Accepted signed and dated POC
45523 - 6/3/25

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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056079	A. BUILDING _____ B. WING _____	C 05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENDORA GRAND, INC	805 W. ARROW HWY. GLENDORA, CA 91740

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey. Facility Reported Incident Number: CA00960706 The inspection was limited to the specific Facility Reported Incident investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for the Facility Reported Incident: CA00960706 (Refer to F740).	F 000	Please accept this Plan of Correction as our Credible Allegation of Compliance. The deficiencies cited will be corrected as specified and they will be monitored to prevent recurrence. Preparation and /or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies and plan of correction. The Provider submits this Plan of Corrections with the intention that it is inadmissible by any third party in any civil or criminal action or proceedings against the Provider, its employees, agents, officers, directors, or shareholders. Plan of Correction is submitted to meet requirements established by state and federal law The Provider reserves the right to challenge the cited findings if at any time the Provider determines that the disputed findings are relied upon in a manner adverse to the interest of the Provider, either by the governmental agencies or third party. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and California Evidence Code Section 1151 and should be admissible in any proceedings on that basis.	5/27/25
F 740 SS=D	CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 1) was provided with the necessary behavioral health care and services to address Resident 1's history of suicidal ideation (SI- a range of thoughts, fantasies, or contemplations about ending one's own life) by failing to:	F 740		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator — 5/27/25

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.

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F 740	Continued From page 1 1. Ensure the Social Services Director (SSD) and/or admitting licensed nurse accurately assessed and documented Resident 1's episode of suicidal ideation while Resident 1 was in the General Acute Care Hospital (GACH) 1 on 4/20/2025. 2. Develop a care plan for Resident 1's history of suicidal ideations. 3. Monitor Resident 1 for suicidal ideations. These deficient practices had the potential to worsen Resident 1's mental condition and increase Resident 1's risk for suicide and self-harm. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was originally admitted to the facility on 11/18/2024, and readmitted on 4/29/2025, with diagnoses that included schizophrenia (a mental disorder characterized by disruptions in thought, perceptions, emotional responsiveness, and social interactions), unspecified psychosis (severe mental condition in which thought and emotions are so affected that contact is lost with reality), generalized anxiety disorder (a mental health disorder that produces fear, worry, and a constant feeling of being overwhelmed), and major depressive disorder (a mood disorder that causes persistent feeling of sadness, and loss of interest). During a review of Resident 1's physician order (PO) dated 4/16/2025, the PO indicated Resident 1 had an order to transfer to GACH 1 on 4/17/2025 for further evaluation secondary to behavior of increased verbal and physical	F 740	**F 740** **Behavioral Health Services** **483.40** Resident 1 was discharged to acute hospital for evaluation of his aggressive behavior on 5/6/25. All residents in house census as of 5/16/25 were reviewed by the DON and RN/LVN supervisors. Review was initiated on 5/16/25 to ensure that residents with history of suicidal ideations has been assessed, care planned and monitored. Review was completed on 5/22/25. NO other residents were affected.	5/22/25

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F 740	Continued From page 2 aggression and destroying facility property. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 4/17/2025, the MDS indicated Resident 1's cognitive (ability to think and reason) skills for daily decision making were modified independence (some difficulty in new situations only). The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching steadying and/or contact guard assistance as resident completes activity) with oral, toileting, and personal hygiene, showering/bathing, upper and lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 1 had delusions (misconceptions or beliefs that are firmly held, contrary to reality) and exhibited verbal behavioral symptoms directed toward others for one (1) to three (3) days of the assessment and other behavioral symptoms not directed toward others daily. During a review of Resident 1's GACH 1 Psychiatric Evaluation (GACH 1 PE) dated 4/20/2025, the GACH 1 PE indicated, "He (Resident 1) reported having suicidal thoughts 2 days ago with a plan to overdose (taking more than the recommended amount of a medicine or drug) on his medication." The GACH 1 PE indicated, "When asked why he (Resident 1) is in the hospital he replies, "I was having suicidal thoughts." The GACH 1 PE indicated Resident 1 reported feeling helpless, hopeless, and worthless because he had been getting abused, and no one would do anything about it. The GACH 1 PE indicated Resident 1 stated Resident 1's hand was broken because Resident 1 punched the wall. The GACH 1 PE indicated	F 740	Social services department and licensed nurses were in serviced by the DON on 5/15 and 5/19/25 regarding Behavioral Health Services; Social services and licensed nurse to accurately assess and document suicidal ideation upon admission; Develop a care plan and to monitor the suicidal ideation behavior. Every other month, licensed staff and Social services department will be given an in-service regarding Behavioral Health Services by the DON. RN/LVN supervisors will monitor compliance during weekly admissions review using the suicidal ideation admission review log to ensure that resident's suicidal ideations has been assessed upon admission, care planned and behavior is being monitored. Any findings will be corrected immediately and will be given to the DON for follow up. Any significant findings will be reported by the DON during the quarterly QA&A meetings for discussion and recommendation for 6 months.	5/27/25

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F 740	Continued From page 3 Resident 1 stated, "I don't remember why I got angry." The GACH 1 PE indicated Resident 1 was positive for hallucinations, talked to himself and stated, "The voices keep telling me to go home." The GACH 1 PE indicated Resident 1's mood was labile (easily altered) and unpredictable (something that can change suddenly, unexpected and cannot be planned for). The GACH 1 PE indicated Resident 1 was unable to be managed at a lower level of care at this time. During a review of Resident 1's Nursing Progress Note (NPN) dated 4/29/2025, timed at 10:08 PM, the NPN indicated Resident 1 was transferred to GACH 1 on 4/17/2025 due to Resident 1's increasing verbal aggression when Resident 1's demands were not met, destroying facility property, striking out glass panel of the station, and walking in the hallway with Resident 1's fist clenched on the right hand. The NPN indicated Resident 1 was readmitted from GACH 1 (on 4/29/2025). The NPN indicated Resident 1 was calm and cooperative with staff at this time. During a review of Resident 1's Social Service History & Initial Assessment (SSHIA) dated 4/30/2025, timed at 11:30 AM, the SSHIA indicated, "Readmitted Resident 1 from acute hospital back to secure unit for wandering behavior, after going out for aggressive behavior here at facility manifested by destroying facility property ..." The SSHIA indicated Resident 1 remained guarded and did not engage well in conversation. The SSHIA indicated the SSD would monitor Resident 1's care/psychosocial health. The SSHIA indicated, under "Psychosocial Adjustment Factors," the SSD did not check off the boxes for history of depression and history of	F 740		

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F 740	Continued From page 4 suicidal ideation/gestures. During a concurrent interview and record review on 5/15/2025 at 10:28 AM with the Director of Nursing (DON), Resident 1's admission record was reviewed. The DON stated Resident 1 was readmitted to the facility on 4/29/2025, and did not have a diagnosis of suicidal ideations (SI) on Resident 1's admission record. The DON stated there were no suicidal ideation assessments completed, no care plan developed with interventions, and no monitoring initiated to address Resident 1's report of suicidal ideation while in GACH 1, upon Resident 1's readmission to the facility. During an interview on 5/15/2025 at 11:25 AM with the SSD, the SSD stated the SSD had met with Resident 1 to go over the history interview (on 4/30/2025). The SSD stated, "I did notice that he (Resident 1) went out for aggression and when he (Resident 1) came back from the hospital (GACH 1), on the History and Physical (H&P/GACH 1 PE), he (Resident 1) had a history of suicidal ideation. The SSD stated when Resident 1 came back to the facility, the SSD had a talk with Resident 1 and Resident 1 wanted to call Resident 1's mom. The SSD stated the SSD asked how Resident 1 felt and Resident 1 stated Resident 1 felt fine. The SSD stated the SSD asked Resident 1 twice if Resident 1 felt like Resident 1 wanted to hurt himself or if Resident 1 had ever tried to hurt yourself. The SSD stated Resident 1 answered, "No." During the same interview on 5/15/2025 at 11:25 AM with the SSD, the SSD stated the SSD did not document the conversation the SSD had with Resident 1 regarding Resident 1's SI. The SSD	F 740		

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F 740	Continued From page 5 stated the SSD should have documented the conversation about SI on Resident 1's Social Service History & Initial Assessment. The SSD stated if Resident 1 had a positive SI answer, the SSD should have notified the nursing department and participated in an Interdisciplinary Team (IDT- a group of healthcare professionals, including nurses, doctors, therapists, and social workers, who collaborate to provide comprehensive care and services to residents) meeting, and considered documenting a change of condition (COC) for Resident 1. The SSD stated in general, upon admission of a resident, the SSD needed to complete the history and physical of the resident including history about family or health issues. The SSD stated in the form the SSD used to complete the resident's H&P (in general), there was a check list for social services staff to check off if there were any issues or concerns with the resident having SI. The SSD stated for Resident 1, the SSD left the area for history of suicidal ideation/gestures blank because of the conversation the SSD had with Resident 1 (on 4/30/2025). The SSD stated the SSD completed the assessment by interviewing Resident 1 and reviewing Resident 1's history and physical. During a concurrent interview and record review on 5/15/2025 at 11:36 AM with DON, Resident 1's medical record was reviewed. The DON stated if a resident (in general) had SI, there should have been an assessment upon admission, CP created with interventions to keep the resident safe, monitoring, COC initiated, and an IDT meeting held. The DON stated the resident's doctor should have been notified, and new orders would have been given. The DON stated the SSD should have checked off the history of SI in the SSD's assessment of Resident 1. The DON	F 740		

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F 740	Continued From page 6 stated the SSD should have documented any type of conversation she had with Resident 1 whether Resident 1 verbalized SI or not. The DON stated that because the SSD did not complete the SI assessment, there could have been potential and/or actual harm to Resident 1. During an interview on 5/15/2025 at 12:45 PM with the Administrator (Admin), the Admin stated the facility staff needed to assess Resident 1 for suicide ideations due to Resident 1's history upon admission. The Admin stated it was very important to assess Resident 1 for suicidal ideations to prevent harm and the way to do so was by making sure the steps were put into place where Resident 1 was assessed, monitored, and kept safe. The Admin stated if there was an assessment done specially about suicide, the staff needed to document the assessment. The Admin stated the SSD should have documented the conversation the SSD had with Resident 1 and notified nursing staff right away. During an interview on 5/15/2025 at 4 PM with Registered Nurse (RN) 2, RN 2 stated that if a resident (in general) was suicidal or had history of SI, it needed to be taken very seriously because if it was missed, it could place the resident at risk of danger to himself/herself. RN 2 stated there needed to be documentation of the interview with the resident even if the resident was currently not having SI. RN 2 stated documenting any type of SI information from a resident helped to clarify to the rest of the staff and staff were able to access the information. RN 2 stated if it was not documented, it could affect the care given to the resident and the continuity and quality of care provided. RN 2 stated a missed assessment could cause potential harm to the resident. RN 2	F 740		

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F 740	Continued From page 7 stated there should be a care plan developed to make sure the resident had adequate interventions even if it was just a history of SI." During the same interview on 5/15/2025 at 4 PM with RN 2, RN 2 stated, "Undocumented suicidal thoughts mean staff may not be aware of the patient's risk level, leading to inadequate supervision, safety precautions, and a missed opportunity for interventions that could potentially save the residents life. If it's not documented, it wasn't done." RN 2 stated, it was important to document any resident's history of suicidal thoughts to decrease the resident's risks of injury and even death and that was what we (the staff) were here for. RN 2 stated that even if the resident did not currently have suicidal thoughts, it was important to document the history. RN 2 stated, "It doesn't hurt to document it." During a review of the facility's policy and procedure (P&P) titled, "Behavior Management Program," undated, the P&P indicated, "Residents who display mental or psychosocial adjustment difficulty should receive appropriate services, in an attempt to correct the problem." The P&P indicated, "Behaviors shall be identified through the Resident Assessment Instrument (RAI- a process that is used to gather information about residents' needs, strengths, and preferences to create individualized care plans and ensure residents receive quality care and maintain their quality of life) and through staff interaction ... Further assessments to identify and manage behaviors may be conducted... Identified behaviors should be evaluated and documented on MAR (Medication Administration Record) or other specified location." The P&P indicated, "The Interdisciplinary Team should decide which	F 740		

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F 740	Continued From page 8 residents need a behavior management program vs. residents that are care planned with appropriate interventions, by evaluating them." During a review of the facility's P&P titled, "Suicide Assessment," undated, the P&P indicated, "It is the policy of this facility to assess residents for suicidality." The P&P indicated, "Residents will be assessed for suicide risk upon admission and as indicated. The facility social worker or designee will conduct a medical record review and then interview the resident regarding any risk factors that have been identified. Protective factors will be explored with the resident as well." The P&P indicated, "Risk factors include, but are not limited to ...History of prior suicide attempts or self-injurious behaviors ...Current or past psychiatric disorder(s) and/or recent change in psychiatric treatment (change in medication/treatment/ provider or recent discharge from inpatient psychiatric setting) ... Symptoms such as hopelessness, helplessness, anxiety/panic, and impulsivity..." The P&P indicated, "Objectively and thoroughly document the resident's mood and behaviors, as well as all actions taken, in the medical record." During a review of the facility's P&P titled, "Baseline Care Plan", undated, the P&P indicated, "The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care." The P&P indicated, "The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident	F 740		

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F 740	Continued From page 9 and resident representative, if applicable ... Once gathered, initial goals shall be established that reflect the resident's stated goals and objectives ... Interventions shall be initiated that address the resident's current needs including ... Any health and safety concerns to prevent decline or injury ... Any identified needs for supervision, behavioral interventions ..." During a review of the facility's job description for Social Services Designee (JD SSD) titled, "Social Services Designee, the JD SSD indicated, "The Social Service Designee will participate in discharge planning, development and implementation of care plans and resident assessments. The Social Service Designee will accurately and completely document social service actions and interactions in each resident's medical record. The Social Service Designee will ensure that residents who display mental illness, or psychosocial difficulties such as coping with grief and loss, have access to appropriate treatment and resources."	F 740		