STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055523	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Post Acute Center	250 N. Verdugo Road Glendale, CA 91206

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44372 Based on interview and record review, the facility failed to ensure the management of Resident 1 ' s psychotropic medications met the psychotropic medication requirements, in accordance with the facility ' s policy and procedures (P&P) titled Medication Utilization and Prescribing - Clinical Protocol, Psychotropic Medication use, and Appendix 3: Medication Issues Of Particular, Relevance In Older Adults by failing to: 1. Ensure Resident 1 ' s Depakote (brand name as divalproex sodium, used to treat epilepsy and bipolar disorder, medication works by affecting chemicals in the brain) use from 12/11/2024 to 12/18/2024 was given only when necessary to treat a specific diagnosed and documented clinical condition, that was based upon a clinical assessment of the resident ' s condition and consistent with clinical standards of practice. Resident 1 was administered Depakote from 12/11/2024 to 12/18/2024 for the treatment of seizures, despite the resident not having a seizure disorder or diagnosis. Resident 1 ' s diagnosis for Depakote use was later changed to Mood swings on 12/18/2024, without adequate clinical assessment and/or a comprehensive review of the resident that included an evaluation of the resident's signs and symptoms to identify underlying causes. 2. Ensure the facility ' s licensed nurses adequately monitor and document the Depakote for efficacy and adverse consequences (side effects) from 12/11/2024 to 12/28/2024. 3. Prevent, identify, and respond to adverse consequences for the use of Depakote from 12/11/2024 to 12/27/2024, when Resident 1 was observed by LVN 1 and communicated by Responsible Party (RP) 1 to the facility staff as quiet, drowsy, sedated and with poor oral intake. 4. Licensed Vocational Nurse (LVN) 1 did not arrange a follow-up visit with the Psychiatrist to reevaluate Resident 1 ' s psychotropic medication/s, as ordered by Resident 1 ' s attending physician (MD)1 on 12/12/2024, until 12/27/2024. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Facility did not develop a comprehensive care plan for administration of Depakote from 12/11/2024 to 12/18/2024 that includes clear guidelines for medication management, such as ensuring proper dosage, schedule, and purpose (seizure control, mood stabilization, or migraine prevention). Document episodes of agitation, aggression, irritability, outburst of anger or unusual behavior. Also note any changes in the patient's typical behavior patterns. Regular monitoring for both common side effects (like drowsiness and weight loss, dehydration) and serious ones (such as liver damage and pancreatitis) is essential, along with routine lab tests for liver function, CBC, and renal health. These failures resulted to a delay in Resident 1 ' s management of Depakote adverse consequences that included abdominal pain, drowsiness, poor oral intake. Resident 1 was transferred to the General Acute Care Hospital (GACH) 2 on 12/29/2024, with diagnoses that included lower gastrointestinal (GI) bleed, hypernatremia, and dehydration. Findings: During a review of Resident 1 ' s Face Sheet (admission record) indicated the resident was admitted to Facility 1 on 10/31/2024 with diagnoses of unspecified Dementia, unspecified severity, without behavior disturbances , psychotic disturbance , mood disturbance , and anxiety(Memory loss, difficulty with problem-solving or planning, confusion about time or place, and problems with speaking or writing without psychosis (loss from reality), anxiety disorder unspecified(a diagnosis given to people who have symptoms of anxiety panic attack, inability to stay still and anxiety significant enough to be distressing but does not meet the criteria for another anxiety disorder), insomnia(persistent problems falling and staying asleep). During a review of Resident 1 ' s History and Physical, dated 11/05/2024, the History and Physical indicated Resident 1 has fluctuating capacity to understand and make decisions. The H&P did not indicate Resident 1 had a history or diagnosis of seizures. During a review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 11/04//2024, the MDS indicated Resident 1 cognition severely impaired (significant loss or reduction in a person ' s cognitive abilities, such as memory, reasoning, problem-solving, attention, and language, which severely interfere with the individual ' s ability to function normally in everyday life, including performing basic tasks, making decisions, or communicating effectively. During a review of Resident 1 ' s Change of Condition (COC), dated 12/08/2024 timed at 4:07 PM, the COC indicated Resident 1 complained of abdominal pain, noted with distended abdomen, with active peristalsis heard using the stethoscope. The COC indicated the resident complained of pain when defecating. The COC indicated Resident 1 was on monitoring for dysuria and recent urinalysis result, did not indicate an infection. The COC indicated a recommendation transfer to the acute hospital (GACH 1). The COC indicated Resident 1 was transferred to GACH 1 on 12/8/2024. During a review of Resident 1 ' s GACH 1 record titled History and Physicals dated 12/9/2024 electronically signed by MD 1 at 11:18 PM, the GACH 1 record under Diagnoses, indicated to admit Resident 1 to GACH 1 for chest pain, constipation, elevated troponin and under Plan for cardiac work up, milk of magnesia, dulcolax suppository, enema and Depakote for her psychosis. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s GACH 1 record titled Orders-Medication- Inpatient medications, the GACH 1 record indicated Resident 1 last received divalproex sodium (Depakote) on 12/10/2024 at 9:03 AM, 12/10/2024 at 3:10 PM, and 12/10/2024 at 8:19 PM, as ordered by MD 1 on 12/09/2024 timed at 11:13 PM. During a review of Resident 1 ' s GACH 1 record titled Discharge summary electronically signed on 12/13/2024, the GACH 1 record indicated Resident 1 was transferred to the GACH on 12/08/2024 with an admitting diagnosis of chest pain. The GACH Discharge Summary indicated Resident 1 was discharged back to the facility on [DATE], with GACH 1 discharge medications that included Depakote EC 250 mg 1 tablet daily three times a day. During a review of Resident ' s 1 Facility 1 ' s Telephone Order Summary dated 12/18/2024 and timed at 12:36 PM, authored by the ADON, the order indicated the Depakote oral tablet delayed release was changed (decreased) to 125 mg, one tablet by mouth every 12 hours for mood swings manifested by sudden outbursts of anger related to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. During a review of Resident ' s 1 Facility 1 Telephone Order Summary dated 12/26/2024 and timed at 12:39 PM, authored by LVN 1, the order indicated the Depakote oral tablet delayed release 125 mg, one tablet by mouth every 12 hours for mood swings was discontinued Per (Responsible Party [RP] 1) request. During a review of Resident 1 ' s Medication Administration Records (MAR), dated 12/1/2024 to 12/31/2024, the MAR indicated the resident received: -Divalproex Sodium (Depakote) 250 mg 1 tablet oral tablet 3 times a day for seizure that started from 12/11/2024 to 12/17/2024 and 1 tablet on 12/18/2024 at 9:00 AM. The MAR order indicated the Divalproex Sodium or Depakote was discontinued on 12/18/2024 timed at 12:36 PM. There was no documented evidence Resident 1 was monitored for side effects of Depakote and was monitored for any seizures from 12/11/2024 to 12/18/2024. - Divalproex Sodium (Depakote) 125 mg 1 tablet oral every 12 hours times a day for mood swings M/B sudden outbursts of anger related to unspecified dementia. Unspecified severity, without behavioral disturbance, psychotic disturbance that started from 12/19/2024 to 12/25/2024 and 1 tablet was received on 12/26/2024 at 9:00 AM. The MAR order indicated the Divalproex Sodium or Depakote was discontinued on 12/26/2024 timed at 12:38 PM. The MAR indicated an order to monitor Resident 1 for mood swings manifested by sudden anger outbursts every shift for the use of Depakote. The MAR indicated Resident 1 had episodes of anger outbursts on 12/19/2024 during the AM shift (7 am to 3 pm), no episodes of anger outbursts on 12/20/2024, 12/21/2024, 12/22/2024, 12/23/2024, 12/24/2024. The MAR further indicated Resident 1 had episodes of anger outbursts on 12/25/2024 during the AM shift, PM shift (3 pm to 11 pm) and night shift (11 pm to 7 am). The MAR indicated Resident 1 had episodes of anger outburst on 12/26/2024 during the AM shift and no episodes on 12/27/2024 and 12/28/2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Nurses Note, dated 12/12/2024 at 2:04 PM, as authored by MD 1, the Nurses Note indicated visited by MD 1 in the facility with the following order: Follow up with Psych (Psychiatrist). The resident ' s records did not indicate there was an actual physician order transcribed that indicated Resident 1 was referred back to the Psychiatrist for an evaluation or reevaluation during Resident 1 ' s readmission back to the facility from 12/11/2024 to 12/28/2024. During a review of Resident 1 Change of Condition (COC), dated 12/26/2024 and timed 11:55 PM, the COC indicated Poor PO intake. The COC indicated Patient (Resident 1) not consuming any of her meals on her own or by being fed. The COC indicated MD 1 was notified by leaving a voicemail message but Awaiting reply. The resident ' s records did not indicate an actual physician order or documented evidence of MD 1 ' s response to Resident 1 ' s COC for 12/26/2024. During a review of Resident 1 ' s Nurses Note, dated 12/26/2024 at 12:39 PM, the Nurses Note indicated MD 1 replied with new orders to stop Depakote. There was no documented evidence that indicated a physician order on 12/26/2024 was transcribed to discontinue Resident 1 ' s Depakote due to drowsiness. During a review of Resident 1 ' s Psychiatric Progress Note dated, 12/27/2024, the Psychiatric Progress Note indicated, Depakote was discontinued because patient has been having poor oral intake and drowsier. During a review of Resident 1 Change of Condition (COC), dated 12/28/2024 and timed 11:55 PM, the COC indicated Resident has increased confusion during the shift. During a review of Resident 1 ' s GACH 2 records, titled Discharge Summary dated 1/12/2024 at 3:05 PM indicated Resident 1 was admitted to GACH 2 on 12/29/2024 with admitting diagnoses of dehydration, hypernatremia, and lower GI bleed and was discharged to another facility (Facility 2) on 1/03/2025. During an interview on 1/10/2025 at 2:10 PM with Resident 1 ' s Responsible Party (RP) 1, RP 1 stated Resident 1 does not have a diagnosis of seizure. RP 1 stated the Assistant Director of Nursing (ADON) informed him that Depakote was ordered at GACH 1 on 12/10/2024 and it has to be continued. RP 1 stated when he visited Resident 1 at the facility from 12/11/2024 to 12/26/2024, he had observed Resident 1 drowsy, poor intake, and sedated. RP 1 stated he asked MD 1, ADON, and LVN 1 continuously since 12/11/2024, to discontinue the Depakote but the facility staff did not evaluate Resident 1 after informing them many times that Resident 1 looks sedated from the new medication ordered from GACH 1 (Depakote). RP 1 stated the facility only decreased the dose and finally discontinued the Depakote on 12/26/2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review of Resident 1 ' s MAR for the month of December 2024 on 1/10/2025 at 2:50 PM, with LVN 1, LVN 1 stated since Resident 1 was readmitted back to the facility from GACH 1 on 12/11/2024, LVN 1 stated he observed Resident 1 was quiet, drowsy and with poor oral intake. LVN 1 stated RP 1 had requested him and the Assistant Director of Nursing (ADON) to stop the Depakote. LVN 1 stated that according to the MAR, Resident 1, received Depakote 250 mg 1 tablet oral, 3 times a day for diagnosis of seizure from 12/11/2024 to 12/17/2024 and 1 tablet on 12/18/2024 at 9:00 AM and the Psych MD decreased the Depakote dose on 12/18/2024, to Depakote 125 mg, 1 tablet orally every 12 hours and changed the indication from a diagnosis of seizures to an indication of Mood swings, manifested by sudden outbursts of anger related to unspecified dementia, however, Resident 1 continued to be drowsy . LVN 1 stated the MAR indicated Resident 1 received Depakote 12 mg tablet, every 12 hours from 12/19/2024 to 12/25/2024 and 1 tablet on 12/26/2024 at 9:00 AM for unspecified dementia without behavioral disturbance. LVN 1 stated that it was MD 1 (not Psych MD) who discontinued the Depakote order (125 mg) on 12/26/2024. LVN 1stated since Resident readmitted from hospital on 12/11/2024, LVN 1 stated he observed Resident 1 was quiet, drowsy with poor intake stated RP requested him and Assistant Director of Nursing (ADON) to stop the Depakote. LVN 1 stated the Psych MD decreased the Depakote dose on 12/18/2024, however, Resident 1 continued to be drowsy. LVN 1 stated MD 1 discontinued the Depakote order on 12/26/2024. LVN 1 stated he could not find documentation and could not recall the date that MD 1 was informed about Resident 1 being drowsy and sedated. During a concurrent interview and record review on 1/10/2025 at 3:01 PM with LVN 1, Resident 1 admitting Diagnosis, nurses note, MD order, and MAR for the month of December 2024, was reviewed. LVN 1 stated Resident 1 does not have diagnosis of seizure, stated he is unable to find documented evidence the indication of the use of medication from 12/11/2024 to 12/18/2024 also unable to find documented evidence to monitor side effect of Depakote from 12/11/2024 to 12/26/2024. LVN 1 stated it is important to know what kind of behavior to monitor to track resident ' s progress to know if medication is effective or even the resident needs that medication. LVN 1 stated it is important to monitor Medication side effects to inform MD. During an interview and record review on 1/10/2025 at 3:49 PM with ADON, Resident 1 ' s Interdisciplinary Team (IDT) Behavior Management, dated 12/18/2025 at 12:29, reviewed. The IDT Behavior Managment indicated Resident has no episodes of inability to sit still. Only issues with anger outbursts but rarely. Psychiatrist ordered to decrease Depakote to 125mg by mouth every 12 hours. The ADON stated based on his observation Resident 1 was calm from 12/11/2024 to 12/18/2024 but still experience outburst of anger, so he reports the symptoms by phone to Psychiatrist and the psychiatrist placed a telephone order to decrease the dose of Depakote to 125 mg by mouth every 12 hours. and discontinued on 12/26/2024 by MD 1 per and per son request (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the interview on 1/10/2024 at 5:36 PM with the Psychiatric Mental Health Nurse Practitioner (PMHNP), the PMHNP stated the Depakote was used as both mood stabilizer or anti-seizure medication for Resident 1. The PHMNP stated she did not visit Resident 1 from 12/11/2024 to 12/27/2024 (readmission) and did not receive the facility referral to follow up and visit Resident 1 back at Facility 1 on 12/10/2024 and initiation of Depakote by the GACH. The PHMNP stated the Depakote level may be higher or low in some patients depending on age, the medication they are taking, liver and kidney functions are important to monitor. The PHMNP stated that the facility staff should monitor specific behavior to justify the use of Depakote and also the side effects such as drowsiness, diarrhea, abdominal pain, nausea and dehydration. The PHMNP stated if the facility staff informed her of Resident 1 ' s drowsiness and poor oral intake, she would have discontinued the Depakote and ordered to check the resident ' s Depakote levels. The PHMNP stated the facility staff did not communicate these symptoms (drowsiness and poor oral intake) to her immediately and these symptoms may have led to dehydration, liver damage and eventually hospitalization and coma. During an interview and record review on 1/10/2025 at 6:02 PM with the DON, Resident ' s 1 MAR for the month of December 2024, was reviewed. The DON stated Resident ' s 1 MAR for the month of December 2024, the DON stated that Resident 1 received Depakote from 12/11/2024 to 12/18/2024 for seizure management despite Resident 1 did not have a diagnosis of seizure. The DON stated he could not find documentation to justify the use of Depakote for mood swings and behavioral monitoring for episodes outburst of anger, from 12/11/2024 to 12/18/2024. In addition. the DON stated he could not find documented evidence that staff monitor the side effects of Depakote, such as drowsiness, nausea, or dehydration from 12/11/2024 to 12/26/2024. The DON also stated no laboratory orders was drawn for Depakote levels while Resident was receiving Depakote at the facility. During a concurrent interview and record review on 1/10/2025 at 6:10 PM, with the DON, all care plan for Resident 1 was reviewed. The DON stated no care plan was developed for Resident 1 ' s use of Depakote. The DON stated care plan is necessary to provide directions for the staff on how to care for the resident who is receiving Depakote. During a concurrent interview and record review on 1/10/2025 at 6:15 PM, with the DON a review of Resident 1 ' s Nurses Note, dated 12/12/2024 at 2:04 PM, the Nurses Note indicated MD 1 ordered to follow up with a psychiatrist visit. The DON stated Resident 1 was not visited or reassessed by a psychiatrist (Psych MD or NP) while residing at the facility from 12/11/2024 (readmission to Facility 1) and up to 12/28/2024 (discharged to GACH 2). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s Policy and Procedure (P&P) titled Medication Utilization and Prescribing - Clinical Protocol, revised 2018 , indicated When a medication is prescribed for any reason, the physician and staff will identify the indications (condition or problem for which it is being given, or what the medication is supposed to do or prevent), considering the resident's age, medical and psychiatric conditions risk health status and existing medication regimen. Symptoms should be characterized in sufficient detail (onset, duration, frequency, intensity, location, etc.) to help identify whether a problem exists or whether a symptom is just a variation of normal. The physician will provide and/or document a rationale when the indication, dose, duration, or frequency of a prescribed medication is greater than commonly accepted practice or the manufacturer's recommendations or the medication is considered high-risk compared to other available, relevant alternatives. A symptom (confusion, pain, etc.) may have diverse causes so it is usually relevant to try to identify likely causes and pe1iinent non-pharmocological interventions. A diagnosis by itself may not be sufficient justification for prescribing a medication. The existence of a condition or risk does not necessarily require a treatment and the treatment may be something besides, or in addition to, medication. The staff and physician will periodically re-evaluate the conditions and symptoms for which each resident is receiving medications to determine if the medication and doses are still relevant and are not causing undesired complications. The staff and physician will monitor the progress of anyone with a probable adverse drug reaction and anyone for whom medications have been adjusted because of the possibility of an adverse drug reaction. If the physician has stopped, tapered, or changed an existing medication, the staff will monitor for, document, and report any return of symptoms. During a review of the facility ' s P&P titled Psychotropic Medication use, with no date, indicated Residents will not receive medications that are not clinically indicated to treat a specific condition, a psychotropic medication is any mediation that affects brain activity associated with mental processes and behavior. Categories of medication which affect brain activity such as antihistamine. anti-cholinergic medications, and central nervous system in medication that arc prescribed as a substitute for or an adjunct to a psychotropic medication are monitored and managed as psychotropic medications. Consideration of the use of any psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes. Residents receiving psychotropic medications are monitored for adverse consequences, including: a. anticholinergics effects - flushing, blurred vision, dry mouth, altered mental status, difficulty urinating, falls, excessive sedation and constipation; metabolic effects increased cholesterol poorly controlled or unstable blood sugar, weight gain; neurologic effects - agitation, distress, extrapyramidal symptoms, neuroleptic malignant syndrome, Parkinsonism, tardive dyskinesia, cerebrovascular . If psychotropic medications are identified as possibly causing or contributing to adverse consequences, the prescriber will determine whether the medication(s) should be continued, and document the rationale for this decision. Residents (and/or representatives) have the right to decline treatment with psychotropic medications. The staff and physician will review with the resident/representative the risks related to not taking the medication as well as appropriate alternatives. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s P&P titled Appendix 3: Medication Issues Of Particular, Relevance In Older Adults, with no date, the P&P indicated, All anticonvulsants, example phenytoin, primidone, (divalproex sodium) valproic acid, may also be used to treat other disorders . in addition to seizures, such as bipolar disorder, schizoaffective disorder, chronic neuropathic pain, and for prophylaxis of migraine headaches. Need for indefinite continuation should be based on confirmation of the condition (for example, distinguish epilepsy from isolated seizure due to medical cause or distinguish migraine from other causes of headaches) and its potential causes (medications, electrolyte imbalance). The P&P further indicated If used to manage behavior, stabilize mood, or treat a psychiatric disorder, refer to Section V - Tapering of a Medication Dose/Gradual Dose Reduction (GDR) in the guidance .The P&P further indicated the medication that should be monitored with periodic serum concentrations were phenytoin, phenobarbital, primidone, divalproex sodium, and carbamazepine. During a review of the same facility P&P titled Appendix 3: Medication Issues Of Particular, Relevance In Older Adults, with no date, the P&P indicated, under Monitoring: Serum medication concentrations may help identify toxicity, but significant signs and symptoms of toxicity can occur even at normal or low serum concentrations. When anticonvulsants are used for conditions other than seizure disorders (e.g., as mood stabilizers), the same concerns exist regarding the need for monitoring for effectiveness and side effects; but evaluation of symptoms-not serum concentrations-should be used to adjust doses. Toxic serum concentrations should, however, evaluated and considered for dosage adjustments. Symptom control for seizures or behavior can occur with subtherapeutic serum medication concentrations. The P&P further indicated under Adverse Consequences: May cause liver dysfunction, blood dyscrasias, and serious skin rashes requiring discontinuation of treatment may cause nausea/vomiting, dizziness, ataxia, somnolence/lethargy, incoordination, blurred or double vision, restlessness, toxic encephalopathy, anorexia, headaches .