

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  12/11/2025
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</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

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on Interview and record review, the facility failed to ensure to develop and implement a care plan for one of three sampled residents (Resident 2) regarding the use of rollator walker (an assistive device designed to aid individual with walking difficulties that requires proper training and instruction for safe use to prevent falls and injuries). This deficient practice placed resident at risk for fall and injuries. On 11/27/2025, Resident 2 fell while attempting to get up from the rollator walker and sustained a left acute humeral neck fracture (a break in the humerus [the long bone in the upper arm, running from the shoulder to elbow] bone of the left arm). During a review of Resident 2's admission Record (AR), the AR indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis that included end-stage renal disease (ESRD, permanent stage of kidney disease when kidneys can no longer support body's needs) with hemodialysis (HD, a life-sustaining medical treatment that filters waste, toxins, and excess fluid from the blood when kidneys fail), and Diabetes Mellitus Type 2 (a chronic condition where the body does not use insulin properly (insulin resistance) or cannot produce enough insulin, leading to high blood sugar levels). During a review of Resident 2's History and Physical Examination (H&amp;P), dated 12/5/2025, the H&amp;P indicated Resident 2 has the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS, a federally mandated assessment tool), dated 8/29/2025, the MDS indicated Resident 2's cognition was intact. The MDS indicated Resident 2 was independent for eating and oral hygiene. The MDS indicated Resident 2 required partial to moderate assistance (helper does less than half the effort) for toileting hygiene, shower, lower body dressing, putting on/taking off footwear, and personal hygiene. During a review of Resident 2's Care Plan Report (CP), initiated on 4/21/2025, the CP indicated, The resident is at risk for falls r/t gait/balance problems, psychoactive drug use, unaware of safety needs and weakness d/t medical diagnosis of ESRD on HD. The CP's Goal section indicated Resident 2 will be free of falls and will not sustain serious injury. During a review of the Physical Therapy - PT Discharge summary, dated [DATE], the PT Discharge Summary's Discharge Recommendations section indicated, pt (patient) may ambulate at lib (at libitum, as desired) with 4WW (4-wheel walker [a mobility aid with wheels on all four legs] within the facility. During a review of Resident 2's SBAR Communication Form (SBAR-Situation, Background, Assessment, Recommendation, a communication tool), dated 11/27/2025, the SBAR indicated, Staff reported that Resident 2 had a witnessed fall on the outside patio, upon assessment, some shoulder pain reported 6/10 (a numeric pain scale/tool used to measure pain intensity from 0 to 10, 0 indicating no pain, and 10 indicating worst pain imaginable). The SBAR indicated that Resident 2 verbalized wanting to get up from her walker but then she lost balance and fell. The Recommendations of Primary Clinicians section indicated immediate x-ray (imaging study that takes pictures of bones and soft tissues). During a review of Resident 2's Progress Notes (PN), dated 11/27/2025, at 1:40 pm, the PN indicated fall was witnessed outside on the patio while Resident 2 was getting up from the walker. The PN indicated that fall resulted hospitalization. During a review of Resident 2's Patient Report for left shoulder X-ray, dated 11/27/2025, the radiology report's Findings section indicated acute humeral neck fracture. During a concurrent interview and record review on 12/11/2025 at 3:00 pm with Director of Nursing (DON), Resident 2's care plans were reviewed. The DON stated that they do not have a care plan for the use of rollator walker for Resident 2 and there should be one. The DON stated there is no documentation indicating nurses were aware of the need for the care plan, and there was no communication between physical therapy and licensed nurses. The DON stated that Resident 2 had a left humeral neck fracture from the fall in the patio while using rollator walker. During a concurrent interview and record review on 12/11/2025 at 3:00 pm with Director of Nursing (DON), the facility's policy and procedure (P&amp;P), titled Care Plans, Comprehensive Person-Centered, revised in March 2022, was reviewed. The P&amp;P's Policy Statement Section indicated, A comprehensive, person-centered care plan that includes measurable objective and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&amp;P's Policy interpretation and Implementation section indicated:1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.7. The comprehensive, person-centered care plan:a. includes measurable objectives and timeframes.b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being During a concurrent interview and record review of the Care Plans</p>		