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	04/01/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed to prevent the transmission of disease and infection for two of three sampled residents (Residents 1 and 2) when: Residents 1 and 2 took a shower in the shower room next to the facility's dining room while the shower drain was clogged. Facility staff failed to empty Resident 1's 3 full urinals hanging on the foot of Resident 1's bed.These failures had the potential to result in the spread of infections among the residents (in general) residing at the facility.(Cross reference F584)a. During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 11/5/2025 with diagnoses including anorexia nervosa (an eating disorder defined by restriction of energy intake relative to requirements), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 2/6/2026, the MDS indicated Resident 1 had no impairment in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for putting on footwear. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) from staff for bathing and toileting hygiene. The MDS indicated Resident 1 required partial/moderate (helper does less than half the effort) assistance from staff for oral hygiene and lower body dressing.b. During a review of Resident 2's AR, the AR indicated the facility admitted Resident 2 on 10/14/2020 and readmitted Resident 2 on 1/25/2026 with diagnoses including cellulitis (a spreading skin infection) of both legs, lack of coordination, and hypertension (high blood pressure).During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 was moderately impaired in cognitive skills. The MDS indicated Resident 1 required substantial/maximal assistance from staff for bathing, lower body dressing, and toileting hygiene. The MDS indicated Resident 2 required partial/moderate assistance from staff for oral hygiene and upper body dressing.During a concurrent observation and interview on 3/26/2026 at 11:30 AM with Resident 2 in the shower room next to the facility's dining room, there was a pool of water over the shower drain. Resident 2 stated Resident 2 had to stand in the pool of water when Resident 2 took a shower because the water drain was clogged. Resident 2 stated Resident 2 felt disgusted from standing in the pool of water over the clogged shower drain. Resident 2 stated the clogged shower drain made Resident 2 feel dirty.During a concurrent observation and interview on 3/27/2026 at 9:38 AM with the Maintenance Director (MD) in the shower room next to the facility's dining room, there was a pool of water over the shower drain. The MD stated the shower drain was clogged.During an interview on 3/27/2026 at 11:03 AM with Resident 1, Resident 1 stated Resident 1 took a shower 3 days ago in the shower room next to the dining room. Resident 1 stated Resident 1 was sitting in a shower chair, but the water was not draining. Resident 1 stated the water puddle was disgusting. Resident 1 stated the unidentified Certified Nursing Assistant (CNA) assisting Resident 1 was standing in the puddle of water.During a review of the facility's policy and procedure (P&P) titled, Quality of Life - Homelike (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Environment, revised May 2017, the P&P indicated, Residents are provided with a safe, clean, comfortable and homelike environment . The P&P indicated, The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include.Clean, sanitary and orderly environment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to administer physician ordered medication to one of three sampled residents (Resident 1) on 3/13/2026 and 3/14/2026. This failure had the potential to result in Resident 1 experiencing itching and dryness to the face. During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 11/5/2025 with diagnoses including anorexia nervosa (an eating disorder defined by restriction of energy intake relative to requirements), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 2/6/2026, the MDS indicated Resident had no impairment in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for putting on footwear. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) from staff for bathing and toileting hygiene. The MDS indicated Resident 1 required partial/moderate (helper does less than half the effort) assistance from staff for oral hygiene and lower body dressing.During a review of Resident 1's Order Summary Report (OSR), dated 3/27/2026, the OSR indicated Resident 1 had a physician order, dated 3/3/2026, to apply Clotrimazole External Solution 1 % (a liquid medication applied to the skin used to treat skin infections) to Resident 1's face every day shift (7 AM to 3 PM) for eczema (a skin condition that causes dry, itchy skin). During an interview on 3/26/2026 at 1:30 PM with Resident 1, Resident 1 stated Resident 1 had a physician order to receive a topical solution for itching and eczema. Resident 1 stated the facility staff did not provide Resident 1 with the medication for 5 days beginning on 3/11/2026.During a concurrent interview and record review on 3/27/2026 at 12:08 PM with Treatment Nurse (TN) 1, Resident 1's Treatment Administration Record (TAR), dated March 2026, and Resident 1's Progress Notes (PN), dated 3/27/2026, were reviewed. The TAR indicated, on 3/13/26 and 3/15/2026, facility staff did not apply Clotrimazole External Solution 1 % to Resident 1's face as ordered. The PN indicated the solution was not given on 3/13/2026 because the medication was not on hand. TN 1 stated TN 1 did not give Resident 1 the Clotrimazole External Solution 1 % on 3/13/2026 because the medication was not on hand. TN 1 stated TN 1 did not reach out to the pharmacy to determine why the medication was not available. TN 1 stated TN 1 did not notify Resident 1's physician that the ordered medication was not given to Resident 1.During an interview on 3/27/2026 at 12:40 PM with the Director of Nursing (DON), the DON stated if a resident's (in general) medication was not available, the nurse (in general) must follow up with the pharmacy and notify the medication prescriber that the prescribed medication was not provided to the resident.During an interview on 3/27/2026 at 2:25 PM with the DON, the DON stated the facility did not have a Policy and Procedure (P&P) for medication administration.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure five of 35 sampled staff (Licensed Vocational Nurse [LVN] 1, LVN 3, Care Coordinator [CC] 1, Treatment Nurse [TN] 2, and the Hairdresser [HD]) followed state regulations by failing to wear identification name badges while on duty.This failure had the potential for residents (in general) not to know who was providing care for the residents (in general). a. During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 11/5/2025 with diagnoses including anorexia nervosa (an eating disorder defined by restriction of energy intake relative to requirements), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 2/6/2026, the MDS indicated Resident 1 had no impairment in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for putting on footwear. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) from staff for bathing and toileting hygiene. The MDS indicated Resident 1 required partial/moderate (helper does less than half the effort) assistance from staff for oral hygiene and lower body dressing.b. During a review of Resident 3's AR, the AR indicated the facility admitted Resident 1 on 1/7/2026 with diagnoses of a fracture (broken bone) of the right arm, type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and lack of coordination.During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident was moderately impaired in cognitive skills. The MDS indicated Resident 3 required substantial/maximal assistance from staff for bathing, lower body dressing, and toileting hygiene. The MDS indicated Resident 3 required partial/moderate assistance from staff for oral hygiene and upper body dressing.During a concurrent observation and interview on 3/26/2026 at 11:24 AM with Licensed Vocational Nurse (LVN) 3, LVN 3's identification (ID) badge was clipped to LVN 3's pants pocket (below the waist). LVN 3 stated that LVN 3 usually wore LVN 3's ID badge that way.During a concurrent observation and interview on 3/26/2026 at 11:52 AM with Care Coordinator (CC) 1, CC 1 was with Resident 3 in the facility lobby. CC 1 was having Resident 3 sign documents. CC 1 was not wearing an ID badge. CC 1 stated CC 1 did not have CC 1's ID badge with CC 1.During a concurrent observation and interview on 3/26/2026 at 11:56 AM with the Hairdresser (HD), the HD was going from resident room to resident room. The HD was not wearing an ID badge. The HD stated the HD did not have an ID badge.During a concurrent observation and interview on 3/26/2026 at 12 PM with Treatment Nurse (TN) 2, TN 2 was not wearing an ID badge. TN 2 stated TN 2 was a newly hired facility staff and had not been given a badge yet.During a concurrent observation and interview on 3/26/2026 at 12:04 PM with LVN 1 at the South Nurses' Station, LVN 1 was not wearing an ID badge. LVN 1 stated LVN 1 had forgotten to put LVN 1's ID badge on when LVN 1 returned from LVN 1's lunch break.During an interview on 3/26/2026 at 1:30 PM with Resident 1, Resident 1 stated that multiple facility staff (in general) did not wear ID badges when working at the facility. Resident 1 stated Resident 1 needed staff (in general) to wear their ID badges so Resident 1 knew who was taking care of Resident 1.During a review of the facility's policy and procedure (P&P) titled, Identification Name Badges, revised January 2008, the P&P indicated, In order to promote safety and security measures established by our facility, each employee must wear his/her identification name badge at all times while on duty.According to the California Code of Regulations Title 22, Section 72501(h), The licensee shall ensure that all employees serving patients or the public shall wear name and title badges unless contraindicated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed to prevent the transmission of disease and infection for two of three sampled residents (Residents 1 and 2) when: a. Residents 1 and 2 took a shower in the shower room next to the facility's dining room while the shower drain was clogged.b. Facility staff failed to empty Resident 1's 3 full urinals hanging on the foot of Resident 1's bed. These failures had the potential to result in the spread of infections among the residents (in general) residing at the facility.(Cross reference F584)a1. During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 11/5/2025 with diagnoses including anorexia nervosa (an eating disorder defined by restriction of energy intake relative to requirements), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 2/6/2026, the MDS indicated Resident 1 had no impairment in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for putting on footwear. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) from staff for bathing and toileting hygiene. The MDS indicated Resident 1 required partial/moderate (helper does less than half the effort) assistance from staff for oral hygiene and lower body dressing.a2. During a review of Resident 2's AR, the AR indicated the facility admitted Resident 2 on 10/14/2020 and readmitted Resident 2 on 1/25/2026 with diagnoses including cellulitis (a spreading skin infection) of both legs, lack of coordination, and hypertension (high blood pressure).During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 was moderately impaired in cognitive skills. The MDS indicated Resident 1 required substantial/maximal assistance from staff for bathing, lower body dressing, and toileting hygiene. The MDS indicated Resident 2 required partial/moderate assistance from staff for oral hygiene and upper body dressing.During a concurrent observation and interview on 3/26/2026 at 11:30 AM with Resident 2 in the shower room next to the facility's dining room, there was a pool of water over the shower drain. Resident 2 stated Resident 2 had to stand in the pool of water when Resident 2 took a shower because the water drain was clogged. Resident 2 stated Resident 2 felt disgusted and did not want to get an infection from standing in the pool of water over the clogged shower drain.During a concurrent observation and interview on 3/27/2026 at 9:38 AM with the Maintenance Director (MD) in the shower room next to the facility's dining room, there was a pool of water over the shower drain. The MD stated the shower drain was clogged.During an interview on 3/27/2026 at 11:03 AM with Resident 1, Resident 1 stated Resident 1 took a shower 3 days ago in the shower room next to the dining room. Resident 1 stated Resident 1 was sitting in a shower chair, but the water was not draining. Resident 1 stated the water puddle was disgusting. Resident 1 stated the unidentified Certified Nursing Assistant (CNA) assisting Resident 1 was standing the puddle of water. Resident 1 stated the pool of water over the clogged shower drain made Resident 1 worry about bacteria spreading from the drain to Resident 1 and other residents (in general).b. During a concurrent observation and interview on 3/26/2026 at 12:14 PM with Resident 1 in Resident 1's room, there were 3 urinals (a container used to collect urine), full of urine, hanging on the foot of Resident 1's bed. Resident 1 stated the facility staff had not emptied Resident 1's urinals all day. Resident 1 stated the facility staff should come to Resident 1's room to check if Resident 1's urinals needed to be emptied. Resident 1 stated the facility staff knew Resident 1 used a urinal. Resident 1 stated that it happened all the time that facility staff would not empty Resident 1's urinals.During an interview on 3/26/2026 at 12:25 PM with Certified Nursing Assistant (CNA) 1, CNA 1 stated CNA 1 was assigned to care for Resident 1 during the current shift. CNA 1 stated CNA 1 had not emptied Resident 1's urinals during (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the current shift. CNA 1 stated CNA 1?s practice was to not enter Resident 1's room when Resident 1 was in the room. CNA 1 stated CNA 1 did not enter Resident 1's room because Resident 1 did not press the call light (a device used by a resident to signal his or her need for assistance from staff).During an interview on 3/27/2026 at 10:27 AM with the Infection Preventionist (IP), the IP stated the facility staff should round on residents (in general) every 2 hours. The IP stated Resident 1's urinals should be emptied at least every 2 hours. The IP stated if the urinals are not emptied, Resident 1 could spill urine on himself or onto the floor which could possibly spread contaminants onto Resident 1's environment.During a review of the facility's policy and procedure (P&P) titled, Bedpan/Urinal, Offering/Removing, revised May 2017, the P&P indicated, Bathrooms, including showers, . are cleaned and disinfected daily in accordance with our established procedures.During a review of the facility's policy and procedure (P&P) titled, Bedpan/Urinal, Offering/Removing, revised February 2018, the P&P indicated, The purpose of this procedure is to provide the resident with bedpan and/or urinal assistance The P&P indicated, If the resident prefers to keep a urinal at his bedside, check it frequently. Empty and clean it as necessary.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to be adequately equipped to allow residents (in general) to call for staff assistance, when:One of three sampled residents (Resident 2) did not have a functioning call light (a device used by a resident to signal the need for assistance) when taking a shower in the shower room next to the facility's dining room.One of three of the facility's shower room (across from the South Nurses' Station) call light pull cord did not reach down to the ground.These failures had the potential for residents to experience harm if residents were unable to alert staff during an emergency. During a review of Resident 2's AR, the AR indicated the facility admitted Resident 2 on 10/14/2020 and readmitted Resident 2 on 1/25/2026 with diagnoses including cellulitis (a spreading skin infection) of both legs, lack of coordination, and hypertension (high blood pressure).During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 was moderately impaired in cognitive skills. The MDS indicated Resident 1 required substantial/maximal assistance from staff for bathing, lower body dressing, and toileting hygiene. The MDS indicated Resident 2 required partial/moderate assistance from staff for oral hygiene and upper body dressing.During a concurrent observation and interview on 3/26/2026 at 11:30 AM with Resident 2 in the shower room next to the facility's dining room, the call light did not activate when the call light cord was pulled. Resident 2 stated Resident 2 took showers by himself in the shower room. Resident 2 stated If Resident 2 fell on the ground Resident 2 could not call for help because the call light did not work.During a concurrent observation and interview on 3/27/2026 at 9:38 AM with the Maintenance Director (MD) in the shower room next to the facility's dining room, the call light did not activate when the call light cord was pulled. The MD confirmed the call light did not activate when the call light cord was pulled. The MD stated the call light needed to work in case a resident (in general) fell and needed assistance.During a concurrent observation and interview on 3/27/2026 at 9:42 AM with the Maintenance Director (MD) in the shower room across from the South Nurses' Station, the call light pull cord did not extend to the ground. The MD confirmed the call light cord was too short. The MD stated the call light pull cord needed to reach low enough so that if a resident (in general) had fallen to the ground, the resident (in general) could activate the call light.During an interview on 3/27/2026 at 2:25 PM with the DON, the DON stated the facility did not have a Policy and Procedure (P&P) regarding the call light system.