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	01/29/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews 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) in accordance with the facility's Policy and Procedure (P&P) titled, Abuse Prevention/Prohibition, and Resident Rights for one of four sampled residents (Resident 4) when Resident 3 hit Resident 4 on the back of the head on 1/19/2026. This failure resulted in Resident 4 being subjected to physical abuse by Resident 3 while under the care of the facility. Findings: Cross Reference: F656 During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 4/27/2025 and re-admitted on [DATE] with diagnoses including paranoid schizophrenia (a mental illness that is characterized by disturbances in thought) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 3's Situation Background Assessment Recommendation (SBAR-a standardized communication tool used in healthcare to convey resident's status, especially during emergencies or handoffs) Communication Form dated 8/8/2025, the SBAR indicated that Resident 3 was in hallway attempting to hit others. During a review of Resident 3's Skilled Nursing Facility to Hospital Transfer Form dated 8/11/2025, the Transfer Form indicated Resident 3 was transferred to a General Acute Care Hospital (GACH) for aggressive behavior, shouting, screaming, and attempting to hit others. During a review of Resident 3's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 11/3/2025, the MDS indicated Resident 3 had severely impaired cognition (the ability to think and process information). The MDS indicated Resident 3 required partial/moderate assistance (helper does less than half the effort) with activities of daily living (ADL- self-care activities) and mobility. During a review of Resident 4's AR, the AR indicated the facility admitted Resident 4 on 12/5/2025 with diagnoses including pneumonia (an infection/inflammation in the lungs) and anxiety disorder (group of mental disorders characterized by feelings of anxiety [an unpleasant state of inner turmoil] and fear). During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4 had moderately impaired cognition. The MDS indicated Resident 4 required substantial/maximal assistance (helper does more than half the effort) with ADL and mobility. During a review of Resident 4's Situation Background Assessment Recommendations (SBAR-a standardized communication tool used in healthcare to convey patient status, especially during emergencies or handoffs) Communication Form dated 1/19/2026, the SBAR indicated Resident 4 was sitting by the time clock on the North Station when Resident 4 was hit on the back of the head by Resident 3. Resident 4 complained of 7/10 pain to Resident 4's head. Resident 4 was transferred to General Acute Care Hospital 1 (GACH 1) for further evaluation and treatment. During an interview with Resident 3 on 1/28/2026 at 4:30 PM, Resident 3 was reluctant to discuss the altercation with Resident 4 and provided minimal information. Resident 3 stated Resident 3 could not recall the exact date or time of the incident. When asked what occurred, Resident 3 made a fist gesture, motioning as (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

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 01/29/2026
NAME OF PROVIDER OR SUPPLIER Mesa Glen Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 638 E Colorado Avenue Glendora, CA 91740	

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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	if Resident 3 had punched Resident 4 in the back of the head. Resident 3 did not verbally admit to striking Resident 4 but demonstrated the motion with Resident 3's hand. Resident 3 stated, I was mad because he (Resident 4) was blocking my way and did not move. During an interview with Resident 4 on 1/29/2026 at 11:27 AM, Resident 4 stated Resident 4 was seated in the lobby area watching the clock when Resident 4 noticed Resident 3 approached Resident 4 in a wheelchair. Resident 4 stated Resident 4 attempted to move out of the way to allow Resident 3 to pass but before Resident 4 could reposition, Resident 3 struck Resident 4 in the back of the head. Resident 4 stated the contact as sudden and unexpected. Resident 4 stated Resident 4 experienced emotional distress following the incident, stating Resident 4 was shaken by the unexpected nature of the strike from Resident 3. During a telephone interview on 1/29/2026 at 2:54 PM, RN 2 stated RN 2 was at the North Nursing Station charting on the computer while monitoring the unit. RN 2 stated Residents 3 and 4 were seated in their wheelchairs in the lobby area directly across from the nursing station. RN 2 stated RN 2 suddenly heard someone yelled, Ow, he hit me. RN 2 stated RN 2 immediately got up and responded, separating Residents 3 and 4. RN 2 stated RN 2 did not physically witness Resident 3 strike at Resident 4 but saw Resident 3 making a fist-like motion as if Resident 3 had punched Resident 4. RN 2 stated Resident 3 did not verbally admit to striking Resident 4. RN 2 stated Resident 3 had occasional verbal outbursts toward staff but had not previously witnessed physical aggression toward other residents. RN 2 stated that when a resident has a known history of aggressive behavior-whether directed toward staff or other residents, the care plan must be individualized, person-centered, and include specific, measurable interventions. RN 2 stated appropriate interventions should include clearly defined supervision levels, identification of behavioral triggers, early intervention strategies, structured de-escalation techniques, environmental modifications, redirection methods, staff approach guidelines, and criteria for escalation of care. RN 2 stated if the care plan had vague or generalized interventions and lacked behavior-specific guidance, staff would not have clear directions to proactively prevent escalation. RN 2 stated failure to implement clear, individualized interventions would contribute to resident-to-resident altercations and compromise resident safety. During a concurrent interview with the Director of Nursing (DON) on 1/29/2026 at 3:33 PM and review of Resident 3's Care Plan Report, the DON stated following Resident 3's psychiatric hospitalization and subsequent readmission to the facility on 9/23/2025, the facility initiated a care plan addressing aggressive behavior. The DON acknowledged that although a care plan to address Resident 3's aggressive behavior was implemented, the interventions were vague and not individualized or behavior specific. The DON stated that when a resident has a known history of aggressive behavior, the care plan must be person-centered and include clear, specific, and measurable interventions. The DON stated that the interventions should include identified triggers, defined supervision levels, early intervention strategies, structured de-escalation techniques, environmental modifications, staff approach guidelines, and clear escalation protocols. The DON stated aggressive behaviors could remain dormant for extended periods but were unpredictable and could recur any time. The DON stated, without detailed individualized interventions in place, staff lack clear direction to proactively prevent escalation, increasing the risk for resident-to-resident altercation, even if the aggressive behavior had remained dormant for several months and the resident had otherwise appeared stable. During a review of the facility's P&P titled, Abuse Prevention/Prohibition, updated 7/2024, the P&P indicated: Abuse is defined as the willful inflictions of injury, involuntary seclusions, physical, or chemical restraint not required to treat the residents' symptoms, intimidation or punishment with resulting in physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including caretaker, of goods or services that (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesa Glen Care Center	638 E Colorado Avenue Glendora, CA 91740

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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	are necessary to attain or maintain physical, mental, and psychosocial well-being. Physical Abuse is defined as hitting, slapping, pinching, and or kicking. It also includes controlling behavior through corporal punishment.Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident's property. During a review of the facility's P&P titled, Resident Rights, updated 2/2021, the P&P indicated:Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:Be free from abuse, neglect, misappropriation of property, and exploitation.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to implement timely and individualize the care plan interventions to address a resident's known history of aggressive behaviors for one of four sampled residents (Resident 3). This deficient practice placed the residents at risk for physical harm, psychological distress, and/or a decline in overall well-being.Findings: During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 4/27/2025 and re-admitted on [DATE] with diagnoses including paranoid schizophrenia (a mental illness that is characterized by disturbances in thought) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 3's Situation Background Assessment Recommendation (SBAR-a standardized communication tool used in healthcare to convey resident's status, especially during emergencies or handoffs) Communication Form dated 8/8/2025, the SBAR indicated that Resident 3 was in hallway attempting to hit others. During a review of Resident 3's Skilled Nursing Facility to Hospital Transfer Form dated 8/11/2025, the Transfer Form indicated Resident 3 was transferred to a General Acute Care Hospital (GACH) for aggressive behavior, shouting, screaming, and attempting to hit others. During a review of Resident 3's readmission History & Physical (H&P) dated 9/24/2025, the H&P indicated Resident 3 was re-admitted to the facility after Resident 3 was placed on 5150 hold (a state law which allows an adult who is experiencing a mental health crisis to be involuntarily detained for a 72-hour psychiatric hospitalization when evaluated to be a danger to others, or to himself or herself, or gravely disabled) for being physically aggressive to staff. During a review of Resident 3's Care Plan Report initiated on 9/26/2025, the facility initiated a care plan addressing Resident 3's aggressive behavior. The care plan was not individualized or resident specific. The care plan did not include documented monitoring parameters, identified behavioral triggers, and staff guidance on how to approach, redirect, and manage Resident 3's aggressive behaviors. The care plan was initiated on 9/26/2025, but the interventions were not added nor implemented until 11/5/2025. The care plan was not implemented in a timely manner to address the resident's known behaviors, and did not reflect a comprehensive, person-centered approach. During a review of Resident 3's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 11/3/2025, the MDS indicated Resident 3 had severely impaired cognition (the ability to think and process information). The MDS indicated Resident 3 required partial/moderate assistance (helper does less than half the effort) with activities of daily living (ADL- self-care activities) and mobility. During an interview and concurrent record review on 1/29/2026 at 1:57 PM, Resident 3's Care Plan Report was reviewed with Registered Nurse 1 (RN 1). RN 1 stated that following Resident 3's readmission after a 5150 hospitalization, a care plan addressing aggressive behavior was initiated on 9/26/2025. RN 1 stated the care plan did not reflect a comprehensive, individualized, person-centered approach to manage the resident's known aggressive behaviors. RN 1 stated the care plan lacked resident-specific information related to monitoring, identified triggers, and staff guidance on how to approach, redirect, and intervene during behavioral episodes. RN 1 stated the care plan was initiated on 9/26/2025 but the documented interventions were not initiated until 11/5/2025. RN 1 stated the interventions were generic and did not provide sufficient direction for consistent staff implementation. RN 1 stated the lack of a comprehensive, individualized, person-centered care plan for a resident with known aggressive behaviors could result in unmet care needs and an increased risk for resident-to-resident altercations, placing the residents at risk for physical harm, psychological distress, and a decline in overall well-being. During an interview and concurrent record review on 1/29/2026 at (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3:45 PM, Resident 3's Care Plan Report initiated on 9/26/2025 was reviewed with the Director of Nursing (DON). The DON acknowledged the care plan addressed Resident 3's aggressive behavior but did not reflect a comprehensive, individualized, person-centered approach. The DON stated the care plan was missing resident-specific guidance related to monitoring, identified triggers, and staff direction for managing aggressive behaviors. The DON stated the documented interventions were not implemented in a timely manner until 11/5/2025, which limited the staff's ability to consistently prevent and manage Resident 3's behaviors and increased the potential for resident-to-resident altercation, impacting resident's safety. During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, revised on 3/2022, the P&P indicated:A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.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.The Care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including:The right to participate in the planning processParticipate in establishing the expected goals and outcomes of care, andParticipate in determining the type, amount, frequency, and duration of careThe comprehensive, person-centered care plan:Includes measurable objectives and timeframesDescribes the services that are to be furnished to attain or maintain the resident's physical, mental, and psychosocial well-being, includingThe resident's stated goals upon admission and desired outcomesReflects currently recognized standards of practice for problem areas and conditionsCare plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.The interdisciplinary team reviews and updates the care plan:When the resident has been readmitted to the facility from a hospital stay.