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	04/16/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure one of three sampled residents' (Resident 5's) medical record was complete when documentation regarding assisting Resident 5 with dinner and providing oral hygiene to Resident 5 on 2/2/2026 evening shift (3 PM to 11 PM) and providing Resident 5 oral hygiene on 2/3/2026 night shift (11 PM to 7 am) was not found in Resident 5's medical record.This failure resulted in incomplete documentation in Resident 5's medical record and had the potential for Resident 5 not to receive necessary services and adequate care.During a review of Resident 5's admission Record (AR), the AR indicated the facility originally admitted Resident 5 on 10/4/2022 and readmitted on [DATE] with diagnoses which included primary arthritis (a degenerative joint disease, mainly affects joints in hands, knees, hips and spine), dementia (a progressive state of decline in mental abilities), and gastro-esophageal reflux disease (a condition when stomach acid flows back into the esophagus, causing persistent heartburn, regurgitation, chest pain, and difficulty swallowing).During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 2/28/2026, the MDS indicated Resident 5 was severely impaired in cognitive skills (ability to make daily decisions) and was dependent (helper does all of the effort to complete the activity) with toileting hygiene, showering/bathing self, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort to complete the activity) with eating, oral hygiene and upper body dressing.During a review of Resident 5's Order Summary Report (OSR), dated 2/1/2026, the OSR indicated that Resident 5 is on regular diet minced and moist. The OSR indicated that Resident 5 needed RNA (Restorative Nursing Assistant- provides specialized care to help patients recover and keep their functional abilities) to assist with feeding for breakfast, lunch, and dinner.During a review of Resident 5's Care Plan (CP), dated 10/15/2025, the CP indicated Resident 5 had a swallowing problem related to difficulty or pain with swallowing. The CP interventions included checking Resident 5's mouth after meal for pocketed food and debris, reporting to nurse, and providing oral care to remove debris.During a review of Resident 5's CP, dated 10/16/2025, indicated Resident 5 had an ADLs (Activities of Daily Living- activities such as bathing, dressing and toileting a person performs daily) self-care performance deficit related to limited mobility, confusion, dementia, and pain. The CP indicated the resident required staff assistance to eat and the resident had their own teeth and required oral inspection every shift for oral care.During a review of Resident 5's Documentation Survey Report (DSR) for ADLs in February 2026, there was no entry for eating and oral hygiene on 2/2/2026 evening shift (3 PM-11 PM) and 2/3/2026 night shift (11 PM-7 AM).During a review of Resident 5's medical record, RNA or Certified Nursing Assistant (CNA) documentation regarding assisting Resident 5 with dinner and providing oral hygiene on 2/2/2026 evening shift and providing oral hygiene on 2/3/2026 night shift was not found.During an interview on 4/16/2026 at 1:46 PM with CNA 6, CNA 6 stated that the nursing staff who assisted Resident 5 with eating needed to make sure Resident 5 swallowed all foods and document the eating conditions in the chart (medical record) such as the percentage of meal consumed. CNA 6 stated the nursing staff should document assisting (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 5 with eating and oral hygiene on the ADL charting every shift for Resident 5.During an interview on 4/16/2026 at 3:07 PM with Licensed Vocational Nurse (LVN) 4, LVN 4 stated that the nursing staff who assisted the resident with eating should document assisting the resident with eating and oral hygiene on the ADL charting every time for the resident.During a concurrent interview and record review on 4/16/2026 at 4:52 PM with the Director of Nursing (DON), Resident 5's DSR for ADL was reviewed. The DON stated Resident 5's DSR for ADL on eating and oral hygiene was incomplete on 2/2/2026 evening shift and 2/3/2026 night shift. The DON stated it was important to complete the documentation accurately to verify the resident's health condition and reflect the care provided.During a review of the facility's policy and procedure (P&P) titled, Assisting the Resident with In-Room Meals, revised 12/2013, the P&P indicated, under documentation, The person performing this procedure should record the following information in the resident's medical record:1. The date and time the procedure was performed.2. The name and title of the individual(s) who performed the procedure.3. How much of the meal the resident consumed (i.e., 25%, 50%, 75%, etc.).4. If and how the resident participated, or any changes in the resident's ability to participate with the meal.5. Any special request(s) made by the resident concerning his or her eating time or food likes and dislikes.6. Any difficulty the resident had in feeding himself or herself, chewing or swallowing.7. If the resident refused the meal or to eat, the reason(s) why and the intervention taken.8. The signature and title of the person recording the data.