| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555416 | A. Building<br>B. Wing | 11/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Glendora Canyon Transitional Care Unit | 401 W. Ada Ave.<br>Glendora, CA 91741 |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781<br><br>Based on observation, interview, and record review, the facility failed to ensure call lights were within reach for three of three sampled residents (Residents 14, 211 and 251) as indicated in the facility's Policy and Procedure (P&P) titled Call System, Resident.<br><br>These deficient practices had the potential for the residents to receive delayed services and placed the residents at risk for falls/accidents.<br><br>Findings:<br><br>a. During a review of Resident 14's Admission Record (AR), the AR indicated Resident 14 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) affecting left non-dominant side.<br><br>During a review of Resident 14's untitled Care Plan dated 12/5/2022, the Care Plan indicated Resident 14 was at risk for fall and/or injuries related to decreased strength and endurance. The Care Plan interventions indicated for nursing staff to ensure the call light was within reach and encourage the resident to use it for assistance as needed.<br><br>During a review of Resident 14's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/30/2024, the MDS indicated Resident 14 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 14 was dependent (helper did all the effort and lifted or held trunk or limbs) to staff for oral/toileting hygiene, shower, upper and lower body dressing. putting on/taking off footwear and personal hygiene.<br><br>During a review of Resident 14's Fall Risk Assessment (FRA- method of assessing a patient's likelihood of falling) dated 8/30/2024, the FRA indicated Resident 14 was assessed as high risk for fall due to intermittent confusion, being chair bound and the presence of predisposing disease condition.<br><br>During an observation on 11/5/2024 at 9:59 am, Resident 14 was lying in bed. Resident 14's call light was hanging and stuck at the back of the resident's right padded bed side rails. Resident 14 was unable to reach the call light.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview on 11/5/2024 at 10 am, with the facility's Infection Prevention Nurse (IPN), the IPN stated Resident 14 was unable to reach the call light because it was at the back of the padded bed side rails. The IPN stated, Resident 14's call light needed to be within reach for Resident 14 to use to communicate with the staff if Resident 14 needed help and assistance.<br><br>b. During a review of Resident 251's AR, the AR indicated Resident 251 was admitted to the facility on [DATE].<br><br>During a review of Resident 251's untitled Care Plan dated 11/4/2024, the Care Plan indicated Resident 251 was at risk for fall secondary to dizziness and recent fall with femur (thigh bone) fracture (break in the continuity of a bone). The Care Plan interventions indicated for nursing staff to keep the resident's call light and bed controls within easy reach and for staff to answer the resident's call light in timely manner.<br><br>During a review of Resident 251's FRA dated 11/4/2024, the FRA indicated Resident 251 was assessed as at risk for fall due to one to two falls in the past three months and presence of predisposing disease condition.<br><br>During a review of Resident 251's History and Physical (H&P) dated 11/5/2024, the HP indicated Resident 251 had diagnoses including knee replacement.<br><br>During an observation on 11/5/2024 at 10:53 am, Resident 251 was awake and lying in bed. Resident 251's call light was at the upper right side of the bed. Resident 251 stated, I could not find my call light. Resident 251 was unable to find/see the call light.<br><br>During a concurrent observation and interview on 11/5/2024 at 10 am, with the facility's IPN, the IPN stated Resident 251 was unable to see and reach the call light because it was at the upper right side of the bed. The IPN stated, Resident 251's call light needed to be in reach for Resident 251.<br><br>During an interview on 11/6/2024 at 10:40 am with the facility's Director of Nursing (DON), the DON stated the call light was a device used by the residents as a mode of communication to the staff. The DON stated the resident's call light needed to be reachable for the residents to use and in order for staff to provide care in a timely manner.<br><br>40438<br><br>c. During a review of Resident 211's AR, the AR indicated Resident 211 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive decline in mental abilities), and depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities).<br><br>During a review of Resident 211's untitled Care Plan (CP) dated 10/30/2024, the CP indicated Resident 211 was at risk for falls and/or injuries related to balance deficit and cognitive impairment and had activities of daily living (ADL) self-care performance deficit related to activity intolerance. The CP interventions included for staff to attach the resident's call light within reach and encourage the resident to use it for assistance as needed.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 211's MDS dated [DATE], the MDS indicated Resident 211 had severely impaired cognition. The MDS indicated Resident 211 required supervision or touching assistance with eating and partial/moderate assistance with oral, toileting hygiene, lower body dressing and personal hygiene.<br><br>During a concurrent observation and interview on 11/5/2024 at 10:15 am with the Minimum Data Set Coordinator (MDS C) inside Resident 211's room, Resident 211 was standing on the left side of the bed. Resident 211's call light was rolled on the wall on the right side of the bed. Resident 211 stated she needed to go around the bed to reach her call light. MDS C stated Resident 211's call light needed to be placed where the resident could easily reach it each time Resident 211 needed help.<br><br>During an interview on 11/6/2024 at 8:40 am with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated, the resident's call light should be within reach and on the strong arm/hand of the resident to use when needed.<br><br>During an interview on 11/6/2024 at 10:00 am with the Assistant Director of Nursing (ADON), the ADON stated, resident's call lights should be on the strong arm/hand of the resident and placed where the resident could easily reach and use each time help was needed.<br><br>During a review of the facility's P&P titled, Call System, Resident, dated 9/2022, the P&P indicated each resident was provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438<br><br>Based on interview and record review, the facility failed to implement its Policy and Procedure (P&P) on Advance Directives (AD, a legal document indicating resident preference on end-of-life treatment decisions) for four of four sampled residents (Residents 47, 82, 89 and 92) by failing to:<br><br>a. Ensure a copy of Resident 47's AD was in the resident's medical record/chart.<br><br>b. Ensure a copy of Resident 89's Advance Directive Acknowledgement (ADA) Form was in the medical record/chart.<br><br>c. Complete the ADA Form on admission for Resident 82.<br><br>d. Ensure a copy of Resident 92's AD was in the medical record/chart.<br><br>These deficient practices had the potential for the facility staff to provide medical treatment and services against the will of the residents.<br><br>Findings:<br><br>a. During a review of Resident 47's Admission Records (AR), the AR indicated Resident 47 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cellulitis (a skin infection that causes swelling and redness) of the left and right lower limbs and lymphedema (swelling caused by lymphatic blockage).<br><br>During a review of Resident 47's ADA Form dated 5/22/2024, the ADA From indicated Resident 47 had executed an AD. Resident 47's AD was not in the resident's chart.<br><br>During a review of Resident 47's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/27/2024, the MDS indicated Resident 47 had moderately impaired cognition (ability to understand). The MDS indicated Resident 47 required set up or clean up assistance (helper sets up or cleans up, resident completes activity) and supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with toileting, upper body dressing and personal hygiene.<br><br>During a concurrent interview and record review on 10/6/2024 at 3:51 PM with Medical Records (MR) staff, Resident 47's PointClickCare (PCC, a cloud-based software) was reviewed. MR stated there was no copy of Resident 47's AD uploaded in the PCC.<br><br>During an interview on 11/7/2024 at 11:03 am with the Social Services Director (SSD), the SSD stated, a copy of Resident 47's AD needed to be in the resident's chart and uploaded in PCC for the staff to know what kind of care the resident wanted especially during emergency.<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 11/7/2024 at 11:28 am with the Assistant Director of Nursing (ADON), ADON stated, a copy of the resident's AD should be in the chart and uploaded in the PCC for staff to provide care and treatment to meet the resident's wishes and preferences while in the facility.<br><br>42781<br><br>b. During a review of Resident 89's AR, the AR indicated the facility initially admitted Resident 89 on 7/8/2024 and readmitted on [DATE] with diagnoses that included essential hypertension (elevated blood pressure without a known cause) and type 2 diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine).<br><br>During a review of Resident 89's MDS dated [DATE], the MDS indicated Resident 89 had moderately impaired cognition. The MDS indicated Resident 89 required moderate (helper does less than half of the effort) assistance with toileting hygiene and shower/bathe self. The MDS indicated Resident 89 required set up or clean assistance for oral hygiene, upper/lower body dressing, putting on/taking off footwear and personal hygiene.<br><br>During a concurrent interview and record review of Resident 89's medical records/chart on 11/5/2024 at 12:43 pm with the Infection Prevention Nurse (IPN), the IPN stated there was no ADA Form in Resident 89's chart.<br><br>During an interview on 11/5/2024 at 12:45 pm with the facility's SSD, SSD stated there was no ADA Form in Resident 89's chart. The SSD stated, ADA Form needed to be in the resident's chart.<br><br>During an interview on 11/6/2024 at 10:45 am with the facility's Director of Nursing (DON), the DON stated ADA Form needed to be initiated and formulated by SSD upon admission. The DON stated, the ADA Form needed to be in the chart for accessibility and to determine Resident 89s wants and wishes.<br><br>48905<br><br>c. During a review of Resident 82's AR, the AR indicated Resident 82 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Parkinson's disease (PD, brain disorder that causes uncontrollable movements) and deficits in communication.<br><br>During a review of Resident 82's MDS dated [DATE], the MDS indicated Resident 82's cognitive abilities were severely impaired.<br><br>During a review of Resident 82's H&P dated 10/31/2024, the H&P indicated Resident 82 was able to make needs known but cannot make medical decision.<br><br>During an interview on 11/5/2024 at 1:20 PM with Resident 82's Family Member 1 (FM 1), FM 1 stated FM 1 was the Responsible Party (RP) for Resident 82. FM 1 stated, facility staff did not discuss the purpose of an AD on admission.<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent interview and record review on 11/6/2024 at 9:35 AM with the SSD, Resident 82's ADA Form was reviewed. The ADA Form was blank and did not indicate if the RP or resident were informed of the right to formulate an AD. The SSD stated the ADA Form was blank and should have been completed on admission. The SSD stated if the ADA Form was not completed, staff would not be able to identify measures the resident or RP would want. The SSD stated if the ADA Form was blank, it would indicate education was not provided to the resident or RP on how to formulate an AD.<br><br>d. During a review of Resident 92's AR, the AR indicated Resident 92 was admitted to the facility on [DATE] with diagnoses that included dementia and hypertension (HTN, high blood pressure).<br><br>During a review of Resident 92's MDS dated [DATE], the MDS indicated Resident 92 had severely impaired cognition and required supervision with eating and oral hygiene (ability to clean teeth).<br><br>During a review of Resident 92's H&P dated 9/19/2024, the H&P indicated Resident 92 did not have the capacity to understand and make decisions.<br><br>During a concurrent interview and record review on 11/6/2024 at 9:32 AM with the SSD, Resident 92's ADA Form dated 9/13/2024 was reviewed. The ADA Form indicated Resident 92 had executed an AD. The SSD stated the ADA Form indicated Resident 92 had an AD but was not in the resident's medical or electronic chart. The SSD stated the purpose of the ADA Form was to indicate the wishes and interventions of the resident and to indicate which emergency measures the resident want. The SSD stated if the AD was not in the chart, the facility would not know the resident's wishes.<br><br>During an interview on 11/6/2024 at 10:46 AM with the DON, the DON stated the ADA Form needed to be completed on admission and stated if it was not filled out correctly, staff would not be aware on how to execute the wishes of the resident.<br><br>During the review of facility's P&P titled, Advance Directives, revised December 2016, the P&P indicated, Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. Prior to or upon admission of a resident, the social services director or designee will inquire of the resident his/her family members and/or his or her legal representative, about the existence of any written advance directives. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037<br><br>Based on observation, interview and record review, the facility failed to ensure the Minimum Data Set (MDS, a federally mandated resident assessment tool) was accurately coded for language preference for one of one sampled resident (Resident 17).<br><br>This failure had the potential risk for Resident 17 not to receive necessary care services.<br><br>Findings:<br><br>During a review of Resident 17's Admission Record (AR), the AR indicated Resident 17 was readmitted to the facility on [DATE], with diagnoses that included heart failure ( condition when the heart cannot pump enough blood to meet the body's needs) and hypotension (low blood pressure).<br><br>During a review of Resident 17's quarterly MDS dated [DATE], the MDS indicated Resident 17's preferred language was English. The MDS indicated Resident 17 had clear speech, had ability to understand others and had the ability to make self-understood. The MDS indicated Resident 17 required partial/moderate assistance (helper does less than half the effort) for personal hygiene and chair/bed-to-chair transfer.<br><br>During an observation and interview on 11/5/2024 at 2:47 pm, in Resident 17's room, Resident 17 was lying in bed talking over the phone using a foreign language. During a concurrent interview with Resident 17, Resident 17 was not able to communicate in English. Resident 17 stated, Resident 17's preferred language was Turkish, not English.<br><br>During an observation on 11/5/2024 at 2:53 pm, in Resident 17's room, Certified Nursing Assistant 1 (CNA1) tried to communicate with Resident 17 regarding Resident 17's care. Both CNA1 and Resident 17 were not able to understand each other. During a concurrent interview, CNA1 stated, Resident 17 spoke Turkish with very limited English.<br><br>During an interview on 11/6/2024 at 9:49 am, the MDS Coordinator (MDSC) stated, Resident 17's primary language was Turkish and Resident 17 spoke limited English. MDSC stated, MDSC did not code Resident 17's preferred language correctly in the quarterly MDS dated [DATE]. MDSC stated, MDSC should code Resident 17's preferred language as Turkish, not English. MDSC stated, the MDS should be coded accurately to reflect the resident's current assessment and preference to provide quality of care.<br><br>During a review of the facility's Policy and Procedure (P&P) titled Resident Assessment, revised 11/2019, the P&P indicated The resident assessment coordinator responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements . |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905<br><br>Based on interview and record review, the facility failed to create a baseline care plan (CP) for one of one sampled resident (Resident 82) upon admission on 10/30/2024.<br><br>This failure had the potential for delayed provision of necessary care and services for Resident 82.<br><br>Findings:<br><br>During a review of Resident 82's Admission Record (AR), the AR indicated Resident 82 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Parkinson's disease (PD, brain disorder that causes uncontrollable movements), deficits in communication, chronic non-pressure ulcers of the right heel, right midfoot, and left foot, and a right hip stage three PU (deep wound that has gone through all layers of the skin exposing subcutaneous fat).<br><br>During a review of Resident 82's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 10/23/2024, the MDS indicated Resident 82's cognitive abilities (ability to think, learn, and process information) were severely impaired. The MDS indicated Resident 82 was dependent with staff in sitting to lying, eating, and toileting hygiene.<br><br>During a review of Resident 82's History and Physical (H&P) dated 10/31/2024, the H&P indicated Resident 82 was able to make needs known but cannot make medical decisions.<br><br>During a concurrent interview and record review on 11/7/2024 at 3:11 PM with the Director of Nursing, Resident 82's baseline CP was reviewed. The baseline CP indicated it was in progress. The DON stated there was no baseline CP created and it should have been completed within 48 hours of Resident 82's admission on 10/30/2024. The DON stated the baseline CP would guide staff how to take care of the resident based on the resident's immediate care needs. The DON stated not creating a baseline CP on admission placed the resident at risk of interruption in patient care.<br><br>During a review of the facility's Policy and Procedure (P&P) titled Care Plan-Baseline revised 12/2016, the P&P indicated to assure the resident's immediate care needs are met and maintained, a baseline CP will be developed within 48 hours of the resident's admission. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781<br><br>Based on interview and record review, the facility failed to develop an individualized/person- centered care plan for one of five sampled residents (Resident 96) who was on Haloperidol (antipsychotic medication to treat serious mental disorder in which people interpret reality abnormally) in accordance with the facility's Policy and Procedure (P&P) titled Care Plans, Comprehensive Person - Centered.<br><br>This deficient practice had the potential for Resident 96 to not receive appropriate treatment and/or services related to the use of Haloperidol.<br><br>Findings:<br><br>During a review of Resident 96's Admission Record (AR), the AR indicated Resident 96 was admitted to the facility on [DATE] with diagnoses that included depression (a feeling of severe sadness or hopelessness) and dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning).<br><br>During a review of Resident 96's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/14/2024, the MDS indicated Resident 96 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 96 was dependent (helper did all the effort and lifted or held trunk or limbs) with staff for toileting hygiene, shower, and lower body dressing. The MDS indicated Resident 96 needed maximum assistance (helper did more than half the effort and lifted or held trunk or limbs) with staff for oral hygiene, upper body dressing and putting on/taking off footwear.<br><br>During a review of Resident 96's Physician Order (PO) dated 10/25/2024, the PO indicated for licensed staff to administer Haloperidol Lactate Oral Concentrate 0.5 millimeter (ml, unit of measurement) by mouth every six hours as needed for agitation.<br><br>During a concurrent interview and record review of Resident 96 medical records (chart) on 11/5/2024 at 12:51 pm with the facility's Infection Prevention Nurse (IPN), the IPN stated there was no clinical documentation that a care plan was initiated and implemented for the management of Haloperidol to ensure Resident 96 received the proper care and effective interventions from nursing staff.<br><br>During a concurrent interview and record review of Resident 96's chart on 11/6/2024 at 10:47 am with the facility's Director of Nursing (DON), the DON stated comprehensive care plan needed to be developed and implemented to provide proper intervention which was specific and individualized to Resident 96 for the use of Haloperidol.<br><br>During a review of the facility's P&P titled, Care Plans, Comprehensive Person - Centered, revised 12/2016, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timeless to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident. The P&P indicated the comprehensive, person-centered care plan was developed within seven (7) days of the completion of the required comprehensive assessment. |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037<br><br>Based on observation, interview, and record review, the facility failed to provide an effective communication method for two of two non-English speaking sampled residents (Residents 17 and 92).<br><br>This failure had the potential for Residents 17 and 92 not to receive necessary care and services affecting their quality of life.<br><br>Findings:<br><br>a. During a review of Resident 17's Admission Record (AR), the AR indicated Resident 17 was readmitted to the facility on [DATE], with diagnoses that included heart failure (a serious condition that occurs when the heart cannot pump enough blood to meet the body's needs) and hypotension (low blood pressure).<br><br>During a review of Resident 17's quarterly Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/19/2024, the MDS indicated Resident 17's preferred language was English. The MDS indicated Resident 17 had clear speech, had ability to understand others and had the ability to make self-understood. The MDS indicated Resident 17 required partial/moderate assistance (helper does less than half the effort) for personal hygiene and chair/bed-to-chair transfer.<br><br>During an observation and interview on 11/5/2024 at 2:47 pm, in Resident 17's room, Resident 17 was lying in bed talking over the phone using a foreign language. During a concurrent interview with Resident 17, Resident 17 was not able to communicate in English. Resident 17 stated, Resident 17's preferred language was Turkish, not English.<br><br>During an observation on 11/5/2024 at 2:53 pm, in Resident 17's room, Certified Nursing Assistant 1 (CNA1) tried to communicate with Resident 17 regarding Resident 17's care. Both CNA1 and Resident 17 were not able to understand each other. During a concurrent interview, CNA1 stated, Resident 17 spoke Turkish with very limited English. CNA1 stated, the facility provided communication board to communicate with non-English speaking residents and there were no other methods provided by the facility. CNA1 stated, it was important to communicate with the resident using their preferred language so that staff would understand the resident and provide needed services.<br><br>During an interview on 11/5/2024 at 3:20 pm with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated, LVN 3 was not aware Resident 17 was not speaking English. LVN 3 stated, the facility provided communication board to communicate with non-English speaking residents. LVN 3 stated, there was no other method provided by the facility. LVN 3 stated, it was important for the facility to provide an effective communication method for non-English speaking residents, so staff would understand the resident's need and provide the residents with quality care.<br><br>During a review of the facility's Policy and Procedure (P&P) titled Communication with Person with Limited English Proficiency, revised 6/2024, the P&P indicated, Language assistance will be provided through the use of bilingual staff, staff interpreters, use of Google Translate App and a communication board.<br><br>(continued on next page) |

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|---|---|---|---|
| | 555416 | A. Building<br>B. Wing | 11/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Glendora Canyon Transitional Care Unit | 401 W. Ada Ave.<br>Glendora, CA 91741 |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 48905<br><br>b. During a review of Resident 92's AR, the AR indicated Resident 92 was admitted to the facility on [DATE] with diagnoses that included dementia (impaired ability to remember, think, or make decisions that interfere with doing everyday tasks) and hypertension (HTN, high blood pressure).<br><br>During a review of Resident 92's MDS dated [DATE], the MDS indicated Resident 92's preferred language was English and indicated Resident 92's cognitive abilities (ability to think, learn, and process information) were severely impaired. The MDS indicated Resident 92 required supervision with eating and oral hygiene (ability to clean teeth) and required moderate assistance with walking 10 feet (ft, unit of measurement for distance).<br><br>During a review of Resident 92's History and Physical (H&P) dated 9/19/2024, the H&P indicated Resident 92 did not have the capacity to understand and make decisions.<br><br>During a concurrent observation and interview on 11/5/2024 at 3:06 PM with CNA 3 in Resident 92's room, CNA 3 provided 1:1 monitoring at the bedside of Resident 92. CNA 3 used google translate and stated CNA 3 spoke and understood Spanish language only and uses google translate to translate from Spanish to English for CNA 3 to communicate with Resident 92 who was English speaking. CNA 3 stated it was CNA 3's first time taking care of Resident 92 and Resident 92 required 1:1 because Resident 92 wandered into other residents' rooms.<br><br>During an interview on 11/5/2024 at 3:24 PM with Registered Nurse 1 (RN 1), RN 1 stated if CNA 3 was doing 1:1 for Resident 92 and only speaks Spanish there should be a communication board at Resident 92's bedside. RN 1 stated there was no communication board at Resident 92's bedside to help translate from English to Spanish. RN 1 stated the risk of not having a communication board at the bedside was that Resident 92 and CNA 3 would not be able to understand each other or if there was an emergency.<br><br>During an interview on 11/8/2024 at 8:51 AM with the Director of Nursing (DON), the DON stated there should have been a communication board at the bedside if a staff member does not speak the preferred language of the resident. The DON stated the risk of not having a communication board was not meeting the resident's needs due to the lack of communication between staff and the resident and an emergency.<br><br>During a review of the facility's policy and procedure (P&P) titled Communication with Persons with Limited English Proficiency revised 6/2024, the P&P indicated a communication board will be available in the resident's rom that is easily accessible to the resident and staff providing care to the resident and indicated staff will utilize the communication board to meet the needs of the resident. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905<br><br>Based on observation, interview, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for two of two sampled residents (Residents 82 and 301) by failing to:<br><br>a. Implement Resident 82's care plan (CP), when Resident 82's bilateral (both) feet with arterial ulcers (open wounds that form when there was not enough blood flowing to the bilateral extremities) were not offloaded (elevating an extremity to relieve pressure). This failure had the potential to result in worsening or delayed wound healing.<br><br>b. To provide transportation for one of one sampled resident (Resident 301) to the resident's scheduled physician's appointment. This failure resulted in the delay of Resident 301's diagnostic exam.<br><br>Findings:<br><br>a. During a review of Resident 82's Admission Record (AR), the AR indicated Resident 82 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic non-pressure ulcers of the right heel, right midfoot, and left foot.<br><br>During a review of Resident 82's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 10/23/2024, the MDS indicated Resident 82's cognitive abilities (ability to think, learn, and process information) were severely impaired. The MDS indicated Resident 82 was dependent in changing positions from sitting to lying, eating, and toileting hygiene.<br><br>During a review of Resident 82's History and Physical (H&P) dated 10/31/2024, the H&P indicated Resident 82 was able to make needs known but cannot make medical decisions.<br><br>During a concurrent observation and interview on 11/6/2024 at 2:59 PM with Certified Nursing Assistant 2 (CNA 2) in Resident 82's room, Resident 82's bilateral heels were lying directly on the mattress. CNA 2 stated Resident 82's bilateral heels should be offloaded because Resident 82 had wounds on both feet. CNA 2 stated the risk of not offloading Resident 82's bilateral feet was that wounds could get worse and possibly develop a pressure ulcer (PU, injuries to the skin and underlying tissue that are result of pressure on the skin for long periods of time).<br><br>During an interview on 11/6/2024 at 4:28 PM with Registered Nurse 2 (RN 2), RN 2 stated CNAs and RNs were responsible for offloading if a resident was high risk for skin breakdown. RN 2 stated if the CP interventions included to offload the resident's extremity, staff needed to follow and implement the CP interventions. RN 2 stated if the CP was not implemented the resident would be at risk for worsening the wound.<br><br>During a concurrent interview and record review on 11/7/2042 at 3:16 PM with the facility's Director of Nursing (DON), Resident 82's CP for the right lateral foot arterial ulcers dated 10/31/2024 was reviewed. The CP indicated for staff to float/offload heels as tolerated. The DON stated if Resident 82's bilateral heels were not offloaded, the resident would be at risk for delayed wound healing. The DON stated staff should follow and implement the CP.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's Policy and Procedure (P&P) titled Repositioning revised 5/2013, the P&P indicated for staff to check the CP to determine the resident's specific positioning needs.<br><br>40037<br><br>b. During a review of Resident 301's AR, the AR indicated Resident 301 was admitted to the facility on [DATE] with diagnosis that included pneumonia (lung infection) and End Stage Renal Disease (ESRD, irreversible kidney failure).<br><br>During a review of Resident 301's Physician Order (PO), dated 10/24/2024, the PO indicated an order for Resident 301 for fistulagram (a procedure to examine a fistula [a surgical connection between an artery and a vein]) on Monday 10/28/2024 at 11 am and for the facility to set up transportation.<br><br>During a review of Resident 301's MDS dated [DATE], the MDS indicated Resident 17 had no speech, sometimes understood others, and sometimes made self-understood. The MDS indicated Resident 301's cognitive (ability to think and understand) skills for daily decision making was severely impaired. The MDS indicated Resident 301 was dependent (helper does all the effort) with staff for personal hygiene and chair/bed-to chair transfer.<br><br>During an observation on 11/6/2024 at 3:37 pm, in Resident 301's room, Resident 301 was lying in bed with eyes closed. Resident 301 was not able to communicate when asked questions. Resident 301's Family Member 1 (FM 1) was at the resident's bedside. FM 1 stated, Resident 301 had a scheduled appointment for fistulagram on 10/28/2024 at 10 am and the facility did not provide transportation to Resident 301 for the resident's appointment. FM 1 stated, Resident 301's right arm was swelling around the fistula site and that was the reason for fistulagram. FM 1 stated, the facility staff told her that they forgot about Resident 301's appointment and there was no transportation set up for Resident 301 on 10/28/2024.<br><br>During an interview and concurrent record review on 11/6/2024 at 3:57 pm, the Director of Nursing (DON) stated, Resident 301 missed Resident 301's fistulagram appointment scheduled on 10/28/2024 because the facility did not set up transportation for Resident 301. The DON stated, there was a PO written on 10/24/2024 upon Resident 301's admission, but the appointment was missed. The DON stated, the Social Service department arranged transportation for the resident. The DON stated, there was no documentation in Resident 301's medical record/chart that Social Service personnel arranged transportation for Resident 301's fistulagram appointment scheduled on 10/28/2024. The DON stated it was important to ensure the resident go to their appointment to prevent delay in providing needed care and services.<br><br>During an interview and concurrent record review on 11/7/2024 at 11:52 am with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated, Resident 301 was not able to go to Resident 301's fistulagram appointment as scheduled on 10/28/2024 at 10 am, because there was no transportation set up. LVN 2 stated, the nursing station had an appointment book/binder that nursing staff place a copy of the physician's order for scheduling transportation. LVN 2 stated, there was no copy of Resident 301's transportation order in the appointment book. LVN 2 stated, it was important to have transportation set up to ensure the resident goes to the appointment, as ordered.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's P&P titled Transportation and Appointments, revised 12/2008, the P&P indicated The facility will assist residents in arranging transportation and escort to/from appointments when necessary. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905<br><br>Based on observation, interview, and record review the facility failed to provide wound care treatments as ordered by the Medical Doctor (MD) for an unstageable pressure ulcer (PU, pressure ulcer [injuries to the skin and underlying tissue that are result of pressure on the skin for long periods of time] that was not stageable due to coverage of the wound by slough [white, yellow, tan, gray, or green in color that consist of dead tissue] and or eschar [thick, dry, black or brown scab like covering that forms over the wound]) on the right midback from 10/30/2024 to 11/7/2024 (eight days) for one of two sampled residents (Resident 82).<br><br>This failure had the potential to result in worsening of Resident 82's right midback unstageable PU.<br><br>Findings:<br><br>During a review of Resident 82's Admission Record (AR), the AR indicated Resident 82 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Parkinson's disease (PD, brain disorder that causes uncontrollable movements) and chronic non-pressure ulcers of the right heel, right midfoot, left foot, and a right hip stage three PU (deep wound that has gone through all layers of the skin exposing subcutaneous fat).<br><br>During a review of Resident 82's care plan (CP) for potential for skin breakdown dated 9/12/2024, the CP indicated to initiate treatment as ordered by the MD.<br><br>During a review of Resident 82's Minimum Data Set, (MDS, (MDS, a federally mandated resident assessment tool) dated 10/23/2024, the MDS indicated Resident 82's cognitive abilities (ability to think, learn, and process information) were severely impaired.<br><br>During a review of Resident 82's History and Physical (H&P) dated 10/31/2024, the H&P indicated Resident 82 was able to make needs known but cannot make medical decisions.<br><br>During a concurrent interview and record review on 11/7/2024 at 10:40 AM with Treatment Nurse 1 (TN 1), Resident 82's Admission Orders (AO) dated 10/30/2024 and Admission/Readmission Initial Assessment (AIA) dated 10/30/2024 were reviewed. The AIA indicated Resident 82 was readmitted to the facility on [DATE] with an upper midback (PU). The AO indicated an MD order to cleanse with Normal Saline (NS), apply hydrocolloid dressing (dressing that provides a moist environment to promote wound healing) to the right midback and change the dressing every three days on Monday, Wednesday, and Friday for 30 days. TN 1 stated Resident 82 did not receive treatment for the right mid back unstageable PU from 10/30/2024 to 11/7/2024 and stated there was no MD order for treatment of the right mid back. TN 1 stated the wound would get worse if treatment was not provided as ordered.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 11/7/2024 at 11:04 AM with the Director of Nursing (DON), the DON stated the order to treat the right mid back unstageable PU was discontinued by a registry Registered Nurse (RN) on 10/31/2024. The DON stated the order should not have been discontinued. The DON stated all admission orders were discontinued and reentered on 10/31/2024. The DON stated treatment for the right midback unstageable PU and heel protectors every shift was missed. The DON stated the DON was not aware of the right mid back unstageable PU.<br><br>During a concurrent observation and interview on 11/7/2024 at 11:51 AM with Resident 82, Resident 82 was lying on Resident 82's left side in bed. Resident 82 stated Resident 82 was unsure on how Resident 82 got the unstageable PU on the right midback.<br><br>During a concurrent observation and interview on 11/7/2024 at 11:57 AM with the DON in Resident 82's room, Resident 82's right midback unstageable PU was inspected. The DON stated the surrounding area of the right midback unstageable PU was reddish with eschar and slough in the wound bed. The DON stated the unstageable PU measured 1.1 centimeters (cm, unit of measurement) in length, 2.4 cm in width, with no depth.<br><br>During a concurrent interview and record review on 11/8/2024 at 10:01 AM with the DON, Resident 82's Hospice Skin Assessment (HSA) dated 10/30/2024 was reviewed. Resident 82's HSA indicated the right midback unstageable PU measured 2 cm in length, 2 cm in width, and unable to determine depth on 10/30/2024. The DON stated missing wound treatments could result in worsening of the wound or a delay in wound healing.<br><br>During a review of the facility's Policy and Procedure (P&P) titled Pressure Ulcers/Skin Breakdown-Clinical Protocol reviewed 4/2018, the P&P indicated the MD will order pertinent wound treatments that include pressure reduction surfaces, wound cleansing and debridement approaches, dressings, and application of topical agents. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781<br><br>Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents' indwelling catheter (foley catheter, a tube that allows urine to drain from the bladder into a bag) was assessed and monitored for the presence of white sediments (visible particles in the urine that may contain red or white blood cells, casts, bacteria) in the urine in accordance with the facility's Policy and Procedure (P&P) titled Catheter Care, Urinary and the resident's care plan (Resident 44).<br><br>This deficient practice had the potential for Resident 44 to receive delayed care and treatment to prevent urinary tract infection (UTI, condition in which bacteria invade and grow in any part the urinary system).<br><br>Findings:<br><br>During a review of Resident 44's Admission Record (AR), the AR indicated Resident 44 was admitted to the facility on [DATE] with diagnoses that included spinal stenosis (abnormal narrowing of the spinal canal) and essential hypertension (elevated blood pressure without a known cause).<br><br>During a review of Resident 44's untitled care plan initiated on 8/29/2024, the care plan indicated Resident 44 had an indwelling catheter. The care plan interventions included for staff to monitor/record/report Resident 44 to the physician for signs and symptoms of UTI such as pain, burning, blood-tinged urine, cloudiness, no urine output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns.<br><br>During a review of Resident 44's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/2/2024, the MDS indicated Resident 44 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 44 was dependent (helper did all the effort and lifted or held trunk or limbs) to staff for toileting hygiene, shower, lower body dressing and putting on/taking off footwear.<br><br>During a review of Resident 44's Physician's Order Summary Report (POSR) dated 9/16/2024, the POSR indicated for licensed staff to insert foley catheter French (a type of catheter) 16 (size of the catheter) to straight drainage system.<br><br>During an observation in Resident 44's room on 11/5/2024 at 10:11 am, Resident 44 was asleep, lying in bed. Resident 44 had a foley catheter hanging on the left side of the bed. Resident 44's foley catheter tubing and drainage bag contained white sediments.<br><br>During a concurrent observation and interview on 11/5/2024 at 10:12 am, with Infection Prevention Nurse (IPN), the IPN stated the foley catheter tubing and drainage bag had white sediment. The IPN stated white sediments in the tubing and bag could indicate a sign of infection. The IPN stated, the tubing needed to be flushed and the physician needed to be notified of the presence of white sediments in Resident 44's foley catheter tubing and bag.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review of Resident 44's medical records (chart) on 11/6/2024 at 10:42 am, with the facility's Director of Nursing (DON), the DON stated, Resident 44's foley catheter needed to be monitored for signs and symptoms of infection such as presence of sediments, and cloudiness in the urine by licensed nurses every eight hours to prevent UTI. The DON stated there was no other clinical documentation that Resident 44 was monitored for signs and symptoms of UTI.<br><br>During a review of the facility's P&P titled, Catheter Care, Urinary, dated 9/2014, the P&P indicated for facility staff to observe for signs and symptoms of urinary tract infection or urinary retention and report findings to the physician or supervisor immediately. The P&P indicated to document the character of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood) and odor. |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438<br><br>Based on observation, interview, and record review, the facility failed to implement the facility's Policy and Procedure (P&P) on the use of siderails for two of two sampled residents (Residents 26 and 28) by failing to:<br><br>a. Ensure Resident 26 had a doctor's order for siderails, siderail use was consented and appropriate alternative interventions were attempted and did not meet the resident's needs before the installation of side rails.<br><br>b. Ensure Resident 28 was assessed for the use of siderails and appropriate alternative interventions were attempted and did not meet the resident's needs before the installation of side rails.<br><br>These deficient practices placed Residents 26 and 28 at risk for entrapment and injury from the use of siderails.<br><br>Findings:<br><br>a. During a review of Resident 26's Admission Record (AR), the AR indicated Resident 26 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included osteomyelitis (inflammation of bone or bone marrow) of the left ankle and foot, peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs) and dementia (a progressive state of decline in mental abilities).<br><br>During a review of Resident 26's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/1/2024, the MDS indicated Resident 26 had severely impaired cognition (ability to understand). Resident 26 required partial/moderate assistance (helper did less than half the effort) with eating, oral and personal hygiene, substantial/maximal assistance with toileting hygiene and upper body dressing and dependent with shower, and lower body dressing.<br><br>During a concurrent observation in Resident 26's room and interview with the Minimum Data Set Coordinator (MDS C) on 11/5/2024 at 9:42 am, Resident 26 was in bed, lying on his back with 1/4 side rails up on both sides of the bed. MDS C stated Resident 26 was confused.<br><br>During a concurrent interview and record review on 11/6/2024 at 2:05 pm with the facility's Assistant Director of Nursing (ADON), Resident 26's medical chart and PointClickCare (PCC, a cloud-based software platform) chart were reviewed. The ADON stated was no documented evidence that appropriate alternative interventions were attempted and did not meet the needs of the resident before the side rails were installed to prevent potential entrapment and injury to Resident 26. The ADON stated Resident 26 did not have an order and did not have a consent for the use of siderails. The ADON stated siderails could not be started without a physician's order and consent from the resident or responsible party.<br><br>(continued on next page) |

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| Glendora Canyon Transitional Care Unit | 401 W. Ada Ave.<br>Glendora, CA 91741 |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | b. During a review of Resident 28's AR, the AR indicated Resident 28 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included multiple rib fractures (break in the bone), hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body).<br><br>During a review of Resident 28's Order Summary Report (OSR), dated 6/24/2024, the OSR indicated Resident 28 had an order for bilateral 1/4 side rail up used as mobility aid to improve functional ability when in bed.<br><br>During a review of Resident 28's MDS dated [DATE], the MDS indicated Resident 28 had severely impaired cognition. The MDS indicated Resident 28 required substantial/maximal assistance (helper did more than half the effort) with eating and oral hygiene and dependent (helper did all of the effort, resident did none of the effort to complete the activity) with toileting hygiene, shower, upper and lower body dressing and personal hygiene.<br><br>During a review of Resident 28's Situation, Background, Assessment and Recommendation (SBAR) Form, dated 9/19/2024, the SBAR indicated, Resident 28 had an unwitnessed fall.<br><br>During a concurrent observation in Resident 28's room and interview with the MDSC on 11/5/2024 at 10:21 am, Resident 28 was in bed, lying on her back with 1/4 side rails up on both sides of the bed. MDS C stated Resident 28 was confused.<br><br>During a concurrent interview and record review on 11/6/2024 at 1:25 pm with the ADON, Resident 28's medical chart and PCC chart were reviewed. The ADON stated there was no documented evidence that appropriate alternative interventions were attempted and did not meet the needs of the resident before side rails were installed to prevent potential entrapment and injury to Resident 28. The ADON stated Resident 28 did not have a siderail use assessment completed before siderails were applied.<br><br>During a review of the facility's P&P titled, Use of Side Rails, revised December 2016, the P&P indicated, The safe use of siderails as resident mobility aids and to prohibit the use of siderails as restraints unless necessary to treat a resident's medical symptoms. An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using siderails. Consent for using restrictive devices will be obtained from the resident or legal representative per facility protocol. Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails. |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Post nurse staffing information every day.<br><br>36924<br><br>Based on observation, interview, and record review, the facility failed to follow its Policy and Procedure (P&P) to post actual nursing hours within two hours of the start of each shift. During a tour of the facility, the posted nursing hours for one of one sampled day (11/7/24) was not updated and did not reflect the current date.<br><br>This deficient practice had the potential to inaccurately reflect the actual nursing staff providing direct care to the residents.<br><br>Findings:<br><br>During an observation and concurrent interview with the Director of Staff Development (DSD) on 11/7/24 at 2:57 p.m., the facility's Daily Nursing Staff Posting for 11/6/24 was posted in the facility's entrance lobby. The DSD stated the daily nursing staff posting (DNSP) should be the DNSP dated 11/7/24. The DNSP posted was for 11/6/24. The DSD stated the posted DNSP was dated 11/6/24 and the DNSP was not posted within two hours of the beginning of the shift on 11/7/24.<br><br>During an interview with the DSD on 11/7/24 at 3:02 p.m., the DSD stated the DNSP should be updated by the night (11:00 p.m.-7:30 a.m.) shift staff. The DSD stated the facility policy was not followed.<br><br>During a review of the facility's P&P titled, Posting Direct Care Daily Staffing Numbers, revised July 2016, the P&P indicated within two hours of the beginning of each shift, the number of licensed nurses (RN's, LPN's and LVN's) and the number of unlicensed nursing personnel (CNA's) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. Within two hours of the beginning of each shift, the shift supervisor shall compute the number of direct care staff . The shift supervisor shall date the form, record the census, and post the staffing information in the locations designated by the administrator. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905<br><br>Based on interview and record review, the facility failed to implement the facility's Policy and Procedure (P&P) on psychotropic (medications that alter brain function) and antipsychotic (medications that reduce delusions or hallucinations) medication use, for two of five sampled residents (Residents 82 and 96) by failing to:<br><br>a. Ensure as needed (PRN) psychotropic medication was ordered with a stop date of 14 days when Resident 82 was receiving Lorazepam (medication to treat anxiety) 0.25 milliliters (mL, unit of measurement for volume) every four hours PRN for restlessness and or agitation.<br><br>b. Ensure Resident 96's target behavior and adverse side effects (unwanted or undesirable effect) was monitored, and the order included a specific indication for the use of Haloperidol (antipsychotic).<br><br>These deficient practices had the potential to result in the use of unnecessary psychotropic medications, which may result in significant adverse (harmful) consequences to Residents 82 and 96.<br><br>Findings:<br><br>a. During a review of Resident 82's Admission Record (AR), the AR indicated Resident 82 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Parkinson's disease (PD, brain disorder that causes uncontrollable movements) and communication deficits.<br><br>During a review of Resident 82's Minimum Data Set (MDS-federally mandated resident assessment tool) dated 10/23/2024, the MDS indicated Resident 82's cognitive abilities (ability to think, learn, and process information) were severely impaired.<br><br>During a review of Resident 82's History and Physical (H&P) dated 10/31/2024, the H&P indicated Resident 82 was able to make needs known but cannot make medical decisions.<br><br>During a concurrent interview and record review on 11/6/2024 at 10:55 AM with Registered Nurse 1 (RN1), Resident 82's Medical Doctor (MD) order dated 11/2/2024 was reviewed. The MD order indicated for licensed staff to administer Lorazepam 0.25 ml PRN every four hours for restlessness and agitation. There was no end date in the order. RN 1 stated there was no stop date for Lorazepam. RN 1 stated there should be a stop date. RN 1 stated psychotropic medications should have an end date no later than 14 days because it would put the resident at risk for unnecessary medication use.<br><br>During an interview on 11/7/2024 at 3:15 PM with the Director of Nursing (DON), the DON stated PRN psychotropic medications should have a stop date no later than 14 days and stated the risk of not having a stop date would put the resident at risk for unnecessary psychotropic medication use.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's P&P titled, Antipsychotic/Psychotropic Medication Use revised 12/2016, the P&P indicated the need to continue PRN orders for psychotropic medications beyond 14 days require the Practioner to document a rationale for the extended order, and indicated the duration of the PRN order will be indicated in the order.<br><br>42781<br><br>b. During a review of Resident 96's AR, the AR indicated Resident 96 was admitted to the facility on [DATE] with diagnoses that included depression (persistent feelings of sadness and worthlessness and a lack of desire to engage in formerly pleasurable activities) and dementia (long term and often gradual decrease in the ability to think resident and remember severe enough to affect a person's daily functioning).<br><br>During a review of Resident 96's MDS dated [DATE], the MDS indicated Resident 96 had severely impaired cognition for daily decision making. The MDS indicated Resident 96 was dependent (helper did all the effort and lifted or held trunk or limbs) to staff for toileting hygiene, shower, and lower body dressing. The MDS indicated Resident 96 needed maximum assistance (helper did more than half the effort and lifted or held trunk or limbs) to staff for oral hygiene, upper body dressing and putting on/taking off footwear.<br><br>During a review of Resident 96's Physician Order (PO) dated 10/25/2024, the PO indicated for licensed staff to administer Haloperidol Lactate Oral Concentrate 0.5 ml by mouth every six hours as needed for agitation.<br><br>During a concurrent interview and record review of Resident 96's medical records (chart) on 11/5/2024 at 12:51 pm with the Infection Prevention Nurse (IPN), the order for Haloperidol did not have a specific diagnosis for its use. The IPN stated, there was no documented monitoring for Resident 96's target behavior for agitation for the use of Haldol and adverse side effects were not monitored since Resident 96's admission to the facility. The IPN stated, target behavior needed to be monitored every shift to determine if the medication was effective. The IPN stated, adverse side effects needed to be monitored every shift to determine if the medication was working effectively for the resident.<br><br>During a concurrent interview and record review on 11/6/2024 at 10:47 am with the facility's DON, Resident 96's Medication Administration Record (MAR) dated 11/1/2024 to 11/5/2024 was reviewed. The DON stated there was no monitoring done for Resident 96's target behavior for agitation and adverse side effects of Haloperidol use. The DON stated Resident 96's target behavior needed to be monitored and documented every shift as ordered, to determine if the medication was effective or not. The DON stated, the medication needed to be administered for a specific diagnosis. The DON stated, agitation is a manifestation and not a diagnosis.<br><br>During a review of the facility's P&P titled, Antipsychotic Medication Use, revised 2023, the P&P indicated staff will observe, document and report to the Attending Physician information regarding the effectiveness of any interventions, including antipsychotic medications. The P&P indicated, based on assessing the resident's symptoms and overall situation, the Physician will determine whether to continue, adjust, or stop existing antipsychotic medication. The P&P indicated nursing staff shall monitor and report any side effects to the attending physician. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>40037<br><br>Based on observation, interview and record review, the facility failed to follow proper sanitation and food handling practices by:<br><br>a. Placing a staff's personal lunch bag inside the facility's one of one walk-in refrigerator used to store residents' food.<br><br>b. Failing to ensure one of one dome drying rack was free from rust and dirt.<br><br>These deficient practices had the potential to result in food-borne illnesses to the residents.<br><br>Findings:<br><br>During an observation of the facility's kitchen on 11/5/2024 at 9:16 am, there was a personal lunch bag placed on the shelf of the facility's walk-in refrigerator. The dome drying rack was rusty and had dirt along the metal line. During a concurrent interview, Dietary Aide 3 (DA 3) stated, it was DA 3's lunch box placed inside the walk-in refrigerator. DA 3 stated, DA 3 should not put personal belongings inside the resident's refrigerator. DA 3 stated, putting personal belongings inside the resident's refrigerator could result in cross contamination of residents' food and the residents could get food borne illness. DA 3 stated, the dome drying rack was rusty with dirt along the metal line. DA 3 stated the facility should use a clean drying dome for the residents. DA 3 stated, the residents could get sick if the dome drying rack was contaminated with dirt.<br><br>During an interview on 11/8/2024 at 9:02 am, the Dietary Supervisor (DS), DS stated the dome drying rack had rust and was dirty. The DS stated the kitchen staff did not have a schedule of cleaning the dome drying rack. The DS stated the dome drying rack should be free from rust and debris, for health and safety reasons. The DS stated staff's personal lunch bag should not be left inside the residents' refrigerator as it could cause cross contamination with the residents' food, potentially causing food born illnesses to the residents.<br><br>During a review of the facility's undated Policy and Procedure (P&P) titled Personnel Management, the P&P indicated Food & Nutrition Services staff personal items such as coats, purses, etc., will be stored in a designated place. These items are not to be stored with the food or in the kitchen.<br><br>During a review of the facility's P&P titled Equipment and Supplies dated 2023, the P&P indicated Effective maintenance management does not just happen. It is brought about by a thorough understanding an implementation of the principles of sanitation, and a knowledge of the necessary tools required for each cleaning task. |

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| F 0847<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037<br><br>Based on observation, interview, and record review, the facility failed to ensure, for one of three sampled residents (Resident 301) who signed the Resident-Facility Arbitration Agreement (AA, a Binding Arbitration Agreement requires the person who signed it resolve any dispute by binding arbitration, rather than in court) on 10/31/2024, had the capacity to understand and make decisions.<br><br>This failure had the potential risk to result in Resident 301 to not be able to make an informed decision and/or his rights to be denied.<br><br>Findings:<br><br>During a review of the facility's Admission Record (AR), the AR indicated Resident 301 was admitted to the facility on [DATE], with diagnoses that included pneumonia (lung infection) and End Stage Renal Disease (ESRD, irreversible kidney failure).<br><br>During a review of Resident 301's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 10/29/2024, the MDS indicated Resident 17 had no speech, sometimes understood others, and sometimes made self-understood. Resident 301's cognitive (mental processing in brain) skills for daily decision making was severely impaired. Resident 301 was dependent (helper does all the effort) for personal hygiene and chair/bed-to chair transfer.<br><br>During a review of Resident 301's History and Physical (H&P) dated 11/3/2024, the H&P indicated Resident 301 did not have the capacity to understand and make decisions.<br><br>During a review of Resident 301's AA dated 10/31/2024, the AA indicated Resident 301 signed the AA.<br><br>During an observation on 11/6/2024 at 3:37 pm, in Resident 301's room, Resident 301 was lying in bed with eyes closed. Resident 301 was not able to communicate when asked with questions.<br><br>During an interview and concurrent record review on 11/7/2024 at 3:18 pm, the Admission Coordinator (AC) stated, Resident 301 signed the AA by self. The AC stated, the AC thought Resident 301 had the capacity to sign without checking Resident's MDS assessment and H&P. The AC stated, the AA was a legal document for the resident to sign, and the facility should ensure the resident fully understood and agreed the AA before signing.<br><br>During a review of the facility's AA, the AA indicated, The resident and/or the person executing this Agreement certifies that he/she has read this agreement, it has been explained in a manner he/she understands, has been given a copy of this agreement, understands this agreement, . |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781<br><br>Based on observation, interview, and record review, the facility failed to follow its Policy and Procedures (P&P) titled Isolation - Categories of Transmission - Based Precautions for one of five sampled resident (Resident 89) when Licensed Vocational Nurse 1 (LVN 1) did not wear the required personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection) while administering medication to Resident 89 inside a Contact (precautions used for infections, diseases, or germs that are spread by touching the patient or items in the room) Precaution room.<br><br>This deficient practice had the potential to transmit infectious microorganisms and increase the risk of infection for the residents in the facility.<br><br>Findings:<br><br>During a review of Resident 89's Admission Record (AR), the AR indicated the facility initially admitted Resident 89 on 7/8/2024 and readmitted on [DATE] with diagnoses that included essential hypertension (elevated blood pressure without a known cause) and type 2 diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine).<br><br>During a review of Resident 89's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 10/11/2024, the MDS indicated Resident 89 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 89 required moderate (helper does less than half of the effort) assistance with toileting hygiene and showering/bathing self. The MDS indicated Resident 89 required set up or clean assistance for oral hygiene, upper/lower body dressing, putting on/taking off footwear and personal hygiene.<br><br>During a review of Resident 89's Physicians Order (PO), dated 11/3/2024, the PO indicated Resident 89's would be placed on Contact and Droplet Precautions for eight weeks for methicillin-resistant staphylococcus aureus (MRSA - a bacteria that does not respond to antibiotics) infection every shift for infection control.<br><br>During a review of Resident 89's untitled care plan initiated on 11/2/2024, the care plan indicated Resident 89 had MRSA of the wound on the right heel. The care plan interventions included to implement appropriate isolation techniques by staff, resident, and visitors. The care plan interventions also indicated contact precautions required due to MRSA of the wound of the right heel.<br><br>During an observation on 11/7/2024 at 11:05 am, LVN 1 was inside Resident 89's room and not wearing the required PPE while administering medication to Resident 89.<br><br>During an interview on 11/7/2024 at 11:07 am with LVN 1, LVN 1 stated Resident 89 was on contact isolation. LVN 1 stated she needed to wear the required PPE such as gloves, and gown before going inside Resident 89's room to prevent the spread of infection to other residents. LVN 1 stated, LVN 1 should have worn gown and gloves while giving medication to Resident 89.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/7/2024 at 11:24 am with the facility's Infection Preventionist Nurse (IPN), the IPN stated, in a contact isolation room, staff needed to wear gown, gloves and mask before entering the room to prevent the spread of infection to other residents and staff.<br><br>During an interview on 11/7/2024 at 3:17 pm with facility's Director of Nursing (DON), the DON stated staff needed to wear gown and gloves when they enter Resident 89's room to prevent the spread of infection to staff and other residents. The DON stated, staff needed to wear the required PPE while administering medications because staff had a direct contact with Resident 89.<br><br>During a record review of the facility's P&P titled, Isolation - Categories of Transmission - Based Precautions, dated 10/2018, the P&P indicated contact precautions may be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident -care items in the resident's environment. The P&P indicated, staff and visitors will wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed. |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037<br><br>Based on observation, interview and record review, the facility failed to ensure a call light device (a means of communication for patients to their care providers that are outside of the patient's room) was functioning for one of one sampled resident (Resident 17).<br><br>This failure had the potential to result in the delay of the provision of needed care and services to Resident 17.<br><br>Findings:<br><br>During a review of Resident 17's Admission Record (AR), the AR indicated Resident 17 was readmitted to the facility on [DATE], with diagnoses that included heart failure (the heart cannot pump enough blood to meet the body's needs) and hypotension (low blood pressure).<br><br>During a review of Resident 17's History and Physical (H&P), dated 3/5/2023, the H&P indicated Resident 17 had the capacity to understand and make decisions.<br><br>During a review of Resident 17's quarterly MDS dated [DATE], the MDS indicated Resident 17 had clear speech, had ability to understand others and had the ability to make self-understood. The MDS indicated Resident 17 required partial/moderate assistance (helper does less than half the effort) for personal hygiene and chair/bed-to-chair transfer.<br><br>During an observation and interview on 11/5/2024 at 2:47 pm, in Resident 17's room, Resident 17 was lying in bed talking on the phone using a foreign language. Resident 17's roommate stated Resident 17 had fallen last month and Resident 17's call light had not been functioning for a couple of months now. Resident 17 was asked to press Resident 17's call light button and it was not functioning. The light outside the door did not light up when Resident 17 pressed the call light button.<br><br>During an observation on 11/5/2024 at 2:53 pm, in Resident 17's room, Certified Nursing Assistant 1 (CNA1) pressed Resident 17's call light button and stated it was not working. CNA1 stated, CNA1 did not know how long Resident 17's call light had not been functioning. CNA1 stated, the call light should be functioning for the resident to use when help was needed. CNA1 stated, if the call light was not working, the resident would not receive the care and services needed.<br><br>During an observation and concurrent interview on 11/5/2024 at 3:20 pm, Licensed Vocational Nurse 3 (LVN 3) pressed Resident 17's call light button and stated the call light was not working. LVN 3 stated, it was important to ensure the resident's call light was functioning, so that staff could respond to the resident's need, timely and for the safety of the resident.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555416 | A. Building<br>B. Wing | 11/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Glendora Canyon Transitional Care Unit | 401 W. Ada Ave.<br>Glendora, CA 91741 |

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 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/6/2024 at 9:38 am, the Maintenance Supervisor (MS) stated, there was a Maintenance Log in each nursing station for nurses to write down any issues with any equipment in the unit. The MS stated MS made rounds during the day to check the log. The MS stated, there was no issue regarding Resident 17's call light documented in the Maintenance Log. The MS stated, MS made rounds for equipment check every first week of each month. The MS but did not have a check list or system in place to ensure all equipment in the unit were checked. The MS stated, there was a communication failure between Nursing Staff and Maintenance Department. The MS stated it was important to ensure all call lights were functioning for resident's safety.<br><br>During a review of the facility's Policy and Procedure (P&P) titled Call System, Resident, dated 9/2022, the P&P indicated Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. |