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	02/03/2026

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 1) was free from physical restraints (any manual method, physical or mechanical device, equipment, or material attached or adjacent to the resident's body that cannot be removed easily by the resident and restricts the resident's freedom of movement or normal access to his/her body). Resident 1's bed was placed against the wall on the left side and a geriatric chair (Geri Chair, a large, padded and mobile reclining chair that prevents a resident from rising) was placed on the right side of Resident 1's bed. The facility did not have a physician's order for the use of Geri Chair for Resident 1. This deficient practice limited Resident 1's mobility, violated Resident 1's right and had the potential to cause physical and/or psychological (mental) harm to Resident 1.Cross Reference: F689 Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction (type of ischemic [deficient supply of blood] stroke [sudden death of brain cells in a localized area due to inadequate blood flow] resulting from a blockage in the blood vessels supplying blood to the brain) affecting the right dominant side and contracture (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of the right upper arm and right knee. During a review of Resident 1's Order Summary Report (OSR) dated 11/25/25, the OSR indicated 1:1 supervision (intervention where a dedicated staff member provides continuous direct monitoring of a resident) for Resident 1 for safety. The OSR did not indicate an order for the use of Geri Chair for Resident 1. During a review of Resident 1's History and Physical (H&P) dated 11/26/25, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment and care screening tool) dated 12/1/25, the MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort to complete tasks) from staff for eating, oral hygiene, toilet hygiene, personal hygiene, shower and bathing, upper and lower body dressing and putting on/taking off footwear. During a review of Resident 1's Fall Risk Evaluation (FRE) dated 12/23/25, the FRE indicated Resident 1 was at high risk for falls with the score of 19. The form indicated a total score of 10 or greater indicated the resident was considered at high risk for potential falls. During a review of Resident 1's untitled Care Plan (CP) initiated on 11/25/25, the CP indicated Resident 1 was at risk for falls related to confusion and history of falls due to attempting to get out of bed unassisted. The CP interventions included Resident 1 to have a 1:1 supervision, to maintain 1:1 observation at all times and not to leave Resident 1 unattended. During an observation inside Resident 1's room on 2/3/26 at 4:54 AM, Resident 1's bed was placed against the wall on the left side and a Geri chair was placed directly against Resident 1's bed on the right side, wedged against the bed fame creating a physical barrier. Resident 1 (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555854	A. Building B. Wing	02/03/2026

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was lying in the center of the bed in a fetal position (curled up posture), wrapped with blanket from head to toe. During an interview inside Resident 1 with Sitter 1 (S1) on 2/3/26 at 4:55 AM, S1 stated the Director of Nursing (DON) gave permission to place the Geri Chair next to Resident 1's bed. During an observation and interview inside Resident 1's room with License Vocational Nurse 1 (LVN1) on 2/3/26 at 4:56 AM, LVN1 stated LVN 1 was aware the Geri Chair was placed against Resident 1's bed. LVN 1 stated the Geri Chair was used as a restraint to prevent Resident 1 from rising up off the bed since Resident 1 tends to wiggle out of the bed. LVN 1 stated the Geri Chair had been there since the day shift of 2/1/26 and both the facility Administrator (Admin) and the DON were aware. During an interview with Registered Nurse Supervisor 1 (RNS 1) on 2/3/26 at 7:51 AM, RNS 1 stated it was dangerous to have a Geri Chair placed against Resident 1's bed because it was considered entrapment (stuck between two structures) and a restraint. RNS 1 stated if Resident 1 attempted to get up from the bed, Resident 1 would be at a higher risk of falling and suffering injuries by becoming entrapped between the bed and the Geri chair. RNS 1 stated other safe alternatives should have been used instead of using the Geri chair as a restraint. RNS 1 stated having the Geri Chair at bedside could increase agitation, confusion, and feelings of anxiety in Resident 1. RNS 1 stated using the Geri Chair as a device to restrain a resident for staff convenience was not acceptable. During an interview with the facility's DON on 2/3/26 at 8:29 AM, the DON stated the Geri Chair should not have been placed blocking Resident 1 in bed because it was considered a form of restraint and could cause harm to Resident 1. During an interview with the facility's Admin on 2/3/26 at 9:54 AM, the Admin stated using a Geri chair to keep residents in bed was unacceptable and considered a type of restraint. During a review of the facility's Policy and Procedure (P&P) titled Use of Restraints, revised 4/2017, the P&P indicated restraints shall only be used to treat the resident's medical symptoms and never for discipline or staff convenience or for the prevention of falls. During a review of the facility's Policy and Procedure (P&P) titled, Safety and Supervision of Residents revised 7/2017, the P&P indicated the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. During a review of the facility's P&P titled, Quality of Life-Dignity revised 2/2020, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem.

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	02/03/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide supervision to prevent accidents for two of two sampled residents (Resident 1 and 2) by failing to:a. Follow the physician's order for one to one (1:1 - an intervention where a dedicated staff member provides continuous direct monitoring of a resident) supervision for Residents 1 and 2.b. Not leave Residents 1 and 2 unattended in accordance with the residents' care plan. These deficient practices had the potential to result in harm that could lead to serious accidents/injury for Residents 1 and 2. Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction (type of ischemic [deficient supply of blood] stroke [sudden death of brain cells in a localized area due to inadequate blood flow] resulting from a blockage in the blood vessels supplying blood to the brain) affecting the right dominant side and contracture (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of the right upper arm and right knee. During a review of Resident 1's Order Summary Report (OSR) dated 11/25/25, the OSR indicated 1:1 supervision for Resident 1 for safety. During a review of Resident 1's History and Physical (H&P) dated 11/26/25, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment and care screening tool) dated 12/1/25, the MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort to complete tasks) from staff for eating, oral hygiene, toilet hygiene, personal hygiene, shower and bathing, upper and lower body dressing and putting on/taking off footwear. During a review of Resident 1's Fall Risk Evaluation (FRE) dated 12/23/25, the FRE indicated Resident 1 was at high risk for falls with the score of 19. The form indicated a total score of 10 or greater indicated the resident was considered as high risk for potential falls. During a review of Resident 1's untitled Care Plan (CP) initiated on 11/25/25, the CP indicated Resident 1 was at risk for falls related to confusion and history of falls due to attempting to get out of bed unassisted. The CP interventions included Resident 1 to have a 1:1 supervision, to maintain 1:1 observation at all times and not to leave Resident 1 unattended. During a review of Resident 2's AR, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including dementia (a decline in mental abilities, including memory, thinking, language, and reasoning severe enough to interfere with daily life), Alzheimer's disease (a progressive, irreversible brain disorder leading to severe cognitive [mental] decline, memory loss, and personality changes) and anxiety disorder (excessive fear or worry about a specific situation). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had moderately impaired cognition (ability to understand). The MDS indicated Resident 2 required supervision or touching assistance for toileting hygiene, shower/bathing self, upper body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 2's OSR dated 1/30/26, the OSR indicated 1:1 supervision for Resident 2. During a review of Resident 2's untitled CP initiated on 1/30/26, the CP indicated the resident had an episode of aggression towards staff. The CP interventions included maintaining 1:1 supervision to ensure resident and staff safety. During a review of Resident 2's untitled CP initiated on 1/30/26, the CP indicated the resident had a behavior problem related to episodes of exit seeking behavior, episodes of unprovoked agitation, crying and aggression towards staff and a 1:1 sitter was placed with the resident for safety purposes. The CP intervention indicated not to leave Resident 2 unattended, to request a reliever before going on break and (continued on next page)

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	02/03/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	notify the charge nurse and to maintain 1:1 observation at all times. During a review of the facility's Sitter Schedule dated 2/1/26 for NOC (night) shift, the Sitter Schedule indicated Sitter (S1) was assigned to both Residents 1 and 2. During an observation inside Resident 1's room on 2/3/26 at 4:54 AM, Resident 1's bed was placed against the wall on the left side and a Geri chair (a large, padded and mobile reclining chair that prevents a resident from rising) was placed directly against Resident 1's bed on the right side, wedged against the bed fame creating a physical barrier. Resident 1 was lying in the center of the bed in a fetal position, wrapped with blanket from head to toe. During an interview inside Resident 1's room with Sitter 1 (S1) on 2/3/26 at 4:55 AM, S1 stated the Director of Nursing (DON) gave permission to place the Geri Chair next to Resident 1's bed. During an interview with Licensed Vocational Nurse 1 (LVN 1) on 2/3/26 at 5:10 AM, LVN 1 stated S1 was assigned to do 1:1 sitter for both Residents 1 and 2. LVN 1 stated S1 was inside Resident 1's room even though S1 was scheduled to watch two residents during the entire night shift. LVN 1 stated, S1 had to check on both residents (Residents 1 and 2) during the entire shift and go back and forth every 15 to 20 minutes between Resident 1 and Resident 2 who was in a room down the hallway. LVN 1 stated a sitter order of 1:1 meant the sitter should only be watching one resident at a time during the entire shift. LVN 1 stated the physician's order for 1:1 for Residents 1 and 2 should have been followed. LVN 1 stated both Residents 1 and 2 required constant supervision. LVN 1 stated Resident 2 had a 1:1 sitter order because Resident 2 would wander and had a history of striking out at others. LVN 1 stated it was not safe to leave Resident 1 nor Resident 2 alone at any time because it could cause one of the residents to suffer an injury or a fall. During an interview with Certified Nurse Assistant 1 (CNA1) on 2/3/26 at 5:42 AM, CNA1 stated if a resident had a 1:1 sitter, a CNA (in general) had to cover for the 1:1 sitter when the 1:1 sitter went on a break. CNA 1 stated it was not feasible for a CNA to be able to cover the 1:1 sitter every 15 or 30 minutes throughout the shift since the CNA had other residents to care for. CNA1 stated if a resident had a 1:1 sitter, the resident should not be left alone at any time because the resident could fall and get injured. During an observation and interview with S1 on 2/3/26 at 5:50 AM, S1 left Resident 1's room leaving Resident 1 alone while S1 walked down the hallway and around the corner to get to Resident 2's room. S1 opened Resident 2's door and peaked inside to check on Resident 2. S1 stated Resident 2 was asleep in bed and did not require monitoring from S1 at this time. S1 closed Resident's 2 door, left Resident 2 alone while S1 walked back around the corner and down the hallway back to Resident 1's room. During a concurrent interview with S1 on 2/3/26 at 5:57 AM, S1 stated Resident 2 had hit another resident in the past. S1 stated Resident 2 had also hit staff including S1 and had thrown a cup at S1's face. S1 stated Resident 2 was unpredictable and Resident 2 could hit someone if S1 was not with Resident 2 at all times. S1 stated, if left alone, Resident 1 could suffer a fall and get injured and Resident 2 could hit another resident. During an interview with CNA 2 on 2/3/26 at 7:53 AM, CNA 2 stated Resident 1 was not to be left alone at any time because Resident 1 was a fall risk and if left alone, Resident 1 could suffer a fall and get an injury. CNA 2 stated if a 1:1 sitter needed to leave Resident 1's room, another staff should cover the 1:1 sitter and not leave Resident 1 alone and unattended. During an interview and record review with Registered Nurse Supervisor 1 (RNS 1) on 2/3/26 at 7:57 AM, RNS 1 stated Resident 1 had a history of a fall and had a 1:1 sitter for safety. RNS 1 stated Resident 2 had a 1:1 sitter order for safety due to history of aggression and striking out at others. RNS 1 did not know why there was only one 1:1 sitter assigned for both Residents 1 and 2. RNS 1 stated Resident 1 and Resident 2 each had a 1:1 sitter physician's order. RNS 1 stated a 1:1 sitter order meant each resident needed to have his/her own sitter for supervision and safety at all times. During an interview (continued on next page)

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	02/03/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with the DON on 2/3/26 at 8:29 AM, the DON stated a sitter should not be assigned to two different residents at the same time when each resident had their own specific 1:1 physician's order for a 1:1 sitter. The DON stated a physician's order for 1:1 was in place for both Residents 1 and 2 to ensure safety, prevent aggression, elopement or falls. The DON stated the 1:1 sitter should stay with the resident the entire time and if the 1:1 sitter went on break, a CNA or the charge nurse (CN) should cover the 1:1 sitter. The DON stated it was not safe for Residents 1 and 2 to be left alone unattended. The DON stated Residents 1 and 2 needed to be monitored at all times to prevent harm or injury. During an interview with the Administrator (Admin) on 2/3/26 at 9:54 AM, the Admin stated when a resident (in general) had a physician's order for 1:1 supervision, a staff should always be with the resident to monitor, and it was not safe to leave the resident alone. During a review of the facility's Policy and Procedure (P&P) titled, 1:1 Supervision/Sitters revised 10/2018, the P&P indicated the purpose of the procedure was to assist residents who need additional supervision and/or companionship in obtaining sitters or companion care. The P&P indicated the sitter will notify the facility staff when taking a break or when the sitter will be away from the resident during his/ her work shift. During a review of the facility's P&P titled, Safety and Supervision of Residents revised 7/2017, the P&P indicated, The facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.