to moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with upper body dressing and personal hygiene.</p> <p>c. During a review of Resident 9's admission Record (AR), the AR indicated Resident 9 was admitted to facility on 5/30/2025 with diagnoses including epilepsy (also known as a seizure disorder- a brain condition that causes recurring seizures [abnormal electrical activity in the brain. It causes changes in awareness and muscle control]), history of falling and schizophrenia (a mental illness that can affect thoughts, mood, and behavior).</p> <p>During a review of Resident 9's History and Physical (H&P), dated 7/8/2025, the H&P indicated that the resident does not have the capacity to understand and make decisions.</p> <p>During a review of Resident 9's CICE, dated 7/9/2025, the CICE indicated Resident 9 had an unwitnessed fall on 7/9/2025 and the staff notified the physician on 7/9/2025 at 7:15 PM.</p> <p>(continued on next page)</p>		

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 09/05/2025
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9 was moderately impaired in cognitive skills. The MDS indicated Resident 9 required partial to moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with lower body dressing. The MDS indicated Resident 9 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with eating, oral hygiene, toileting hygiene, shower/bathe self, and upper body dressing.</p> <p>During a review of Resident 9's CICE, dated 7/11/2025, the CICE indicated Resident 9 had an unwitnessed fall on 7/11/2025 and the staff notified the physician on 7/11/2025 at 10:15 AM.</p> <p>During a review of Resident 9's CICE, dated 8/25/2025, the CICE indicated Resident 9 had a witnessed fall on 8/25/2025 and the staff notified the physician on 8/25/2025 at 7 AM.</p> <p>During a concurrent interview and record review on 9/3/2025 at 11:35 AM with Registered Nurse (RN) 2, Resident 6's Multidisciplinary Care Conference (also known as IDT), dated July, August, and September 2025, were reviewed. RN 2 confirmed that there was no IDT for Resident 6's two falls in July 2025.</p> <p>During the same interview and record review on 9/3/2025 at 11:35 AM with RN 2, Resident 9's IDT, dated July, August, and September 2025 were reviewed. RN 2 confirmed that there was no IDT for Resident 9's two falls in July 2025 and one fall on 8/25/2025. RN 2 stated the facility should conduct an IDT for resident's post fall on the following day.</p> <p>During an interview on 9/4/2025 at 3:46 PM with the Director of Nursing (DON), the DON stated the facility should have a post fall IDT meeting for all residents who experienced a fall.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, "Safety and Supervision of Residents," revised July 2017, the P&P indicated, "The interdisciplinary care team shall analyze information obtained from assessment and observations to identify any specific accident hazards or risks for individual residents."</p> <p>During a review of the facility's P&P titled, "Falls Clinical Protocol," revised March 2018, the P&P indicated, "For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall. Often multiple factors contribute to a falling problem."</p>		

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 09/05/2025
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the nurse staff followed the facility's Administering Medications policy and procedure (P&P) by failing to:a. Administer medications in a timely manner for one of three sampled residents (Resident 6).b. Initial the resident's Medication Administration Record (MAR) after giving each medication and before administering the next ones for one of three sample residents (Resident 5).c. Ensure LVN 2 and LVN 5 documented that they administered Resident 4's medications before administering medications to another resident. Resident 4 did not receive Resident 4's scheduled medications on the evening of 8/12/2025. These deficient practices had the potential to place Resident 6 at risk of not receiving the optimal therapeutic effect (desirable and beneficial effects resulting from a medical treatment) of the medication, which had potential to impair Resident 6's wellbeing and delayed medication administration documentation for Resident 5.(Cross Reference F550, F580, and F689)</p> <p>Findings:</p> <p>a. During a review of Resident 4's &ldquo;AR,&rdquo; the &ldquo;AR&rdquo; indicated Resident 4 was admitted to facility on 4/29/2025 and readmitted to the facility on [DATE] with diagnoses including seizures (a sudden, uncontrolled electrical disturbance in the brain), hypotension (low blood pressure), and acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood).</p> <p>During a review of Resident 4's &ldquo;MDS,&rdquo; dated 8/7/2025, the &ldquo;MDS&rdquo; indicated Resident 4 was moderately impaired in cognitive skills (ability to make daily decisions). Resident 4 was dependent (helper does all the effort) on staff for bathing, lower body dressing, and toileting hygiene.</p> <p>During a review of Resident 4's &ldquo;Order Summary Report (OSR)&rdquo; dated 9/3/2025, the &ldquo;OSR&rdquo; indicated Resident 4 had medications ordered including the following:</p> <ol style="list-style-type: none"> 1. Quetiapine Fumarate (medication used to treat several mental health conditions) Oral Tablet 25 mg Give 25 mg by mouth two times a day for psychosis (a mental disorder characterized by a disconnection from reality) manifested by (M/B) attempt to hurt himself and jumping out of bed 2. Levetiracetam (medication used to treat and control certain types of seizures) Oral Tablet 1000 MG Give 1000 mg by mouth every 12 hours for seizures 3. Phenobarbital (medication used to treat and control certain types of seizures) Oral Tablet 97.2 MG Give 1 tablet by mouth every 12 hours for seizures 4. Clobazam Oral Tablet 20 MG {Clobazam} Give 1 tablet by mouth every 12 hours for epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures). <p>(continued on next page)</p>		

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 09/05/2025
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 9/3/2025 at 1:46 PM with the Director of Nursing (DON), Resident 4's &ldquo;MAR,&rdquo; for August 2025, was reviewed. The &ldquo;MAR,&rdquo; indicated Resident 4 did not receive Resident 4's evening time scheduled medications, including Levetiracetam, Phenobarbital, Clobazam, and Quetiapine Fumarate on 8/16/2025. The DON confirmed Resident 4 was not given the medication. The DON stated LVN 6 failed to give the medication to Resident 4 The DON stated the DON discovered that the medication was not given on the morning of 8/17/2025. The DON stated LVN 6 could not give a reason why the medication was not given.</p> <p>During a concurrent interview and record review on 9/3/2025 at 2:28 PM with LVN 5, Resident 4's &ldquo;MAAR,&rdquo; for 8/1 &ndash; 8/15/2025, was reviewed. The &ldquo;MAAR,&rdquo; indicated LVN 5 administered Resident 4's scheduled medications late, including Quetiapine Fumarate, Levetiracetam, and Phenobarbital, on 8/3 and 8/4/25. The &ldquo;MAAR,&rdquo; indicated LVN 5 administered Resident 4's scheduled medications, including Quetiapine Fumarate, Levetiracetam, Phenobarbital, and Clobazam, late on 8/6/2025. The &ldquo;MAAR,&rdquo; indicated LVN 5 administered Resident 4's scheduled medications, including Levetiracetam, Phenobarbital, and Clobazam late on 8/7/2025. The &ldquo;MAAR,&rdquo; indicated LVN 5 administered Resident 4's scheduled medications, including Levetiracetam, late on 8/8/2025. The &ldquo;MAAR,&rdquo; indicated LVN 5 administered Resident 4's scheduled medications, including Levetiracetam, late on 8/9/2025. The &ldquo;MAAR,&rdquo; indicated LVN 5 administered Resident 4's scheduled medications, including Quetiapine Fumarate, Phenobarbital, and Clobazam late on 8/11/2025. The &ldquo;MAAR,&rdquo; indicated LVN 5 administered Resident 4's scheduled medications, including Levetiracetam, late on 8/13/2025. The &ldquo;MAAR,&rdquo; indicated LVN 5 administered Resident 4's scheduled medications, including Levetiracetam, late on 8/14/2025. LVN 5 denied administering medications late to Resident 4. LVN 5 stated rather than giving the medications late, LVN 5 documented later after LVN 5 had administered medications to all the residents. LVN 4 stated that was his practice because the facility's Wi-Fi (a wireless technology using radio waves to connect devices to a network and the internet without cables) was &ldquo;spotty&rdquo; and that it sometimes took too long to document in Resident 4's electronic medical record (EMR) before passing medications to the next resident (in general).</p> <p>During a concurrent interview and record review on 9/3/2025 at 2:28 PM with LVN 2, Resident 4's &ldquo;MAAR,&rdquo; for 8/1 &ndash; 8/15/2025, was reviewed. The &ldquo;MAAR,&rdquo; indicated LVN 2 administered Resident 4's scheduled medications late, including Levetiracetam, Phenobarbital, and Clobazam, on 8/10/2025. The &ldquo;MAAR,&rdquo; indicated LVN 2 administered Resident 4's scheduled medications late Quetiapine Fumarate, on 8/15/2025. LVN 2 denied giving medications late to Resident 4. LVN 2 stated LVN 2 failed to document as soon as LVN 2 gave medications to Resident 4.</p> <p>b. During a review of Resident 6's admission Record (AR), the AR indicated Resident 6 was originally admitted to facility on 7/15/2024 and readmitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a change in how brain works due to an underlying condition. It can cause confusion, memory loss and loss of consciousness), dementia (a group of thinking and social symptoms that interferes with daily functioning), urinary tract infection (UTI- an infection in the bladder/urinary tract), and arthritis (is the swelling and tenderness of one or more joints).</p> <p>(continued on next page)</p>		

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 09/05/2025
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 7/29/2025, the MDS indicated Resident 6 was severely impaired in cognitive skills (ability to make daily decisions). The MDS indicated resident required substantial to maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with oral hygiene, toileting hygiene, shower/bathe self, and lower body dressing. The MDS indicated the resident required partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with upper body dressing and personal hygiene.</p> <p>During a review of Resident 6's Order Summary Report (OSR) dated 9/3/2025, the OSR indicated Resident 6 had medication order as follows:</p> <ol style="list-style-type: none"> 1. Lidocaine (a medication used to treat pain) External Patch 5% (Lidocaine): Apply to lower back topically one time a day for pain management. Apply 1 patch at 0900 and remove at 2100 and remove per schedule. The medication order started on 8/27/2025. 2. Celecoxib oral capsule 100 milligram (MG, a unit of measurement). Give 1 capsule by mouth two times a day for arthritis pain. The medication order started on 6/9/2025. 3. Lactulose oral solution 10 gram (GM, a unit of measurement)/15 milliliter (ML, a unit of measurement). Give 15 ML by mouth two times a day for prophylaxis hepatic encephalopathy. The medication order started on 6/9/2025 4. Megestrol Acetate oral tablet 40 MG. Give 1 tablet orally two times a day for decreased appetite. The medication order started on 7/7/2025 5. Methenamine Hippurate oral tablet 1 GM. Give 1 tablet by mouth two times a day for UTI prophylaxis. The medication order started on 8/9/2025 6. Saccharomyces Boulardii oral capsule. Give 1 tablet by mouth two times a day for gastrointestinal (GI-referring to the digestive system, which includes the stomach and intestines) supplement. The medication order started on 6/9/2025. <p>During a review of Resident 6's Medication Administration Record (MAR), dated 8/2025, the MAR indicated the medications were scheduled to be administered at 9 AM as follows:</p> <ol style="list-style-type: none"> 1. Lidocaine external patch 5% (Lidocaine), apply to lower back topically one time a day for pain management. 2. Celecoxib oral capsule 100 milligram (MG, a unit of measurement). Give 1 capsule by mouth two times a day for arthritis pain. 3. Lactulose oral solution 10 gram (GM, a unit of measurement)/15 milliliter (ML, a unit of measurement). Give 15 ML by mouth two times a day for prophylaxis hepatic encephalopathy. 4. Megestrol Acetate oral tablet 40 MG. Give 1 tablet orally two times a day for decreased appetite. <p>(continued on next page)</p>		

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 09/05/2025
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. Methenamine Hippurate oral tablet 1 GM. Give 1 tablet by mouth two times a day for UTI prophylaxis.</p> <p>6. Saccharomyces Boulardii oral capsule. Give 1 tablet by mouth two times a day for gastrointestinal (GI-referring to the digestive system, which includes the stomach and intestines) supplement.</p> <p>During an observation on 8/29/2025 at 11:45 AM while in Resident 6's room at the bedside, Registered Nurse (RN) 1 was observed to administer medications to Resident 6 and apply a lidocaine patch on the right side of Resident 1's lower back.</p> <p>During a concurrent interview and record review on 8/29/2025 at 2:39 PM with RN 1, Resident 6's Medication Administration Record (MAR), for August 2025, was reviewed. RN 1 confirmed that six medications were scheduled to be administered at 9 AM and were given more than one and half hours late according to the scheduled time frame for Resident 6. RN 1 stated the facility should administer the medications on time following the orders to make sure the medications are effective for the resident.</p> <p>c. During a review of Resident 5's admission Record (AR), the AR indicated Resident 5 was originally admitted to facility on 1/25/2021 and readmitted to the facility on [DATE] with diagnoses including Parkinsonism (refers to brain conditions that cause slowed movements, rigidity [stiffness] and tremors), epilepsy (also known as a seizure disorder- is a brain condition that causes recurring seizures [abnormal electrical activity in brain. It causes changes in awareness and muscle control]), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing).</p> <p>During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5 had intact cognitive skills. The MDS indicated the resident was dependent (helper does all of the effort resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene. The MDS indicated resident required substantial to maximal assistance with showering and bathing self, upper and lower body dressing, and personal hygiene.</p> <p>During a review of Resident 5's Medication Administration Audit Report (MAAR) dated 9/2/2025, the MAAR indicate Resident 5 had scheduled medications administration documented as follows:</p> <p>1. Lamotrigine Tab ER 24HR 250 MG. Give 1 tablet by mouth every 12 hours for seizure disorder. The medication was scheduled on 8/4/2025 at 9 AM, and the documented administration time was 10:43 AM. The medication was scheduled on 8/7/2025 at 9 PM, and the documented administration time was 10:33 PM.</p> <p>2. Keppra Oral Tablet (Levetiracetam). Give 1500 MG by mouth every 12 hours for seizure disorder. The medication was scheduled on 8/4/2025 at 9 AM, and the documented administration time was 10:43 AM. The medication was scheduled on 8/7/2025 at 9 PM, and the documented administration time was 10:34 PM.</p> <p>3. Trileptal Oral Tablet (Oxcarbazepine). Give 450 MG by mouth two times a day for seizures. The medication was scheduled on 8/4/2025 at 9 AM, and the documented administration time was 10:43 AM.</p> <p>(continued on next page)</p>		

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 09/05/2025
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 9/4/2025 at 2:23 PM with Licensed Vocational Nurse (LVN) 2, Resident 5's MAAR, for August 2025, was reviewed. LVN 2 stated that LVN 2 should document the medication administration right after administering and before administering the next medication.</p> <p>During a concurrent interview and record review on 9/5/2025 at 8:49 AM with LVN 3, Resident 5's MAAR, for August 2025, was reviewed. LVN 3 stated that LNV 3 did not document the medication administration right after administering.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, "Administering Medications," revised April 2019, the P&P indicated, "Medications are administered in accordance with prescriber orders, including a required time frame." The P&P indicated that "Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders)." The P&P indicated that "The individual administering the medication initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones."</p>		

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 09/05/2025
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the doorknob and door of residents' room for three of three sampled residents (Residents 11, 16, and 17) was cleaned daily. This failure had the potential for residents to become sick by contacting germs (microscopic bacteria, viruses, fungi, and protozoa that can cause disease) from the dirty doorknob. Findings: During a review of the facility's, Midnight Census Report (Census), dated 8/29/2025. The Census indicated Residents 11, 16, and 17 resided in Room (RM) A. During a review of Resident 11's admission Record (AR), the AR indicated the facility admitted Resident 11 on 3/13/2025 and readmitted Resident 11 on 5/16/2025 with diagnoses including metabolic encephalopathy (brain disease that alters brain function or structure), chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), and bipolar disorder (a mental illness that causes unusual shifts in a person's mood). During a review of Resident 11's Minimum Data Set (MDS, a resident assessment tool), dated 6/18/2025, the MDS indicated Resident 11 had no impairment in cognitive skills (ability to make daily decisions). The MDS indicated Resident 11 required supervision (oversight, encouragement or cuing) from staff for bathing, dressing, and oral, toileting, and personal hygiene. During a review of Resident 16's AR, the AR indicated the facility admitted Resident 16 on 4/28/2025 and readmitted Resident 16 on 5/13/2025 with diagnoses including pneumonia (infection that inflames air sacs in one or both lungs), dementia (a group of thinking and social symptoms that interferes with daily functioning), and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). During a review of Resident 16's MDS, dated [DATE], the MDS indicated Resident 16 was severely impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 16 required partial to moderate (helper does less than half the effort) assistance from staff for bathing, lower body dressing, and toileting and personal hygiene. During a review of Resident 17's AR, the AR indicated the facility admitted Resident 16 on 1/29/2025 and readmitted Resident 17 on 7/9/2025 with diagnoses including hypertensive (high blood pressure) heart disease with heart failure (condition in which the heart cannot pump enough blood to all parts of the body) and paranoid (where a person feels distrustful and suspicious of other people) schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). During a review of Resident 17's MDS, dated [DATE], the MDS indicated Resident 17 had no impairment in cognitive skills (ability to make daily decisions). The MDS indicated Resident 17 required supervision (oversight, encouragement or cuing) from staff for eating, bathing, dressing, and oral, toileting, and personal hygiene. During an observation on 8/29/2025 at 12:58 PM, Room A's door was observed. [NAME] specks and smudges were noted to be on the doorknob and on the door surrounding the doorknob. During a concurrent observation and interview on 9/2/2025 at 3:37 PM with the infection Preventionist (IP) Room A's door was observed. The door and doorknob were noted to still have brown specks and smudges first observed on 8/29/2025. The IP confirmed the door and doorknob were dirty. The IP stated the doorknob was a high touch area and should be cleaned daily to prevent the spread of infection. During a review of the facility's policy and procedure (P&P) titled, Cleaning and Disinfection of Environmental Surfaces, revised August 2019, the P&P indicated, . Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled.</p>		