STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555854	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesa Glen Care Center	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm) for one of three sampled residents (Resident 1) when on 9/2/2025, Registered Nurse 1 (RN1) threw a cup of juice on Resident 1's face.This failure resulted in Resident 1 being subjected to physical abuse by RN 1 while under the care of the facility. Resident 1 cried and did not answer how Resident 1 felt when RN 1 threw water on Resident 1's face. Findings: During a record review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted on [DATE] with diagnoses including intellectual disability (term used to describe a person with certain limitations in cognition [process of acquiring knowledge] and other skills including communication and self-care), Schizoaffective Disorder Bipolar Type (a mental condition that causes both a loss of contact with reality and mood problems) and Unspecified Anxiety Disorder (excessive and persistent worry and fear that significantly interfere with daily life). During a record review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 6/9/2025, the MDS indicated Resident 1 had severely impaired cognition. The MDS indicated Resident 1 had a history of verbal behaviors of threatening, screaming, and/or cursing toward others. The MDS indicated Resident 1 had lower extremity (hip, knee, ankle, foot) impairment and required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, showering/bathing, lower extremity dressing, putting on and taking off footwear, and personal hygiene. During an observation and concurrent interview with Resident 1 in Resident 1's room on 9/9/2025 at 1:21 p. m., Resident 1 was lying in bed and did not respond to questions asked. Resident 1 was crying intermittently and did not respond to the reason Resident 1 was crying. During a review of Resident 1's untitled Care Plan (CP) initiated on 3/4/2025, the CP indicated Resident 1 had the potential to be physically aggressive related to schizoaffective disorder, intellectual disabilities and poor impulse control. The CP interventions indicated for staff to provide physical and verbal cues to alleviate anxiety. During a review of Resident 1's untitled CP initiated on 3/4/2025, the CP indicated Resident 1 had impaired cognitive function related to developmentally delayed and schizoaffective disorder. The CP interventions indicated for staff to provide Resident 1 with necessary cues and to stop and return to Resident 1 if Resident 1 was agitated. During a review of Resident 1's untitled CP revised 4/6/2025, the CP indicated Resident 1 had a behavioral problem. The CP interventions indicated for staff to provide positive interaction and attention, stop and talk with Resident 1 when passing by Resident 1's room, explain all procedures to Resident 1 before starting, and allow Resident 1 to adjust to changes. During a review of Resident 1's untitled CP revised 4/9/2025, the CP indicated Resident 1 had behavioral symptoms as manifested by resistance to care. The CP interventions indicated approaching Resident 1 in a calm manner. During an interview with Licensed Vocational Nurse 1 (LVN 1) on 9/9/25 at 2:17 p.m., LVN 1 stated Resident 1 displayed anger at times, but those behaviors fluctuated. LVN 1 stated Resident 1's aggressive behavior was handled by staff by attempting to respond to the needs of the resident, using prescribed medications, or by talking with Resident 1 and if none worked, staff would give Resident 1 time alone and return at a later time. LVN 1 stated Resident 1 was only aggressive verbally and was not a physical threat. During an interview on 9/9/25 at 3:31 p.m. and review of a text message sent to RN 2, from RN 1, RN 2 stated the text message was dated 9/8/2025 at 10:53 p.m. RN 2 stated RN 2 did not see the text message from RN 1 until 9/9/2025 while driving to work. RN 2 stated RN 2 contacted the Administrator (ADM) and reported the text message from RN 1. The text message read as follows, I actually got mad when Resident 1 threw juice to my face that I went back to the cart to pour more juice and threw it back at Resident 1. During an interview with Certified Nursing Assistant 2 (CNA 2) on 9/9/2025 at 4:31 p.m., CNA 2 stated Resident 1 was agitated in the morning of 9/2/2025 (unable to give exact time), threw Resident 1's medication on the floor and threw juice on CNA 2 and RN 1. CNA 2 stated CNA 2 picked up the cup and returned it to RN 1, then RN 1 returned to the medication cart for another cup of juice, returned to Resident 1's room, and threw the juice in Resident 1's face and chest. Resident 1 was yelling and screaming profanities, then RN 1 left the room. During a phone interview with RN 1 on 9/9/2025 at 4:43 p.m., RN 1 stated Resident 1 saw RN 1 outside Resident 1's room and Resident 1 was cursing (using foul language), so RN 1 decided to give medications to another resident and returned to Resident 1 after. RN 1 stated, Resident 1 continued cursing as RN 1 gave Resident 1 juice to take with Resident 1's medications. RN 1 stated Resident 1 threw the juice at RN 1's face and on RN 1's clothes, then slapped the medications from

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an incident of physical abuse for one of three sampled residents (Resident 1) within two hours to the California Department of Public Health in accordance with the facility's Policy and Procedure (P&P) titled, Abuse Reporting and Investigation.This failure violated Resident 1's right and had the potential for delay in abuse investigation and continued to expose Resident 1 to further physical abuse.Findings: During a record review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted on [DATE] with diagnoses including intellectual disability (term used to describe a person with certain limitations in cognition [process of acquiring knowledge] and other skills including communication and self-care), Schizoaffective Disorder Bipolar Type (a mental condition that causes both a loss of contact with reality and mood problems) and Unspecified Anxiety Disorder (excessive and persistent worry and fear that significantly interfere with daily life). During a record review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 6/9/2025, the MDS indicated Resident 1 had severely impaired cognition. The MDS indicated Resident 1 had a history of verbal behaviors of threatening, screaming, and/or cursing toward others. The MDS indicated Resident 1 had lower extremity (hip, knee, ankle, foot) impairment and required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, showering/bathing, lower extremity dressing, putting on and taking off footwear, and personal hygiene. During a review of Resident 1's untitled Care Plan (CP) initiated on 3/4/2025, the CP indicated Resident 1 had the potential to be physically aggressive related to schizoaffective disorder, intellectual disabilities and poor impulse control. The CP interventions indicated for staff to provide physical and verbal cues to alleviate anxiety. During a review of Resident 1's untitled CP initiated on 3/4/2025, the CP indicated Resident 1 had impaired cognitive function related to developmentally delayed and schizoaffective disorder. The CP interventions indicated for staff to provide Resident 1 with necessary cues and to stop and return to Resident 1 if Resident 1 was agitated. During a review of Resident 1's untitled CP revised 4/6/2025, the CP indicated Resident 1 had a behavioral problem. The CP interventions indicated for staff to provide positive interaction and attention, stop and talk with Resident 1 when passing by Resident 1's room, explain all procedures to Resident 1 before starting, and allow Resident 1 to adjust to changes. During a review of Resident 1's untitled CP revised 4/9/2025, the CP indicated Resident 1 had behavioral symptoms as manifested by resistance to care. The CP interventions indicated approaching Resident 1 in a calm manner. During an interview with Registered Nurse 2 (RN2) on 9/9/2025 at 3:31 p.m., RN 2 stated staff were taught who to report any type of abuse within a two-hour timeframe. RN 2 stated staff needed to report any type of abuse to the Abuse Coordinator, immediately, within 2 hours of any physical, verbal, sexual, financial, neglect, exploitation, isolation, or mistreatment. In a concurrent review, RN 2 showed a photocopy of a text message from RN 1. RN 2 stated the text message was dated 9/8/2025 at 10:53 pm. The text message indicated: I actually got mad when he (Resident 1) threw the juice to my face that I went back to the cart to pour more juice and threw it back at him (Resident 1). RN 2 stated RN 2 did not see the text message from RN 1 until 9/9/2025 while driving to work. During an interview with Certified Nursing Assistant 2 (CNA 2) on 9/9/2025 at 4:31 p.m., CNA 2 stated Resident 1 was agitated in the morning of 9/2/2025 (unable to state exact time), threw Resident 1's medication on the floor and threw juice on CNA 2 and RN 1. CNA 2 stated CNA 2 picked up the cup and returned it to RN 1, then RN 1 returned to the medication cart for another cup of juice, returned to Resident 1's room, and threw the juice in Resident 1's face and chest. Resident 1 was yelling and screaming profanities, then RN 1 left the room. CNA 2 stated all staff were mandated reporters. CNA 2 stated what happened between RN 1 and Resident 1 should have been reported to the Administrator (ADM), who was also the Abuse Coordinator, but CNA 2 became busy with CNA 2's assignment and failed to report the incident. CNA 2 stated any incident of abuse should be reported within 2 hours of the abuse. During an interview with the facility's Assistant [NAME] President of Operations (AVPOP) on 9/9/2025 at 2:56 p.m., the AVPOP stated the facility's Director of Nursing (DON) informed the AVPOP that a staff member (RN 2) received a text message from RN 1 indicating abuse. The AVPOP stated the text message from RN 1 indicated RN 1 got mad when Resident 1 threw juice at RN 1's face and so RN 1 went back to the medication cart to pour more juice and threw it back at Resident 1. The AVPOP stated staff (in general) needed to report abuse immediately. During a review of the facility's undated Abuse Prevention/Prohibition Policy (APP), the APP indicated abuse is defined as the willful inflictions of injury, involuntary seclusions