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	11/21/2025

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 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. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promptly respond to call lights (a device used by a resident to signal his or her need for assistance from staff) and/or promptly respond to a resident's request for toileting assistance for three of five sampled residents (Residents 1, 4, and 6) according to the facility's Policy and Procedure (P&P) titled, Dignity, revised February 2021.This failure had the potential to result in residents (in general) feeling like their concerns were unheard and to feel frustrated.(Cross Reference F552)a. During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 10/4/2022 with diagnoses including dementia (a group of thinking and social symptoms that interferes with daily functioning), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and hypertension (high blood pressure). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 10/20/2025, the MDS indicated Resident 1 was severely impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) from staff for toileting, personal, and oral hygiene, eating, and upper body dressing. b. During a review of Resident 4's AR, the AR indicated the facility admitted Resident 4 on 9/14/2017 and readmitted Resident 4 on 8/16/2024 with diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), seizures (a sudden, uncontrolled electrical disturbance in the brain), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 had no impairments in cognitive skills. The MDS indicated Resident 4 required substantial/maximal assistance from staff for toileting and oral hygiene, bathing, and lower body dressing. The MDS indicated Resident 4 required partial/moderate (helper does less than half the effort) assistance from staff for upper body dressing and eating. The MDS indicated Resident 4 was incontinent (lack of voluntary control over urination or defecation) of bowel and bladder. During a review of Resident 4's untitled care plan, initiated on 12/9/2024, the care plan indicated Resident 4 was at risk for skin breakdown because Resident 4 was incontinent. The care plan indicated the interventions of, Keep call light within reach, staff to answer promptly, and Keep clean and dry. c. During a review of Resident 6's AR, the AR indicated the facility admitted Resident 6 on 6/11/2025 with diagnoses including Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), dementia (a group of thinking and social symptoms that interferes with daily functioning), and lack of coordination. During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6 had no impairments in cognitive skills. The MDS indicated Resident 6 required partial/moderate assistance from staff for bathing, lower body dressing, and personal hygiene. The MDS indicated Resident 6 was occasionally incontinent with bladder. During a review of Resident 6's untitled care plan, revised on 9/29/2025, the care plan indicated Resident 6 had an activity of daily living (ADL, a term used to describe the skills required to independently care for oneself) self-care performance deficit related to Parkinson's disease. The care plan indicated the interventions of, Encourage the resident to use bell to call for assistance, and The resident requires assistance by staff for toileting. During a telephone interview on 11/18/2025 at 8:58 AM with Resident 1's daughter (RR 1), RR 1 stated RR 1 usually visited Resident 1 at the facility in the evenings. RR 1 stated the facility staff (in general) took a long time to answer Resident 1's call light that RR 1 pushed for assistance. RR 1 stated RR1 would have to walk out to the nurses' station for assistance because the facility staff (in general) would not respond to Resident 1's call light. During an observation on 11/19/2025 at 9:22 AM, the light above Room A's door (a visual request for assistance) was observed to be on when the surveyor walked past the room. Certified Nursing Assistant (CNA) 1 later entered the room at 9:35 AM and spoke to Resident 4 who was lying in Resident 4's bed. The light above Room A's door was turned off at 9:35 AM. During an interview on 11/19/2025, at 9:35 AM with CNA 1, CNA 1 stated Resident 4 had pressed the call light to request assistance with changing Resident 4's soiled brief. During an interview on 11/19/2025, at 9:36 AM with Resident 4, Resident 4 stated Resident 4 had been waiting 30 minutes for someone to answer Resident 4's call light. Resident 4 stated Resident 4 had an incontinent episode and needed assistance to change his brief. Resident 4 stated Resident 4 sometimes had to wait up to 3 hours for assistance after pressing the call light. Resident 4 stated

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) was obtained by the ordering healthcare provider for one of five sampled resident (Resident 1). This failure had the potential to result in Resident 1 receiving medication against Resident 1's wishes. (Cross Reference F550)Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 10/4/2022 with diagnoses including dementia (a group of thinking and social symptoms that interferes with daily functioning), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and hypertension (high blood pressure). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 10/20/2025, the MDS indicated Resident 1 was severely impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) from staff for eating, upper body dressing, and toileting, personal, and oral hygiene. The MDS indicated Resident 1 received psychotropic medications (affect brain activities associated with mental processes and behavior). During a review of Resident 1's Order Summary Report (OSR), dated 10/20/2025, The OSR indicated Resident 1 had the following medication orders upon Resident 1's readmission to the facility on [DATE]:Alprazolam Oral Tablet (Medication used to treat anxiety) 0.25 milligram (mg, a unit of measurement) Give 1 tablet by mouth at bedtime for Anxiety.Citalopram Hydrobromide oral tablet 10 mg (Medication used to treat depression) Give 1 tablet by mouth in the morning related to major depressive disorder.Mirtazapine oral tablet 15 mg (Medication used to treat depression) Give 1 tablet by mouth at bedtime for depression.Seroquel oral tablet 25 mg (medication used to treat schizophrenia [a disorder that affects a person's ability to think, feel, and behave clearly]) Give 0.5 tablet by mouth one time a day for schizophrenia. During a telephone interview on 11/18/2025 at 8:58 AM with Resident 1's daughter (RR 1), RR 1 stated Resident 1 took medications for Resident 1's dementia. RR 1 stated Resident 1's dementia medications were changed without notification being provided to RR 1. During a concurrent interview and record review on 11/20/2025 at 9:56 AM with the Social Service Director (SSD), Resident 1's Multidisciplinary Care Conference (MCC), dated 10/16/2025 was reviewed. The MCC indicated Resident 1 had been transferred to a General Acute Care Hospital (GACH) on 10/8/2025 and readmitted to the facility on [DATE]. The MCC indicated RR 1 had expressed concerns during the care conference meeting that Resident 1's depression medication dosage had been increased. The SSD stated the SSD was present during Resident 1's care conference meeting on 10/16/2025. The SSD stated RR 1's main concern was that RR 1 was not notified of the increased dosage of Resident 1's depression medication. The SSD stated the SSD was not sure if the medication dosages were changed while Resident 1 was at the facility or if the dosage was changed at the GACH and readmitted to the facility and continuing the new dosage. During a concurrent interview and record review on 11/20/2025 at 10:29 AM with the MDS Nurse (MDSN), Resident 1's MCC, dated 10/16/2025 was reviewed. The MDSN stated the MDSN was present during Resident 1's care conference on 10/16/2025. The MDSN stated the medication changes for RR 1 was concerned about happened when Resident 1 was at the GACH. The MDSN stated the facility continued the medication dosages Resident 1 received while at the GACH. During a concurrent telephone interview and record review on 11/20/2025 at 11:42 AM with Resident 1's Psychiatric Mental Health Nurse Practitioner (NP 1), Resident 1's four documents titled, Verification of Informed Consent to Psychotropic Drug, Physical Restraint or Medical Device (Informed Consent), all dated 10/15/2025 were reviewed. The four Informed Consents were for the four psychotropic medications - Alprazolam, Citalopram Hydrobromide, Mirtazapine, and Seroquel. The four Informed Consents incorrectly indicated NP 1 obtained informed consent from RR 1 for Resident 1 to receive the four psychotropic medications. NP 1 stated NP 1 did not obtain informed consent from RR 1 for the four psychotropic medications on 10/15/2025 when Resident 1 was readmitted to the facility. During an interview on 11/20/2025 at 12:23 PM with the Director of Nursing (DON), the DON stated a resident's (in general) healthcare provider who prescribed psychotropic medications was responsible for obtaining an informed consent for the psychotropic medications. The DON confirmed an informed consent must be obtained for psychotropic medications when a resident (in general) was readmitted to the facility with orders psychotropic medications. During a review of the facility's Policy and Procedure (P&P) titled, Psychoactive