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 _____	C 03/25/2025

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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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of two complaints and two Facility Reported Incidents (FRI). Complaint Numbers: CA00951066 and CA00951173 Facility Reported Incidents: CA00951857 and CA00952725 The inspection was limited to the specific complaints and Facility Reported Incidents investigated and does not represent the findings of a full inspection of the facility. No deficiency was identified for Complaint Number: CA00951066. No deficiency was identified for Complaint Number: CA00951173. No deficiency was identified for Facility Reported Incident CA00951857. One deficiency was written for Facility Reported Incident CA00952725 (Refer to F600).	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600	**CORRECTIVE ACTION:** On 3/20/25, Resident 4 was assessed by the licensed nurse, initial treatment was provided, Analgesic was provided for pain and was transferred to a General Acute Care Hospital for further evaluation. Resident 4 returned the same day and room change was initiated. Treatment for scratches to face continued until resolved on 3/31/25. Resident did not have any complaints of pain upon return and throughout the stay at the facility. On 3/21/25 and 3/24/25, Social Services Director conducted a room visit to Resident 4 and Resident 4 had no concerns regarding care or safety	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	04/08/25

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 600	Continued From page 1 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, Certified Nursing Assistant 1 (CNA 1) and Licensed Vocational Nurse 1 (LVN 1) failed to ensure one of five sampled residents (Resident 4) was not physically assaulted (attacked or harmed through physical violence) by another resident (Resident 5) on 3/20/2025. This deficient practice resulted in Resident 4 sustaining a closed head injury (type of traumatic brain injury where the skull remains intact) and mildly comminuted (bones break into pieces), minimally displaced (out of place) right nasal (nose) bone fracture (break in the bone) on 3/20/2025. Resident 4 was transferred to General Acute Care Hospital 1 (GACH 1) for evaluation of moderate head pain after a head injury from an assault. Findings: a. During a review of Resident 5's Admission Record (AR), the AR indicated the facility admitted Resident 5 on 2/27/2025 with diagnoses that included paranoid schizophrenia [a type of schizophrenia (a mental illness characterized by disturbances in thinking) associated with feelings of being persecuted or plotted against] and major depressive disorder (persistent feeling of sadness, hopelessness and loss of interest/pleasure in activities). During a review of Resident 5's Progress Note	F 600	On 3/21/25, Psychiatrist consult was conducted and Resident 4 had no new onset of any Psychiatric concern and stated she feels safe in the facility. On 4/9/25, xray of nose was ordered but resident refused. On 4/10/25, xray was re-offered but resident still refused stating she does not have any pain. Risks and benefits explained but still refused. Primary Physician and Responsible Party was notified. On 3/20/25, Resident 5 was assessed by the licensed nurse, initial treatment was provided, Analgesic was provided for pain, one-on-one sitter was initiated and was transferred to a General Acute Care Hospital for further evaluation. Resident 5 returned to the facility the same day with no major injuries noted. On 3/20/25 and 3/21/25, Social Services Director conducted a room visit to Resident 5 and Resident 5 had no concerns regarding care or safety after she was separated from Resident 4. Resident 5 continued to have one-on-one sitter until transferred to another facility per Resident 5's request. Resident 5 will not return to the facility. On 3/21 and 3/24, all staff was provided in servicing on Resident-to-resident altercation/ abuse prevention, reporting and investigation. On 4/10/2025, an All Staff meeting was conducted with outside resources to in service on behavior management of residents.	

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F 600	Continued From page 2 (PN), dated 3/20/2025 and timed at 11:54 pm, the PN indicated Resident 5 sustained scratches on the right side of the face, the forehead and bleeding on top of Resident 5's nose. The PN indicated Resident 5 continued to scream and yell towards staff. During a review of Resident 5's PN dated 3/21/2025 timed at 5:09 pm, the PN indicated, Resident 5 was transferred to GACH 2 on 5150 hold (a 72-hour involuntary hold when an individual was deemed a danger to self or others or gravely disabled due to a mental order) for evaluation. b. During a review of Resident 4's AR, the AR indicated the facility admitted Resident 4 on 2/19/2025 with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember, severe enough to affect a person's daily functioning), schizophrenia, and major depressive order. During a review of Resident 4's Minimum Data Sheet (MDS, a resident assessment tool) dated 2/25/2025, the MDS indicated Resident 4 had moderately impaired cognition (ability to understand and process information). During a review of Resident 4's Situation, Background, Assessment, Recommendation (SBAR, a communication tool used by healthcare workers when there is a change of condition among the residents) communication form dated 3/20/2025, the SBAR indicated Resident 4 went to Resident 5's (Resident 4's roommate) bed, stood at the end of the bed, held onto the footboard of Resident 5's bed. When Resident 5 got up, Resident 4 grabbed Resident 5's hair.	F 600	**IDENTIFYING OTHER RESIDENTS AT RISK** All residents had potential for harm due the deficient practice. On 4/10/25, facility audited residents with history of aggressive behavior and 16 residents were identified. 2 of 16 identified residents had an altercation on 3/30/25 that was immediately deescalated by staff with no negative outcome. On 4/10/25, SSD/designee interviewed 48 residents with capacity to make decisions and make needs known to ensure resident safety and roommate compatibility. 2 residents who verbalized concerns with roommates were moved to another room per resident's request. **SYSTEMIC CHANGES** Hallway Monitor Program (24/7 monitoring) was initiated on 3/29/25. All Hallway Monitoring Aides have undergone Skills Competency conducted by DSD/Designee. Monitoring aide will do rounds every two hours to identify residents with potential escalating behaviors that could lead to aggression. Findings will be logged onto a Hallway Monitor Form and will be reported and addressed accordingly. A certified Management Assaultive Behavior trainer resource initiated an in-person training on 4/10/25 to staff regarding preventing resident-to-staff and resident-to-resident altercation by identifying potential behaviors and how to deescalate situations that may lead to altercation. Psychology visit will be increased to weekly at minimum for all residents with history of aggressive behavior and will be referred to Psychiatrist as needed.	

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F 600	Continued From page 3 During a review of Resident 4's PN dated 3/20/2025 and timed at 12:55 pm, the PN indicated CNA 1, and LVN 1 heard screaming coming from Resident 4 and 5's room. The PN indicated Resident 4 walked toward Resident 5's bed and started making the bed (the act of preparing/arranging the bed) of Resident 5 while Resident 5 was sleeping in bed. The PN indicated Resident 5 got up from bed and walked towards Resident 4. The PN indicated Resident 5 screamed, hit Resident 4 on the head with Resident 5's fist and scratched Resident 4 on the face with Resident 5's other hand. The PN indicated Resident 4 grabbed the hair of Resident 5. The PN indicated Resident 4 sustained a bump on the forehead, finger scratch marks on the face and bleeding from the right nostril. The PN indicated Resident 4 complained of 5/10 pain on a scale of 0 to 10 (a scale to measure and quantify the intensity of pain; 0 = no pain,10 = worst pain, and 5 = moderate pain) to the face. During a review of Resident 4's Physician's Order (PO) dated 3/20/2025 and timed at 2:36 pm, the PO indicated to transfer Resident 4 to GACH 1 for evaluation. During a review of Resident 4's PN dated 3/20/2025 and timed at 4:04 pm, the PN indicated Resident 4 was transferred to GACH 1. During a review of Resident 4's GACH 1's Emergency Department (ED) records, dated 3/20/2025, the ED records indicated Resident 4 was brought to the ED for evaluation of head pain after a head injury from an assault. The ED records indicated another resident (Resident 5) hit Resident 4 in the facility. The ED records	F 600	**MONITORING EFFECTIVENESS** The SSD/designee will report concerns or issues related to the deficient practice to the DON and/or Administrator for follow up. Staff will also be encouraged to identify trends and vocalize concerns related to the deficient practice by utilizing the Administrator's open door policy and by participating in providing feedback at the mandatory monthly All Staff Meeting. Reports/ findings will be submitted to the QAA Committee for further review and recommendations. Submissions to the committee will be monthly for a period of 3 months or until full compliance is achieved.	04/11/25

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indicated Resident 4 had a Computed Tomography (CT, a medical imaging procedure) of facial bones because of acute (severe and sudden onset) facial pain after an assault. The ED records indicated the CT of Resident 4's facial bones showed mildly comminuted, minimally displaced right nasal bone fracture. The ED records indicated Resident 4 received Tylenol (medication used to relieve mild to moderate pain) 650 milligrams (mg, unit of measurement) by mouth for 6/10 pain (moderate pain) on the face while in the ED. The ED records indicated Resident 4 was discharged back to the facility with a clinical impression (healthcare assessment) of closed head injury and nasal fracture.

During a review of Resident 4's PN dated 3/20/2025 and timed at 9:17 pm, the PN indicated Resident 4 returned to the facility from GACH 1.

During a concurrent observation inside Resident 4's room and interview with Resident 4 on 3/24/2025 at 10:51 am, Resident 4 was lying in bed. Resident 4 had a small brown discoloration on the right forehead. Resident 4 could not recall the altercation (fight) between Resident 4 and Resident 5 on 3/20/2025. Resident 4 stated Resident 4 had 4/10 (moderate) pain on the nose.

During an interview with CNA 1 on 3/24/2025 at 11:20 am, CNA 1 stated CNA 1 was the assigned CNA for Resident 4 on 3/20/2025. CNA 1 stated on 3/20/2025 before 11 am (could not recall exact time), CNA 1 heard yelling coming from Resident 4 and 5's room. CNA 1 stated CNA 1 ran into Resident 4 and 5's room and saw Resident 4 grabbing Resident 5's hair. CNA 1 stated CNA 1 removed and redirected Resident 4 to the dining

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room. CNA 1 stated CNA 1 saw blood on Resident 4 and 5's faces. CNA 1 stated "all residents (in general) with aggressive (likely to attack) behavior should be monitored closely to prevent incidents of physical altercation."

During an interview with LVN 1 on 3/24/2025 at 11:47 am, LVN 1 stated on 3/20/2025 at around 11 am (could not recall exact time) LVN 1 heard screaming coming from Resident 4 and 5's room. LVN 1 stated LVN 1 ran into Resident 4 and 5's room and saw Resident 5 stood at the end of Resident 5's bed and Resident 4 grabbed Resident 5's hair. LVN 1 stated LVN 1 separated Residents 4 and 5. LVN 1 stated Resident 4 sustained finger scratch marks on the right side of Resident 4's face, a small bump on the forehead and bleeding from the right nostril. LVN 1 stated Resident 4 complained of 5/10 pain on the face. LVN 1 stated Resident 5 had bleeding on top of Resident 5's nose and scratches on the right side of the face and forehead. LVN 1 stated Resident 4 was transferred to GACH 1 for medical evaluation. LVN 1 stated on 3/20/2025 at 9:17 pm, Resident 4 returned to the facility with a CT scan result indicating Resident 4 sustained a minimally displaced mildly comminuted fracture of the right nasal bone. LVN 1 stated Resident 5 was transferred to GACH 2 on 3/21/2025 on a 5150 hold. LVN 1 stated all facility staff need to work as a team to ensure safety of the residents and to prevent incidents of resident-to-resident altercation or any type of abuse.

During an interview with the facility's Administrator (ADM) on 3/24/2025 at 2:30 pm, the ADM stated, the ADM was the abuse coordinator (the person that investigates allegations of abuse) of the facility. The ADM stated, LVN 1 notified the ADM

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on 3/20/2025 at 11:30 am of the altercation between Residents 4 and 5 that occurred on 3/20/2025 before 11 am. The ADM stated the result of the facility's investigation indicated Residents 4 and 5 had a resident-to-resident altercation that became physical and both residents sustained physical injuries. The ADM stated all staff should be educated and trained on abuse prevention and abuse reporting to ensure safe interactions with residents.

During a telephone interview with the facility's Director of Nursing (DON) on 3/26/2025 at 11:42 am, the DON stated all residents had the right to be protected from any kind of physical altercation, assault and abuse while residing in the facility.

During a review of the facility's Policy and Procedure (P&P) titled, " Abuse Prevention Program," revised 8/2006, the P&P indicated, "The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual."