

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 12/30/2025
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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to reevaluate and update care plan interventions to address resident's hoarding and the potential for accident hazards for one of five sampled residents (Resident 2). This deficient practice had the potential to place Resident 2 at increased risk for tripping and falling hazards, unsanitary environmental conditions, and fire safety violations. Cross Reference: F689 Findings: During a review of Resident 2's admission Record (AR), the AR indicated Resident 2 was initially admitted to the facility on [DATE] and then readmitted on [DATE] with diagnoses that included bilateral primary osteoarthritis of knee (a condition where both knees experience inflammation and degeneration of the cartilage, the protective layer that cushions the joints), COPD (Chronic Obstructive Pulmonary Disease, a chronic lung disease causing difficulty in breathing), anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can interfere with daily functioning), and personality disorder (a mental health condition where people have a hard time understanding emotions, tolerating distress and acting impulsively). During a review of Resident 2's Initial History and Physical (H&P), dated 8/7/2025, the H&P indicated Resident 2 had the capacity to understand and make medical decisions. During a review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 9/26/2025, the MDS indicated Resident 2 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 2 required setup or clean-up assistance with eating, oral hygiene, toileting hygiene, shower/bathe self, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. During a concurrent observation and interview on 12/30/2025 at 10:28 a.m. in Resident 2's room, the room was full of clutter surrounding Resident 2's bed. Six boxes were observed wrapping around the left side of Resident 2's bed, with another layer of boxes stacked on top of them. The boxes were open with clothing and bags placed on top. At the foot of the bed, a cardboard box was observed with a tote container sitting on top. The tote container was filled with clothes, hangers, and personal grooming items. On the right side of Resident 2's bed, multiple items such as food, drinks, and personal grooming items were observed scattered on the floor and placed on the bedside table. An empty open box was observed in the room, and multiple papers were stacked on top of one another on the floor under the curtain. The call light cord was observed underneath the bedside table on the floor to the right of Resident 2's bed and was not within the resident's reach. During an interview with Resident 2 on 12/30/2025 at 10:31 a.m. in Resident 2's room, Resident 2 stated, the facility will not help her with placing the boxes in her storage unit or give her additional boxes to place items in and get ready to move them out of the room. Resident 2 stated she will have to find someone else to help her move the boxes to her storage unit. During an interview and concurrent record review on 12/30/2025 at 3:05 pm with SSD, reviewed Resident 2's Social Services Progress Notes from September 2025 to December 2025, the progress notes indicated the Social Services Director (SSD) spoke with Resident 2 on 9/9/2025 and 9/10/2025 about Resident 2's room was a hazard to both Resident 2 and Resident 2's roommates. During a review of Resident 2's medical records with SSD, there were no other notes from October 2025 to November 2025 regarding assisting or encouraging Resident 2 to remove the clutter from Resident 2's room. During a review of Nursing Progress Notes, dated 12/22/2025, the progress note indicated Resident 2 refused for the room to be deep cleaned. Resident 2 was educated on proper cleaning and hygiene, but continued to refuse. During a review of Resident 2's Care Plan Report, titled Hoarding: Resident exhibits hoarding behavior as evidenced by overflow of belonging in a disorganized manner, the care plan's Goal section indicated the following goals: (1) Resident will be free of injuries related to clutter; and (2) Resident will maintain a safe and clean living area with assistance of the staff. The care plan report had initiation date of 7/31/2025 and target date of 3/22/2026. The care plan indicated the following interventions: Encouraged resident to place belongings in a secure place and assigned space area. (Date initiated: 8/10/2025. Revision on: 8/10/2025). Offer to clean and organize Resident 2's belongings (Date initiated: 7/31/2025; no revision date). Staff explain the risks and benefits of hoarding belongings and food. (Date initiated: 7/31/2025; no revision date). Staff will assist the resident with cleaning out any old and expired food products. (Date initiated: 7/31/2025, no revision date). Staff will monitor any new or increased behaviors associated with hoarding. (Date initiated: 7/31/2025, no revision date). During a review of Resident 2's Care Plan Report titled Hoarding: Resident exhibits hoarding behavior as evidenced by overflow of</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>		

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<p>F 0689</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 ensure one of five sampled resident's (Resident 2) environment/room remained free of accident hazards and clutter. This deficient practice placed Resident 2 at risk for falls, and injury due to excessive clutter surrounding Resident 2's bed. Cross Reference: F656Findings:During a review of Resident 2's admission Record (AR), the AR indicated Resident 2 was initially admitted to the facility on [DATE] and then readmitted on [DATE] with diagnoses that included bilateral primary osteoarthritis of knee (a condition where both knees experience inflammation and degeneration of the cartilage, the protective layer that cushions the joints), COPD (Chronic Obstructive Pulmonary Disease, a chronic lung disease causing difficulty in breathing), anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can interfere with daily functioning), and personality disorder (a mental health condition where people have a hard time understanding emotions, tolerating distress and acting impulsively). During a review of Resident 2's Initial History and Physical (H&P), dated 8/7/2025, the H&P indicated Resident 2 had the capacity to understand and make medical decisions. During a review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 9/26/2025, the MDS indicated Resident 2 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 2 required setup or clean-up assistance with eating, oral hygiene, toileting hygiene, shower/bathe self, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. During a concurrent observation and interview on 12/30/2025 at 10:28 a.m. in Resident 2's room, the room was full of clutter surrounding Resident 2's bed. Six boxes were observed wrapping around the left side of Resident 2's bed, with another layer of boxes stacked on top of them. The boxes were open with clothing and bags placed on top. At the foot of the bed, a cardboard box was observed with a tote container sitting on top. The tote container was filled with clothes, hangers, and personal grooming items. 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During a review of Resident 2's Care Plan Report, titled Hoarding: Resident exhibits hoarding behavior as evidenced by overflow of belonging in a disorganized manner, the care plan's Goal section indicated the following goals: (1) Resident will be free of injuries related to clutter; and (2) Resident will maintain a safe and clean living area with assistance of the staff. The care plan had initiation date of 7/31/2025 and target date of 3/22/2026. The care plan indicated the following interventions:Encouraged resident to place belongings in a secure place and assigned space area. (Date initiated: 8/10/2025. Revision on: 8/10/2025).Offer to clean and organize Resident 2's belongings (Date initiated: 7/31/2025; no revision date).Staff explain the risks and benefits of hoarding belongings and food. (Date initiated: 7/31/2025; no revision date).Staff will assist the resident with cleaning out any old and expired food products. (Date initiated: 7/31/2025, no revision date). Staff will monitor any new or increased behaviors associated with hoarding. (Date initiated: 7/31/2025, no revision date). During a review of the facility's Policy & Procedure (P&P) titled Homelike Environment with</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a safe and sanitary ice and water handling practices to prevent contamination and the potential for waterborne illness for one of one ice machine serving the facility. This deficient practice had the potential to expose residents to unfiltered ice and water, which can harbor bacteria (Listeria, a bacterium), mold, and other contaminants, posing serious health risks and the potential for illness. During an observation on [DATE] at 1:05 p.m. in the facility kitchen with the Dietary Manager (DM), an expired water filter, dated [DATE], was observed connected to the icemaker. During an observation and concurrent interview with the Dietary Manager (DM) on [DATE] at 1:14 p.m. in the kitchen, DM stated he was new and was unsure when the water filter needed to be changed for the icemaker. Reviewed a log sheet on the side of the icemaker with DM. Observed the log was dated December, but no year was indicated. During an observation with the Dietary Manager (DM) on [DATE] at 1:14 p.m. in the kitchen, a manufacturer's water filter specifications sheet was reviewed. The manufacturer's water filter specifications sheet indicated under Operations Tips: Replace cartridge when flow rate becomes inconveniently slow or before rated capacity is reached. It is recommended to replace cartridge at least once per year. During a review of the facility's current Policy & Procedure (P&P), titled Maintenance Service, with the revision date of [DATE], the P&P indicated, Policy: Maintenance service shall be provided to all areas of the building, grounds and equipment. The P&P's Policy Interpretation and Implementation section further indicated: The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions of maintenance personnel include but are not limited to maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines and maintaining the building in good repair and free from hazards. The Maintenance Director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner. Maintenance personnel shall follow the manufacturer's recommended maintenance schedule. Maintenance personnel shall follow established safety regulations to ensure the safety and well-being of all concerned.</p>		