STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056317	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenoaks Convalescent Hospital	409 W. Glenoaks Blvd. Glendale, CA 91202

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 49900 Based on observation, interview and record review, the facility failed to post accurate nurse staffing information of actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift daily and was not posted in a prominent location readily accessible to residents and visitors for viewing in accordance with the facility ' s policy and procedure titled Nursing Department - Staffing, Scheduling and Posting. This deficient practice of posting inaccurate nurse staffing information could mislead the residents and visitors that may affect the quality of nursing care provided to the residents. Findings: A review of the Facility ' s Daily Nursing Staffing Posting , dated 4/8/24 indicated the facility census, projected ppd (per patient day) for three shifts (day, evening, night) for RN ' s (registered nurse), LVN ' s (licensed vocation nurse), CNA ' s (certified nursing assistant) and RNA ' s (restorative nursing assistant). During an observation, on 4/23/24 at 10:17 a.m., the facility ' s projected daily nursing staffing was observed on the wall of the nursing station. The census was 86. During an interview, on 4/23/24 at 10:17 a.m., Director of Staff Development consultant (DSD consultant) stated the daily staffing should be updated daily, and if she ' s not around, the administrator and RN supervisor should be updating the staffing. It was important to keep staffing assignment updated because it provided information for everyone. The risk of not having the update staffing assignment was not having the accurate information. During an interview, on 4/23/24 at 10:38 a.m., the Director of Nursing (DON) stated the daily nursing staffing posting should be updated daily, and that it was important to keep the daily nursing staffing updated since it was required by the facility. The DON stated the daily nursing staffing posting provided assurance for family, informed family, and visitor that staff was adequate. The DON stated the daily staff posting observed on the wall at the nurses ' station was not updated, and when the staff posting was not updated, information was not readily accessible to visitor or family, and could create a sense of insecurity for adequate staffing. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056317	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure (P&P) titled Nursing Department-Staffing, Scheduling & Postings, revised 10/24/2022, indicated the facility will post the following information daily: and indicating the current date. The P&P indicated the facility would post the nursing staffing data daily at the beginning of each shift.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333 Based on observation, interview, and record review, the facility failed to ensure licensed nursing staff did not administer expired insulin (a medication used to treat high blood sugar) to six out of 10 residents (Resident 5, 6, 7, 8, 12 and 14) whose insulin was found to be expired during the inspection of two of two medication carts (Station 2 Medication Cart 2 and Station 1 Medication Cart 1), and ensure Resident 14 ' s Basaglar (Insulin Glargine) KwikPen (prefilled insulin glargine pen) was administered in accordance with manufacturer ' s specifications of once daily and not as a sliding scale. (Cross Reference F761) These failures resulted in residents (Resident 5, 6, 7, 8, 12 and 14) receiving expired insulin doses and insulin not in accordance with manufacturer ' s specification that could affect the effectiveness of the medication to lower the blood sugar level and the potential to result in serious health complications due to uncontrolled blood sugar levels possibly resulting in hospitalization , coma, or death. Findings: 1. During a concurrent interview and medication cart inspection on 4/23/2024 at 10:00 AM with a Licensed Vocational Nurse (LVN) 3, LVN 3 stated insulin has an expiration date of 28 days once opened per facility and pharmacy policy. LVN 3 stated expired medication would not have the effect it should have. The Blood Glucose (a type of sugar)/Sugar (BG or BS) could spike up, the expired medication would not be doing the job to control the resident ' s BS. a. During a review of Resident 14's Admission Record, (a document containing demographic and diagnostic information), dated 4/23/2024, the Admission Record indicated Resident 14 was admitted to the facility on [DATE], and readmitted on [DATE], diagnoses included Type 2 Diabetes Mellitus (a medical condition characterized by the inability to control blood sugar) and Diabetes Mellitus with Diabetic Neuropathy (nerve damage that can occur with diabetes). During a review of Resident 14's History and Physical (H&P), dated 4/13/2023, Resident 14 ' s H&P indicated the resident did not have the capacity to understand and make decisions. During a concurrent medication cart inspection and interview on 4/23/2024 at 10:03 AM, with LVN 3, Medication Cart 3 on Station 2 was inspected, observed inside of the medication cart was Basaglar labeled for Resident 14, with an open date of 2/25/2024. LVN 3 stated that Resident 14 ' s insulin was expired because the insulin had been opened for more than 28 days. Resident 14 ' s Basaglar opened on 2/25/24 expired on 3/24/2024. Resident 14 ' s prescription label for Basaglar (Insulin Glargine) KwikPen (prefilled insulin glargine pen) injection solution 100 units/milliliters (mL), indicated to inject 12 units subcutaneously (injection under the skin) at bedtime and to hold if blood sugar is less than 100 milligrams (mg, unit of mass) per deciliter (dl, unit of volume). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 14's Order Summary Report (a document containing a summary of all active physician orders), indicated an order for Basaglar (Insulin Glargine) KwikPen (prefilled insulin glargine pen) injection solution 100 units/milliliters (mL), order date 2/26/2024, instructions indicated to inject as per sliding scale (insulin doses based on blood glucose [BG, a type of sugar] level): if 151-200 = 2 units; 201-250 =4 units; 251-300 = 6 units; 301-350 = 8 units; 351-400 = 10 units; if BG is less than 70 or greater than 400 milligrams (mg, unit of mass) per deciliter (dl, unit of volume) Notify MD. Inject subcutaneously (injection just under the skin) before meals and at bedtime for Type 2 Diabetes Mellitus. According to manufacturer, BASAGLAR(R) (insulin glargine) injection 100 units/mL is a once-daily injection. BASAGLAR MUST BE INJECTED ONCE A DAY AT THE SAME TIME EVERY DAY. BASAGLAR may cause serious side effects. Some of these can lead to death. The possible serious side effects of BASAGLAR are: Low blood sugar. This can lead to, dizziness or light-headedness, headache, shakiness, irritability, sweating, blurred vision, fast heartbeat, mood change, confusion, slurred speech, anxiety (a mental disorder characterized by persistent feelings of worry, nervousness, or unease strong enough to interfere with daily activities), and hunger. During a concurrent interview and record review on 4/23/2024 at 10:20 AM with LVN 3, LVN 3 looked through Medication Cart 3 located on Station 2 and stated there was not another Basaglar available for Resident 14. LVN 3 reviewed Resident 14 ' s Basaglar Medication Administration Record (MAR) for the month of 4/2024, and stated Resident 14 was administered Basaglar after the insulin had expired. During a review of Resident 14 ' s 4/2024 MAR documentation indicated licensed nurse initialed administration of Basaglar as a sliding scale insulin and not as a once a day long-acting insulin with nine doses being administered after expiration for Resident 14 on: 4/2/2024 at 4:30 PM, two units 4/5/2024 at 11:30 AM, two units 4/11/2024 at 11:30 AM, two units 4/12/2024 at 11:30 AM, two units 4/20/2024 at 6:30 AM, four units 4/20/2024 at 11:30 AM, two units 4/20/2024 at 4:30 PM, two units 4/22/2024 at 6:30 AM, two units 4/23/2024 at 6:30 AM, two units b. During a review of Resident 12's Admission Record, dated 4/23/2024, the Admission Record indicated, Resident 12 was admitted to the facility on [DATE], diagnoses included Type 2 Diabetes Mellitus, Diabetes Mellitus with Diabetic Neuropathy, and Glaucoma (a group of eye conditions that can cause blindness). (continued on next page)

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Glenoaks Convalescent Hospital	409 W. Glenoaks Blvd. Glendale, CA 91202

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 12's H&P, dated 12/12/2022, Resident 12 ' s H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 12's Order Summary Report indicated an order for Humalog (Insulin Lispro) Injection Solution, order date 10/1/2023, instructions indicated to inject as per sliding scale: if 70 -149 = 0 unit if BS (Blood Sugar) is less than 70, able to swallow give orange juice and recheck in 15 minutes. Notify MD.; if 150-199 = 2 units; 200-249 =4 units; 250-299 = 6 units; 300-349 = 8 units; 350-399 = 10 units; if BS is greater than 400 mg/dl Call MD., subcutaneously before meals for Type 2 Diabetes Mellitus. During a concurrent observation, interview, and record review on 4/23/2024 at 10:20 AM with LVN 3, LVN 3, observed inside of Medication Cart 3 located on Nursing Station 2 was a vial of Insulin Lispro labeled for Resident 12 with an open date of 3/19/2023. LVN 3 stated Resident 12 ' s Insulin Lispro was expired as of 4/16/2024. LVN 3 reviewed Resident 12 ' s Insulin Lispro administration record and stated the resident was administered insulin after the expiration date. Review of the 4/2024 MAR indicated the resident was administered 13 doses of expired Insulin Lispro between 4/17/24 through 4/22/2024 on: 4/17/2024 at 1130 AM, four units 4/17/2024 at 4:30 PM, six units 4/18/2024 at 11:30 AM, two units 4/18/2024 at 4:30 PM, six units 4/19/2024 at 4:30 PM, two units 4/20/2024 at 11:30 AM, two units 4/20/2024 at 4:30 PM, two units 4/21/2024 at 6:30 AM, two units 4/21/2024 at 1130 PM, two units 4/21/2024 at 4:30 PM, ten units 4/22/2024 at 6:30 AM, four units 4/22/2024 at 11:30 AM, four units 4/22/2024 at 4:30 PM, two units (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenoaks Convalescent Hospital	409 W. Glenoaks Blvd. Glendale, CA 91202

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent observation, interview, and medication cart inspection, on 4/23/2024 at 10:44 AM with LVN 1, Medication Cart 1 located on Station 1 was inspected. LVN 1 stated the insulin observed inside of the medication cart labeled with open dates over 28 days were expired and no longer good to administer to the residents. Insulin for the following residents (Residents 5, 6, 7, and 8) were observed expired and available for resident use inside of Medication Cart 1 on Station 1: For Resident 7, one vial of Novolog (insulin Aspart) with an open date of 3/8/2024. LVN 1 stated Resident 7 ' s Novolog expired on 4/5/2024 and that there was not another vial of Novolog available for Resident 7. For Resident 8, one vial of Humalog (Insulin Lispro) with an open date of 2/23/2024 became expired on 3/22/2024. For Resident 6, one Insulin Lispro Pen with an open date of 3/8/2024 became expired on 4/5/2024 For Resident 5, one Insulin Glargine Pen, with an open date of 3/6/2024, became expired on 4/3/2024 a. During a review of Resident 7's Admission Record, dated 4/23/2024, the Admission Record indicated Resident 7 was admitted to the facility on [DATE], diagnoses included Type 2 Diabetes Mellitus and Diabetes Mellitus with Diabetic Neuropathy. During a review of Resident 7 ' s H&P, dated 12/13/2023, Resident 7 ' s H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 7's Order Summary Report dated 4/23/2024, indicated an order for NovoLog Injection Solution 100 UNIT/ML (Insulin Aspart), order date 12/30/2023, instructions indicated to inject as per sliding scale: if 70 - 149 = 0 if BS less than (<) 70 and if resident conscious, give 4-6 ounces of juice and recheck in 15 minutes. Notify MD.; 150 - 199 = 2 units; 200-249 = 4 units; 250 - 299 = 6 units; 300 - 349 = 8 units; 350 - 399 = 10 units; 400+ = 12 units if BS greater than (>) 400 call Hospice MD., subcutaneously before meals and at bedtime for DM II (Type 2 Diabetes Mellitus). During a concurrent interview, and record review on 4/23/2024 at 11:05 AM with LVN 1, Resident 7 ' s MAR was reviewed. LVN 1 stated Resident 7 ' s vial of Novolog (insulin Aspart) with an open date of 3/8/2024 expired on 4/5/2024 and should have been removed from the medication cart. LVN 1 stated expired insulin was no longer effective if administered to residents to control blood sugar. During a review of Resident 7 ' s MAR dated 4/6/2024 to 4/22/2024, the MAR indicated Resident 7 was administered 18 doses of expired Novolog on: 4/7/2024 at 11:30 AM and 4:30 PM 4/8/2024 at 4:30 PM and 9 PM 4/12/2024 at 4:30 PM 4/13/2024 at 11:30 AM, 4:30 PM, and 9 PM (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056317	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenoaks Convalescent Hospital	409 W. Glenoaks Blvd. Glendale, CA 91202

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/14/2024 at 11:30 AM and 4:30 PM 4/15/2024 at 9 PM 4/16/2024 at 6:30 AM 4/17/2024 at 11:30 AM 4/19/2024 at11:30 AM 4/20/2024 at 4:30 PM 4/21/2024 at 4:30 PM 4/22/2024 at 11:30 AM and 4:30 PM b. During a review of Resident 8's Admission Record, dated 4/23/2024, the Admission Record, indicated Resident 8 was admitted to the facility on [DATE], and readmitted on [DATE], diagnoses included Type 2 Diabetes Mellitus. During a review of Resident 8's H&P, dated 4/17/2024, Resident 8 ' s H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 8's Telephone Order dated 4/15/2024 indicated an order for Humalog Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 0 - 150 = 0 units BS <70 and Patient is conscious give 4-6 oz of orange juice and re-check after 15 minutes, notify MD.; 51 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 -400 = 10 units 10 units for blood sugar >401, then call MD, subcutaneously before meals and at bedtime for DM II., subcutaneously before meals and at bedtime for DM 2 During a concurrent interview, and record review on 4/23/2024 at 11:05 AM with LVN 1, Resident 8 ' s MAR was reviewed. LVN 1 stated Resident 8 ' s vial of Humalog (Insulin Lispro) with an open date of 2/23/2024 became expired on 3/22/2024 and should have been removed from the medication cart. LVN 1 stated expired insulin was no longer effective if administered to residents to control blood sugar. During a review of Resident 8 ' s MAR dated 3/23/2024 to 4/9/2024, the MAR indicated Resident 8 was administered 10 doses of expired Humalog on: 3/23/2024 at 11:30 AM 4/2/2024 at 11:30 AM 4/3/2024 at 11:30 AM 4/4/2024 at 6:30 AM 4/5/2024 at 6:30 AM and 11:30 AM (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/6/2024 at 6:30 AM 4/8/2024 at 9 PM 4/9/2024 at 6:30 AM and 11:30 AM c. During a review of Resident 6's Admission Record, dated 4/23/2024, the Admission Record indicated Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE], diagnoses included Type 2 Diabetes Mellitus and Long-Term (Current) Use of Insulin. A review of Resident 6's Admission Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 3/16/2024, indicated Resident 6 had moderate cognitive (mental ability to make decisions of daily living) impairment. During a review of Resident 6's Physician Order indicated an order for Insulin Lispro Injection Solution 100 UNIT/ML Inject as per sliding scale: if 150 - 199 = 1 unit; 200 - 249 = 3 units; 250 - 299 = 5 units; 300 - 349 = 7 units; 350 - 399 = 9 units for BS >400mg/dl notify MD., subcutaneously three times a day for DM before meals, order date 3/6/2024. During a concurrent interview, and record review on 4/23/2024 at 11:27 AM with Director of Nursing (DON) and LVN 1, Resident 6 ' s MAR was reviewed. DON stated Resident 6 ' s Insulin Lispro had an open date of 3/8/2024 and should not have been administered to the resident after 4/5/2024. DON stated the licensed nurses cannot continue to administer insulin beyond 28 days from the open date. DON stated administering expired insulin to residents increase the risk for side effects such as uncontrolled blood glucose (a type of sugar), acidosis (when blood glucose levels remain dangerously high), hospitalization , coma, and death. DON stated the facility ' s practice is to discard insulin 28 days after opened. During a review of Resident 6 ' s MAR dated 3/23/2024 to 4/9/2024, the MAR indicated Resident 6 was administered 6 doses of expired Insulin Lispro on: 4/8/2024 at 6:30 AM 4/10/2024 at 4:30 PM 4/11/2024 at 11:30 AM 4/12/2024 at 11:30 AM 4.18/2024 at 11:30 AM 4/22/2024 at 11:30 AM d. During a review of Resident 5's Admission Record, dated 4/23/2024, the Admission Record indicated Resident 5 was admitted to the facility on [DATE], diagnoses included Type 2 Diabetes Mellitus. During a review of Resident 5's H&P, dated 4/7/2024, Resident ' s H&P indicated the resident had the capacity to understand and make decisions. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 5's Order Summary Report indicated an order for Insulin Glargine subcutaneous Solution 100 UNIT/ML (Insulin Glargine) Inject 25 unit subcutaneously at bedtime for DM Type 2, order date 3/5/2024. During a concurrent interview, and record review on 4/23/2024 at 11:35 AM with Director of Nursing (DON) and LVN 1, Resident 5 ' s MAR was reviewed. DON stated Resident 5 ' s Insulin Glargine had an open date of 3/6/2024 and should not have been administered to the resident after 4/3/2024. DON stated Resident 5 was administered 14 doses of expired Insulin Glargine between 4/8/2024 to 4/23/2024. During an interview on 4/23/2024 at 3:08 PM with the DON, DON stated insulin expiration date was shorten once opened. DON read the facility ' s policy titled, Medication Storage in Facility. A review of the facility ' s Policy and Procedure P&P) titled, Medication Storage in the Facility, dated 1/2022, the P&P indicated, All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining . Nursing staff should consult with the dispensing pharmacist for any questions related to medication expiration dates .When the original seal of a manufacturer ' s container or vial is initially broken, the container or vial will be dated. The nurse shall place a ' date opened ' sticker on the medication and enter the date opened and the new date of expiration (NOTE: the best stickers to affix contain both a ' date opened ' and ' expiration ' notation line .(See Appendix 28 - Medications With Shortened Expiration Dates). A review of the facility ' s undated Appendix 28 titled, Abridged List of Medications with Shortened Expiration Dates, indicated, Once certain products are opened and in use, they must be used within a specific timeframe to avoid reduced stability, sterility and potentially reduced efficacy .A drug product ' s Beyond Use Date (BUD) is the manufacturer supplied expiration date OR the shortened date after opening (See BUD Notes below), whichever comes first. Beyond Use Date (BUD) Notes after accessing Insulin for First Use indicated for Insulin Aspart (Novolog), Insulin Lispro (Admelog and Humalog), Insulin Glargine (Lantus and Basaglar) expired in 28 days.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333 Based on observation, interview, and record review, the facility failed to ensure expired and discontinued medications were discarded and disposed of properly according to the facility's policy and procedure. 1. The facility failed to ensure expired insulin (a medication used to treat high blood sugar) was removed and discarded for 10 out of 12 residents (Residents 1, 5, 6, 7, 8, 9, 11, 12, 13, and 14) medications reviewed in two of two inspected medication carts (Station 2 Medication Cart 2 and Station 1 Medication Cart 1). (Cross Reference F760) 2.The facility failed to ensure medication remaining at the facility after one of one resident (Resident 10) was discharged from the facility was removed from active supply, marked discontinued and securely stored until destroyed in accordance with the facility ' s Policy and Procedure (P&P) titled, Discontinued Medications, dated 1/2022. 3. The facility failed to ensure a medication, Eliquis (a blood thinner) prescribed for Resident 15 was disposed of with a witness and disposal documented in accordance with the facility ' s P&P titled, Medication Destruction for Non-Controlled Medications, dated 1/2022. These failures increased the risk that Residents 1, 5, 6, 7, 8, 9, 11, 12, 13, and 14 could have received medication that had become ineffective or toxic due to improper storage or labeling, which had the potential to lead to health complications related to Diabetes (a group of disease that result in too much sugar in the blood), hospitalization or death. For Resident 10 and Resident 15, the facility failed to ensure discontinued medications were removed from active supply and securely stored until disposal to prevent the potential for inadvertent (accidental) administration to residents, misuse, and medication errors. Findings: 1 a. During a concurrent interview and medication cart inspection on 4/23/2024 at 10:00 AM with a Licensed Vocational Nurse (LVN) 3, LVN 3 stated insulin has an expiration date of 28 days once opened per facility and pharmacy policy. LVN 3 opened Medication Cart 3 located on Station 2 and the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications. a. One vial of Insulin Lispro (Brand names, Admelog and Humalog) labeled for Resident 1 was opened with no open date. b. One vial of Insulin Lispro labeled for Resident 12 with an open date of 3/19/2024, was available for use after 28 days from the opened date. Resident 12 ' s Insulin Lispro expired on 4/17/2024. c. One vial of Insulin Lispro labeled for Resident 13 was opened with no open date (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to manufacturer's labeling, Insulin Lispro (Brand Names: Admelog and Humalog), After opening, store at room temperature. Throw away any part not used after 28 days. d. Three vials of Insulin Glargine (Brand names, Lantus and Basaglar) each labeled for Resident 11 was observed stored in the medication cart undated, one of three vials of Lantus was opened with no open date, and two of three vials were undated and unopened stored unrefrigerated inside of the medication cart. According to manufacturer ' s labeling Store unused Lantus vials in the refrigerator between 36 degrees ( ) Fahrenheit (F, a scale for measuring temperature) to 46 F (2 Celsius [C, a scale for measuring temperature] to 8 C). Store in-use (opened) Lantus vials in a refrigerator or at room temperature below 86 F (30 C) .The Lantus vials you are using should be thrown away after 28 days, even if it still has insulin left in it. e. One Basaglar (Insulin Glargine) KwikPen (prefilled insulin glargine pen) labeled for Resident 14 with an open date of 2/25/2024, was available for use after 28 days from the opened date. Resident 14 ' s Basaglar KwikPen expired on 3/25/2024. According to manufacturer ' s labeling, Unopened Basaglar KwikPens should be stored in the refrigerator. Opened KwikPens should be stored at room temperature for up to 28 days. Once in use, do not return the Basaglar KwikPen to the refrigerator. Do not use the Basaglar KwikPen after the expiration date. During an interview on 4/23/2024 between 10:13 AM with LVN 3 on Nursing Station 2 at Medication Cart 3, LVN 3 stated Resident 14 ' s Basaglar insulin had an open date of 2/25/2024 was expired. LVN 3 stated two vials of Lantus was delivered on 4/22/2024 for Resident 11 and they should have been stored in the refrigerator until opened. LVN 3 read the blue sticker attached to Resident 11 prescription bottles for Lantus that indicated, Refrigerate Until Opened. LVN 3 stated four vials and two insulin pens containing insulin were stored in Medication Cart 3 on Nursing Station 2 which were open and did not have open dates or was expired for five different residents. LVN 3 identified the residents which included Resident 1, Resident 11, Resident 12, Resident 13, and Resident 14. LVN 3 stated expired insulin medication if administered to the residents would not be effective in controlling residents ' blood sugar levels. 1b. During a concurrent interview and medication cart inspection on 4/23/2024 at 10:33 AM with LVN 1, Medication Cart 1 located on Station 1 was inspected and the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications. a. One vial of Insulin Aspart (Brand name Novolog) labeled for Resident 7 with an open date of 3/8/2024, was available for use after 28 days from the opened date. LVN 1 stated Resident 7 ' s insulin with an open date of 3/8/2024 expired and should not be administered to the resident after 4/5/2024. According to manufacturer ' s labeling indicated, Storage after use, keep at room temperature (below 86 F) or refrigerated for up to 28 days .Dispose after 28 days, even if there is insulin left in the pen or vial. (continued on next page)

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	056317	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenoaks Convalescent Hospital	409 W. Glenoaks Blvd. Glendale, CA 91202

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. One vial of Humalog (Generic name, Insulin Lispro) labeled for Resident 8 with an open date of 2/23/2024, was available for use after 28 days from the opened date. According to manufacturer ' s labeling, once opened / in-use or once stored at room temperature, Humalog insulin must be used within 28 days or be discarded. Resident 8 ' s Humalog expired on 3/23/2024. c. One vial of Insulin Lispro labeled for Resident 9 with an open date of 2/23/2024, was available for use after 28 days from the opened date. Resident 9 ' s Insulin Lispro became expired on 3/23/2024. d. Two vials of Lantus insulin labeled for Resident 9 were rubber banded together, one vial had an open date of 3/7/2024 and the second vial had an open date of 4/10/2024. LVN 1 stated the two vials of Lantus labeled for Resident 9 should not have been together because you cannot use the expired medication. LVN 1 stated there is a risked that Resident 9 may be administered the expired insulin. e. One Insulin Glargine Pen labeled for Resident 5 with an open date of 3/6/2024 was written on a yellow sticker attached to insulin pen and written on the prescription label along with another date handwritten on the body of the pen indicated a different open date of 4/1/2024. LVN 1 stated there should not be two different open dates written on insulin for residents, which is confusing, and the nurses would not know which date is correct. LVN 1 stated based on the older open date the licensed nurses should not administer the insulin to Resident 5 because it has been opened for longer than 28 days. f. One Insulin Lispro Pen labeled for Resident 6 with an open date of 3/8/2024 was available for use after 28 days from the opened date. Resident 6 ' s Insulin Lispro became expired on 4/6/2024. During an interview on 4/23/2024, at 11:16 AM, with the Director of Nursing (DON), the DON stated if an expired vial of Lantus insulin was stored together with an unexpired vial of Lantus insulin in the medication cart for Resident 9 there was a high likelihood that the resident could be administered the expired insulin.The DON stated having two different dates on an insulin vial or pen as observed for Resident 7 and Resident 8 were inconsistent and misleading, and no one would know when the medication was originally opened.The DON stated the potency of the insulin could be affected and the residents would not receive the desired effect intended to control the residents blood glucose (a type of sugar) level. The DON stated the facility ' s policy was to discard opened insulin after 28 days. The DON stated licensed nurses should not continue to administer insulin that was beyond 28 days from the date opened that would increase risk to the resident that can include diabetic acidosis (when blood glucose levels remain dangerously high), hospitalization , coma, and death. During a review of the facility ' s P&P titled, Storage of Medication, dated 02/2022, the P&P indicated, All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining . Nursing staff should consult with the dispensing pharmacist for any questions related to medication expiration dates .When the original seal of a manufacturer ' s container or vial is initially broken, the container or vial will be dated. The nurse shall place a ' date opened ' sticker on the medication and enter the date opened and the new date of expiration (NOTE: the best stickers to affix contain both a ' date opened ' and ' expiration ' notation line .(See Appendix 28 - Medications With Shortened Expiration Dates). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility ' s undated Appendix 28 titled, Abridged List of Medications with Shortened Expiration Dates, indicated, Once certain products are opened and in use, they must be used within a specific timeframe to avoid reduced stability, sterility and potentially reduced efficacy .A drug product ' s Beyond Use Date (BUD) is the manufacturer supplied expiration date OR the shortened date after opening (See BUD Notes below), whichever comes first. Beyond Use Date (BUD) Notes after accessing Insulin for First Use indicated for Insulin Aspart (Novolog), Insulin Lispro (Admelog and Humalog), Insulin Glargine (Lantus and Basaglar) expired in 28 days. 2. During a review of Resident 10's Admission Record, (a document containing demographic and diagnostic information), dated 4/23/2024, the admission record indicated that the resident was admitted on [DATE], diagnoses included, Type 2 Diabetes Mellitus (a medical condition characterized by the inability to control blood sugar), Hyperlipidemia (high cholesterol), and Epilepsy (a condition that affects the brain and causes frequent seizures [a sudden, uncontrolled burst of electrical activity in the brain]). During a review of the facility ' s form titled, Notice of Proposed Discharge/Transfer, indicated Resident 10 was transferred out of the facility to a General Acute Care Hospital (GACH) on 4/14/2024. A box was checked on the form which indicated, Reason for Discharge/Transfer: The discharge is necessary for the resident ' s welfare and the resident ' s needs cannot be met in this facility. During a concurrent observation and interview on 4/23/2024 at 11:47 AM, with LVN 1 and DON, Medication Cart 1 located at Station 1 was inspected, inside of Medication Cart 1 was multiple bubble packs (a specific type of packaging used primarily for unit-dose packaging of medications) of medications labeled for Resident 10 mixed in with current residents ' medications. LVN 1 stated Resident 10 was transferred to the hospital on 4/14/2024 and was discharged from the facility on 4/21/2024. DON stated Resident 10 ' s medications should not still be in Medication Cart 1 on Station 1. DON stated medications should be removed immediately from the medication cart once a resident is transferred out of the facility and placed in a designated location in the medication storage room. Prescription medications labeled for Resident 10 observed remaining inside of Medication Cart 1 located on Station 1, after resident ' s transfer and discharge from the facility included the following medications: a. Divalproex (used to treat certain types of seizures [epilepsy]) b. Levetiracetam (used to treat seizures [epilepsy]) c. Benztropine (used for movement problems that are side effects from other medications) d. Tamsulosin (used to treat men who have symptoms of an enlarged prostate gland [a gland in the male reproductive system]) e. Vitamin D (treat Vitamin D deficiency) f. Fenofibrate (treat high cholesterol) g. Folic Acid (helps the body make healthy red blood cells) h. Famotidine (used to prevent and treat heartburn due to acid indigestion) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. Levothyroxine (a hormone needed to regulate the body ' s functions) j. Risperdal (an antipsychotic medication used to treat mental illness) During a review of the facility's P&P titled, Discontinued Medications, dated 01/2022, the P&P indicated, Medications are removed from the medication cart or active supply immediately upon receipt of an order to discontinue (to avoid inadvertent administration). Medications awaiting disposal or return are stored in a locked secure area designated for that purpose until destroyed or picked up by pharmacy. 3. During a review of Resident 15's Admission Record, dated 4/23/2024, the admission record indicated that the resident was admitted on [DATE] and readmitted on [DATE], diagnoses included, Sepsis (the body's most extreme response to an infection), and Cellulitis (potentially serious bacterial skin infection) of Right Lower Limb. During a review of Resident 15's History and Physical, dated 1/5/2024, the document indicated resident has the capacity to understand and make decisions. During a review of Resident 15 ' s Order Summary Report, dated 4/19/2024, included an order for Apixaban (Eliquis) 5 milligram (mg, a unit of measurement of mass), dated 4/18/2024, instructions indicated to administer one tablet by mouth two times a day for Atrial Fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). During a review of Resident 15 ' s Telephone orders, dated 4/18/2024, indicated a new order for Eliquis 5 mg by mouth two times a day, along with an order to discontinue the resident ' s previous order for Eliquis 2.5 mg, one tablet by mouth two times a day, initially started on 3/24/2024. During a concurrent medication pass observation and interview on 4/23/2024 at 8:57 AM, with LVN 3 at Medication Cart 2 on Station 2, LVN 3 was observed preparing medications for Resident 15. LVN 3 pulled out a bubble pack of medication prescribed for Resident 15 that was labeled to contained Eliquis 2.5 mg. LVN 3 stated the Eliquis 2.5 mg tablets was not the correct dosage for Resident 15. LVN 3 pulled out a second bubble pack prescribed for Resident 15 that was labeled to contain Eliquis 5 mg and removed one dose of the Eliquis 5 mg tablet and placed the tablet into a medication cup. LVN 3 stated she would discard the Eliquis 2.5 mg tablets. LVN 3 popped out five tablets of Eliquis 2.5 mg and threw them away in a container located in the bottom drawer of Medication Cart 2. LVN 3 stated Resident 15 ' s Eliquis 2.5 mg tablets was discontinued on 4/18/24. During an interview on 4/23/24 at 9:18 AM with LVN 3, LVN 3 stated to discard medications there were two options: a. Take the medication to the medication room and discard or place the discontinued medication in the medication room or, b. Take the bubble pack, pop out the medications into a medication cup and dispose of the medications in the biohazard container located in the bottle of the medication cart. LVN 3 stated she did not have to document the disposal of non-controlled medications. LVN 3 stated controlled medications must be taken to the DON. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/2024 at 11:59 AM with the DON, the DON stated, all medication destruction must be documented with a record of the medication destruction. The DON stated discarded medication must be; witnessed by a second nurse; placed in a designated container inside of the medication room that gets picked up by a contracted medication disposal company; and a destruction record must be kept. During a review of the facility's P&P titled, Medication Destruction for Non-Controlled Medications, dated 01/2022, the P&P indicated, Medication destruction occurs only in the presence of at least two licensed healthcare professionals or accordance to regulation and applicable law. The licensed healthcare professionals witnessing the destruction ensure that the following information is entered on the medication disposition form: 1) Date of destruction 2) Resident ' s name 3) Name and strength of medication 4) Prescription number, if applicable 5) Amount of medication destroyed 6) Signatures of witnesses