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	05/17/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview and record review the facility failed to develop and implement a resident specific comprehensive care plan to (a document that outlines the facility ' s plan to provide personalized care to a resident based on the resident ' s needs) for one of two sampled residents (Resident 1) by failing to: 1. Address appropriate interventions to prevent major injury during recurrent seizure activity (a sudden, uncontrolled burst of electrical activity in the brain that causes uncontrolled movement and loss of consciousness) to one of two sampled residents (Resident 1). 2. Address appropriate interventions for dementia (a progressive brain disorder that result in memory loss and impairs the thought process). 3. Address appropriate interventions for Resident 1 ' s noncompliance with care and instructions. As a result of these failures Resident fell during seizure activity and resulted in major laceration and bleeding on the head. Findings: A review of Resident 1 ' s GACH 1 record titled History and Physical, dated 1/24/24 timed at 9:25 a.m. and GACH 1 Progress Notes, dated 2/14/24 timed at 12:35 p.m. indicated Resident 1 had a history of head injury (due to an assault), cardiac arrest (a condition when the heart stops beating suddenly), and seizure which can cause changes in behavior, movements, feelings and levels of consciousness). A review of Resident 1 ' s Admission Record indicated Resident 1 was admitted to the facility from GACH 1 on 3/2/24 and readmitted on [DATE] with diagnosis that included Parkinson ' s disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), anoxic brain damage (caused by a complete lack of oxygen to the brain, with symptoms that included problems with thinking and focus, seizures, muscle wasting (a weakening, and loss of muscle caused by disease or lack of use) and atrophy (progressive decline of a body part), difficulty walking, and injury of the head. (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

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 05/17/2024

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 3/17/24, the MDS indicated, Resident 1 ' s cognitive skills for daily decision making was severe impairment (difficulty with or unable to make decisions, learn, remember things). The MDS indicated Resident 1 needed moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limb, but provides les than half the effort) to transfer to and from a bed to a chair/wheelchair, and walk at least ten (10) feet in a room, corridor or similar space. The MDS indicated due to medical conditions or safety concerns, walking 50 feet with two turns had not been attempted for Resident 1. A review of Resident 1 ' s Initial History and Physical (H&P), dated 3/7/24 indicated Resident 1 had dementia. A review of Resident 1 ' s GACH 2 ' s Physician H&P, dated 3/8/24 indicated Resident 1 had Parkinson ' s disease and dementia. During an interview on 5/17/24 at 11 a.m. with Certified Nurse Assistant (CNA) 1, CNA 1 stated, Resident 1 was known to be confused, forgetful at times. CNA 1 stated, Resident 1 tend to get up in bed or chair when the staff looks away and he would not listen to the nurses ' recommendations to call for help and wait for the nurses come before getting up by himself. During an interview on 5/17/24 at 11:40 a.m. with CNA 2, CNA 2 stated, Resident 1 was very unpredictable, forgetful, confused and not compliant with nurse ' s recommendation to call for help before getting up on his own. During an interview on 5/17/24 at 12:15 p.m. with Registered Nurse (RN) 1, RN 1 stated Resident 1 was known for forgetfulness and never listened to the nurse ' s reminder to call for help before getting up. RN 1 stated, a plan of care was not developed for Resident 1 who was noncompliant with not getting out of bed or chair without calling for assistance, and there was no care plan developed since resident was admitted to the facility that specifically indicated interventions to prevent major injury during seizure activity. RN 1 stated Resident 1 had a history of seizures prior to admission to the facility, so a care plan should have been a care plan initiated upon admission for Resident 1 with history of seizure activity. During an interview on 5/17/24 at 12:47 p.m. with LVN 1, LVN 1 stated Resident 1 was restless, non-compliant when nurses asked him to call before getting up. LVN 1 stated, Resident 1 was known to get up from bed or chair and try to walk on his won when no one was watching him. LVN 1 stated, she did not know if the physician was made aware of Resident 1 ' s noncompliance. On 5/17/24 at 2:45 p.m., during a concurrent record review of Resident 1 ' s Nursing Admission Assessment, dated 3/2/24 timed at 8:29 p.m., and interview with the Infection Prevention Nurse (IPN), indicated Resident 1 ' s diagnoses included seizure. The IPN stated, if the resident was admitted with history of seizure, a care plan for seizure monitoring and intervention should be initiated. The IPN stated, he could not find documented evidence that a care plan was developed to address seizure precautions for Resident 1 since facility admission on 3/2/24. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview on 5/17/24 at 3 p.m., Resident 1 ' s GACH 1 record titled History and Physical, dated 1/24/24 timed at 9:25 a.m. and GACH 1 Progress Notes, dated 2/14/24 timed at 12:35 p.m. were reviewed with the IPN. The IPN stated Resident 1 was originally admitted from GACH 1 on 3/2/24. During a concurrent record review and interview on 5/17/24 at 3:15 p.m., Resident 1 ' s History and Physical (H&P) dated 3/7/24 and Resident 1 ' s GACH 2 ' s Physician H&P dated 3/8/24 timed at 7:50 a.m. were reviewed with the IPN. The IPN stated, Resident 1 was sent to GACH 2 after he had a fall on 3/7/24. The IPN stated, the records indicated that Resident 1 had history of dementia or Parkinson ' s disease dementia. The IPN stated, dementia should be listed in Resident 1 ' s admission record and a care plan should had been developed to address dementia should be initiated on 3/8/24. The IPN stated, he could not find any care plan for dementia. During a concurrent record review and interview on 5/17/24 at 4:20 p.m. with the IPN, Resident 1 ' s Care Plan since 3/2/24 was reviewed. The IPN stated, if a resident had non-compliant behaviors with recommendations, it should have been addressed in the care plan. The IPN stated, he could not find any care plan that addressed Resident 1 ' s non-compliant behaviors. During an interview on 5/17/24 at 5:05 p.m. with CNA 3, CNA 3 stated Resident 1 was known for trying to get up from bed or chair by himself if no staff was available to watch him and had history of several falls. During a concurrent interview and record review on 5/17/24 at 5:20 p.m., Resident 1 ' s care plans since 3/2/24 was reviewed with the DON. The DON stated, if the resident was identified as non-compliant, trying to get out of bed, high risk for falls, the behaviors should be addressed in the care plan. The DON stated, in Resident 1 ' s records, there were no care plan that indicated specific behaviors from Resident 1 had that could increase the resident ' s risk for falls. The DON stated it was very important to address Resident 1 ' s non-compliant behavior so that all care providers could be aware and know how to take care of the resident. During a concurrent record review and interview on 5/17/24 at 5:40 p.m., Resident 1 ' s Nursing Admission Assessment, dated 3/2/24 timed at 8:29 p.m. and Order Summary Report dated 3/2/24 were reviewed, the DON stated Resident 1 had history of seizure and the physician ordered Resident 1 to receive Levetiracetam (a type of drug that is used to control/prevent seizures or convulsions) 1000 mg (unit of weight) by mouth two times a day for anticonvulsant (prevent seizure). The DON stated, if a resident had history of seizure and was taking any anticonvulsant medication, he would expect to have a care plan developed and seizure precautions added in the care plan interventions when the resident was admitted to the facility which included padded side rails up, seizure monitoring and floor mats. The DON stated, seizure precautions, monitoring order, and care plan were put in place on 5/9/24, after Resident 1 had a fall incident with seizure activity on 5/2/24, 61 days from facility admission on 3/2/24. During a concurrent record review and interview on 5/17/24 at 6 p.m., Resident 1 ' s H&P dated 3/7/24 and Resident 1 ' s GACH 2 ' s Physician H&P dated 3/8/24 at 7:50 a.m. were reviewed with the DON. Resident 1 had dementia and a care plan should be initiated to make sure all care providers know how to take care the resident. The DON stated, he could not find any dementia care plan for Resident 1. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility ' s Care Planning, revised 10/24/22, indicated the following information: -Ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs. -The Facility will develop a person-centered Baseline Care plan for each resident within 48 hours od admission. The Care Plan will include at least the following information: initial goals based on admission orders; Physician orders. -The Baseline Care Plan will be updated to reflect changes in the resident ' s condition or needs occurring prior to the development of the Comprehensive Care Plan. -Each resident ' s Comprehensive Care Plan will describe the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental and psychosocial well-being

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on interview and record review, the facility failed to prevent one of two sampled residents (Resident 1), who was a high risk for falls, history of seizures [a sudden, uncontrolled burst of electrical activity in the brain], which can cause changes in behavior, movements, feelings and levels of consciousness), and needed two persons, moderate assistance for transferring, from falling and sustaining injuries by failing to: 1. Develop a care plan and place Resident 1 on seizure monitoring and seizure precautions, upon admission to the facility on [DATE], that included the use of seizure pads and floor mats as indicated in the facility's policy and procedures titled Seizure Precautions and Fall Management Program, and bilateral side rails up, in accordance with the physician's order on 3/2/24. 2. Conduct an IDT-Falls Committee meeting within 72 hours when Resident 1 had a fall and sustained physical injuries from the fall and update the resident's care plan interventions, on 3/7/24 and 3/18/24, to prevent further falls that can result to an injury, in accordance with the facility's policy and procedure titled Fall Management Program. Resident 1 sustained a laceration (skin wound) on the left eyebrow after the fall on 3/7/24 and a small skin tear to the right lateral top side of the pinky finger (little finger) after the fall on 3/18/24. As a result, on 5/2/24, Resident 1 was found on the floor bleeding from the head with seizure activity and foaming of the mouth, as witnessed by Certified Nurse Assistant (CNA) 1 for three to five seconds. Resident 1 was transferred to the general acute care hospital (GACH 3) via 911 emergency services for head injury evaluation and surgical incisions to the head. In GACH 3, Resident 1's trauma to the posterior (located behind or toward the back) scalp required laceration repair by skin staples (a surgical procedure to close an open wound) on the scalp that measured 5 centimeters (cm- unit of measurement) long. Findings: A review of Resident 1's GACH 1 records, titled History and Physical (H&P), dated 1/24/24 timed at 9:25 a.m. , and GACH 1 Progress Notes, dated 2/14/24 timed at 12:35 p.m., indicated Resident 1 had a history of head injury (due to an assault), cardiac arrest (a condition when the heart stops beating suddenly), and seizure. A review of Resident 1's facility record titled, Admission Record indicated Resident 1 was admitted to the facility from GACH 1 on 3/2/24 and readmitted on [DATE] with diagnosis that included Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), anoxic brain damage (caused by a complete lack of oxygen to the brain, with symptoms that included problems with thinking and focus, seizures, muscle wasting (a weakening, and loss of muscle caused by disease or lack of use) and atrophy (progressive decline of a body part), difficulty walking, and injury of the head. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's facility records, titled Order Summary Report, for March 2024, indicated a physician order dated 3/2/24, that indicated the resident may have bilateral side rails up as enabler to assist with bed mobility, transfers, and repositioning. A review of Resident 1's record titled, Fall Risk Assessment, dated 3/3/24 timed at 9:09 a.m., indicated Resident 1 was at high risk for falling due to impaired gait (difficulty rising from chair, uses chair arms to get up, bounces to rise; keeps head down when walking, watches the ground; grasps furniture, person, or aid when ambulating; cannot walk unassisted). A review of Resident 1's facility Care plan, dated 3/3/24 indicated, Resident 1 was at risk for falls and/or injuries related to balance deficit, cognitive impairment (a condition when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life), and history of falls. The care plan interventions indicated to attach call light within reach and encourage resident to use it, developing an activity program to refocus resident, educate/remind resident to ask for assistance, frequent visual checks, keep bed in low position, keep resident up in wheelchair in a supervised area, and postural devices as needed. A review of Resident 1's facility Care plan, dated 3/7/24 and revised on 3/8/24 indicated, Resident 1 had an actual fall with left eyebrow laceration with poor balance and unsteady gait. The care plan interventions included to continue interventions on the At risk plan, to determine and address the causative factors of the fall, neuro-checks, and physical therapy consult. A review of Resident 1's Progress Notes New, dated 3/7/24 timed at 2:26 p.m. indicated Resident 1 had an unwitnessed fall around 8:40 a.m. when the resident was found on the floor in the Activity Room, which resulted in laceration on left eyebrow and a transfer to GACH 2. A review of Resident 1's Order Summary Report, for the month of March, 2024 indicated, Resident 1 had a physician order on 3/7/24 to be transferred to GACH 2 via ambulance for further evaluation and treatment. A review of Resident 1's GACH 2 records titled Physician H&P, dated 3/8/24 at 7:50 a.m. indicated Resident 1 was referred to urgent care for evaluation from the facility for evaluation of a head injury that he sustained when he had unwitnessed fall on 3/7/24 and was admitted to GACH 2 for syncope (fainting or passing out), laceration from fall, and bradycardia (abnormal low heart rate). The GACH 2 Physician H&P indicated Resident 1 was bleeding from the left eyebrow. The GACH 2 Physician H&P indicated [Resident 1] had a history of unstable gait that could have led to the fall, but it is possible the patient (Resident 1) may have had a syncopal episode (fainting or passing out). A review of Resident 1's facility record, titled Progress Notes New, dated 3/13/24 timed at 6:54 p.m., indicated the resident was readmitted back from the facility in stable condition. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's facility record indicated the Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 3/17/24, the MDS indicated, Resident 1's cognitive skills for daily decision making was severe impairment (difficulty with or unable to make decisions, learn, remember things). The MDS indicated Resident 1 needed moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limb, but provides less than half the effort) to transfer to and from a bed to a chair/wheelchair, and walk at least ten (10) feet in a room, corridor, or similar space. The MDS indicated due to medical conditions or safety concerns, walking 50 feet with two turns had not been attempted for Resident 1. The MDS under Fall History, indicated Resident 1 had an episode of fall within the last month of the MDS assessment date of 3/17/24. A review of Resident 1's facility records, titled Progress Notes New, dated 3/18/24 at 3:20 p.m. indicated Resident 1 had another unwitnessed fall when the resident was found lying on the right side on 3/18/24 timed at 2:40 p.m. The Progress Note indicated Resident 1's fall on 3/18/24 resulted in a small skin tear noted to the right lateral top side of the pinky finger. A review of Resident 1's facility record indicated a Physician Order, dated 5/2/24 at 5:06 p.m. indicated Resident 1 had an order to be transferred out via 911 emergency services to GACH 3 related to status post (an event that a person experienced previously) unwitnessed fall with seizure activity. A review of Resident 1's facility records, titled Progress Notes New, dated 5/2/24 timed at 5:12 p.m. indicated Resident 1 had an unwitnessed fall at 4:50 p.m. when he was found on the floor bleeding from the head with seizure activity noted from three to five seconds. The Progress Note indicated Resident 1 was transferred to GACH 3 via 911 emergency services on 5/2/24. A review of Resident 1's GACH 3 Emergency Department (ED) Notes dated 5/2/24 timed at 7:20 p.m., indicated the resident was resting in bed . with eyes open. The ED Note indicated Resident 1 was Unable to recall what happened, where he lives but knows he's in the hospital . Patient complains of left hip/leg knee pain, appears uncomfortable. Moving back in fourth in bed [sic] . Patient requires frequent redirection to lay still but forgets and rolls around in bed . A review of Resident 1's GACH 3 records, titled Trauma Surgery History and Physical, dated 5/2/24 at 6:56 p. m. indicated Resident 1 arrived at the GACH 1 ED, status post witnessed seizure and fall. The GACH 3 record indicated, The patient (Resident 1) was found on the ground in a convalescent home following an unwitnessed event that was described as seizure-like. The event lasted for approximately 3-5 seconds and involved the patient foaming at the mouth. The patient was reportedly altered during the entirety of the event. Patient reportedly recently had a cardiac arrest. Staples applied to posterior scalp laceration . A review of Resident 1's GACH 3 records, titled Laceration Repair Procedure Note, dated 5/2/24 timed at 7:06 p.m. indicated, Resident 1 was admitted for trauma to the posterior scalp, which required laceration repair by skin staples on the scalp measuring 5 cm long. A review of Resident 1's GACH 3 records, titled Computed Tomography [CT] (uses a computer linked to an x-ray machine to make a series of detailed pictures of areas inside the body) Brain without contrast, dated 5/2/24 indicated critical finding of Small focus of acute posttraumatic subarachnoid hemorrhage (bleeding in the brain) in the left medial frontal region (area just behind the forehead). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's GACH 3 records, titled Neurology Consult Note, dated 5/3/24 at 10:16 a.m. indicated Patient had a scalp laceration for which he received staples. A review of Resident 1's facility records, titled Progress Notes New, dated 5/8/24 timed at 7:57 p.m., indicated the resident was readmitted back to the facility from GACH 3 with diagnosis of head injury. A review of Resident 1's facility records, titled Skin Observation Checks, dated 5/9/24 indicated Resident 1 had surgical incision with four (4) staples in the back of the head, which measured at 4 x 0.1 centimeters (a unit of length). During an interview on 5/17/24 at 11 a.m. with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 1 was known in the facility to be high risk for falls due to forgetfulness and confusion. CNA 1 stated, on 5/2/24, at around 4 p.m., CNA 1 helped Resident 1 back to bed after sitting on the wheelchair located on the right side of his bed. CNA 1 stated, after putting Resident 1 to bed, while helping CNA 2 with another resident in a different room, CNA 1 heard a sound that indicated somebody had fallen. CNA 1 stated they found Resident 1 on the floor on the right side of his bed, with the resident's head bleeding. CNA 1 stated, that on 5/2/24, CNA 1 observed that there was no floor mat on the right side of Resident 1's bed and the side rails for both sides were down and she did not know why. When asked if CNA 1 had put the bed siderails up for Resident 1 on 5/2/24 at around 4 p.m., CNA 1 stated, she could not recall if she put the side rails up after putting Resident 1 back to bed. CNA 1 stated Resident 1 was not strong enough to put the bed side rails down by himself if the side rails were up. CNA 1 stated, she believed that Resident 1 was trying to go to the bathroom, which was located toward the right side of the bed because going to the bathroom was what Resident 1 frequently requested. CNA 1 stated that Resident 1's stronger side was on the right side where he usually gets up from the bed. CNA 1 stated Resident 1 had a fall a few times in the facility before and needed assistance with walking because his walk was not steady. During an interview on 5/17/24 at 11:40 a.m. with CNA 2, CNA 2 stated she was the first one that saw Resident 1 on the floor, on 5/2/24 at around 4:45 to 4:50 p.m. CNA 2 stated, Resident 1 was in bed when she asked CNA 1 for help in another room around 4:30 p.m. CNA 2 stated, while CNA 1 was helping CNA 2 with one of her assigned residents, they heard a boom sound so CNA 2 went to check each resident's rooms until she went to Resident 1's room and found him lying face up on the floor bleeding from his head. CNA 2 stated the area that they (CNA 1 and 2) were assigned had a lot of residents that were high risk for falls. CNA 2 stated, Resident 1 should be on one-to-one monitoring because Resident 1 was very unpredictable, forgetful, confused and not compliant with nurse's recommendation to call for help before getting up on his own. During an interview on 5/17/24 at 12:15 p.m. with Registered Nurse (RN) 1, RN 1 stated on 5/2/24 in the afternoon, she heard a commotion and went to Resident 1's room. RN 1 stated she saw Resident 1 on the floor with a lot of blood, and there was no floor mat on the right side where Resident 1 was lying. RN 1 stated, Resident 1 was a high fall risk because of his unsteady balance. RN 1 stated, Resident 1 was known for forgetfulness and never listened to the nurse's reminder to call for help before getting up. RN 1 stated, there should be a non-compliance care plan for Resident 1 because he had fallen in the facility before. RN 1 stated Resident 1 had a history of seizures so there should also be seizure care plan initiated upon admission for Resident 1. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/17/24 at 12:47 p.m. with LVN 1, LVN 1 stated she was called by CNA 1 and CNA 2 on 5/2/24 and asked for help. LVN 1 stated, when she came, Resident 1 was lying on the floor on the right side of the bed facing up. LVN 1 stated, there was one floor mat that was placed on the left side of Resident 1's bed but Resident 1 fell on the right side of the bed where there was no floor mat. LVN 1 stated, blood was everywhere, and Resident 1 was Shaking really bad for three to five seconds. LVN 1 stated, Resident 1 did not have any bed side rails up and was not on one-to-one monitoring. LVN 1 stated, Resident 1 had history of falls in the facility prior to the fall on 5/2/24 and was restless, non-compliant when nurses asked him to call before getting up. LVN 1 stated, she did not know if the physician was made aware of Resident 1's noncompliance. During an interview on 5/17/24 at 1:06 p.m. with the Director of Nurses (DON), the DON stated, on 5/2/24 at around 5 p.m., he responded to a call for assistance in Resident 1's room. The DON stated, Resident 1 was lying on the floor and his head was bleeding. The DON stated, Resident 1 was having seizures and foaming from his mouth for about three to five seconds. The DON stated, there was no floor mat on the side that Resident 1 fell in, and the side rails were not up. The DON stated, he did not know for sure if the seizure triggered Resident 1's fall or his noncompliant behavior triggered the fall. The DON stated, for fall risk residents, interventions should be initiated that included frequent monitoring, and use of the floor mats. On 5/17/24 at 2:45 p.m., during a concurrent record review of Resident 1's Nursing Admission Assessment, dated 3/2/24 timed at 8:29 p.m., and interview with the Infection Prevention Nurse (IPN), Resident 1's diagnoses included localization related idiopathic epilepsy [partial seizures that originate from a localized region of the brain that process and register incoming sensory information (data received through our senses such as sight, smell, touch, taste, and hearing) and make possible the conscious awareness of the world] and epileptic syndrome. The IPN stated, the term was the same as seizure. The IPN stated, if the resident was admitted with history of seizure, a care plan for seizure monitoring and intervention should be initiated. The IPN stated, he could not find documented evidence that a care plan was developed to address seizure precautions for Resident 1 since facility admission on 3/2/24. The IPN stated, seizure precaution care plan was initiated on 5/9/24, after Resident 1 was found on the floor with seizure activity on 5/2/24. During a concurrent record review and interview on 5/17/24 at 3 p.m. with the IPN, Resident 1's GACH 1 record titled History and Physical, dated 1/24/24 timed at 9:25 a.m. and GACH 1 Progress Notes, dated 2/14/24, timed at 12:35 p.m. were reviewed, the IPN stated that GACH 1 was the acute hospital where Resident 1 was originally admitted from on 3/2/24. During a concurrent record review and interview on 5/17/24 at 3:15 p.m., Resident 1's History and Physical (H&P) dated 3/7/24 and Resident 1's GACH 2's Physician H&P dated 3/8/24 at 7:50 a.m. were reviewed with the IPN. The IPN stated, GACH 2 was the acute hospital where Resident 1 was sent to after his first fall on 3/7/24. The IPN stated, the records indicated that Resident 1 had history of dementia or Parkinson's disease dementia. The IPN stated, dementia should be listed in Resident 1's admission record and a care plan to address dementia should be initiated on 3/8/24. The IPN stated, he could not find any care plan for dementia. During a concurrent record review and interview on 5/17/24 at 3:45 p.m., with the IPN, Resident 1's Progress Notes, dated from 3/2/24 to 5/17/24 were reviewed, the IPN stated, the records indicated Resident 1 had recurrent falls in the facility that happened on 3/7/24, 3/18/24, and 5/2/24. (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 05/17/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent record review and interview on 5/17/24 at 4:20 p.m. with the IPN, Resident 1's Care Plan since 3/2/24 was reviewed. The IPN stated, Resident 1 had his first fall on 3/7/24 with a care plan created. The IPN stated, when Resident 1 had his second fall on 3/18/24, there should be a revised care plan to evaluate the interventions and make changes as needed to prevent another incident. The IPN stated, he could not find any revised care plan to address the incident on 3/18/24. During the same concurrent record review and interview with the IPN, on 5/17/24 at 4:20 p.m., the IPN stated, if a resident had non-compliant behaviors with recommendations, it should have been addressed in the care plan. The IPN stated, he could not find any care plan that addressed Resident 1's non-compliant behaviors. During an observation on 5/17/24 at 4:55 p.m. with Resident 1, Resident 1's back of the head was observed with stitches. During an interview on 5/17/24 at 5:05 p.m. with CNA 3, CNA 3 stated Resident 1 was known for trying to get up by himself if no staff was available to watch him and had history of several falls. During a concurrent interview and record review on 5/17/24 at 5:20 p.m., Resident 1's care plans since 3/2/24 was reviewed with the DON, the DON stated, if the same fall incidents happened again, the resident's fall risks needed to be reassessed to see the gap in behaviors and root cause so that the interventions could be adjusted. The DON stated, the physician should be notified. The DON stated, prior to the actual fall, if the resident was identified as non-compliant, trying to get out of bed, high risk for falls, the behaviors should be addressed in the care plan. The DON stated, in Resident 1's records, there were no care plan that indicated specific behaviors from Resident 1 had that could increase the resident's risk for falls. The DON stated it was very important to address Resident 1's non-compliant behavior so that all care providers could be aware and know how to take care of the resident. During a concurrent record review and interview on 5/17/24 at 5:40 p.m., Resident 1's Nursing Admission Assessment, dated 3/2/24 timed at 8:29 p.m. and Resident 1's Order Summary Report dated 3/2/24 were reviewed, the DON stated that Resident 1 had history of seizure and had order for Levetiracetam (a type of drug that is used to control/prevent seizures or convulsions) 1000 mg (unit of weight) by mouth two times a day for anticonvulsant since 3/2/24. The DON stated, if a resident had history of seizure and was taking any anticonvulsant medication, he would expect to have a care plan developed and seizure precautions added in the care plan interventions from 3/2/24 facility admission, that included padded side rails up, seizure monitoring and floor mats. The DON stated, he could not find the diagnosis of seizure in Resident 1's medical record. The DON stated, seizure precautions, monitoring order, and care plan were put in place on 5/9/24, after Resident 1 had a fall incident with seizure activity on 5/2/24, 61 days from facility admission on 3/2/24. During a concurrent record review and interview on 5/17/24 at 6 p.m., Resident 1's H&P dated 3/7/24 and Resident 1's GACH 2's Physician H&P dated 3/8/24 at 7:50 a.m. were reviewed with the DON, the DON stated, Resident 1 had dementia as indicated in the records. The DON stated, dementia could be at risk for fall because by nature, the resident's thinking process was impaired. The DON stated, if the resident had a history of dementia, care plan should be initiated to make sure all care providers know how to take care the resident. The DON stated, he could not find any dementia care plan for Resident 1. (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	05/17/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 5/17/24 at 6:15 p.m., Resident 1's clinical records since admitted [DATE] were reviewed with the DON, the DON stated there was no documented evidence that the facility's IDT Falls committee addressed the resident's falls and identify interventions to prevent recurrence of falls to prevent injuries for 3/7/24 and 3/18/24. The DON stated that the IDT meeting should be conducted to identify a root cause of resident's recurrent falls, develop a care plan to identify interventions and revise as needed to prevent future fall incidents. The DON stated, he could only find one IDT Falls committee meeting on 5/9/24, that addressed Resident 1's fall on 5/2/24. The DON stated, there was supposed to be IDT meetings performed on 3/7/24 and 3/18/24 that could have prevented another fall with injury on 5/2/24. During an interview on 5/17/24 at 6:30 p.m., the DON stated, to prevent physical injury when a high-risk resident falls on the floor, the facility utilizes floor mats. The DON stated, floor mats could be placed on both sides of the bed or only one side of the bed. The DON stated, the floor mat should be placed on the side that resident tends to get up to or his strong side. The DON stated that Resident 1's CNAs reported that Resident 1 normally tried getting up from the right side of the bed, then the floor mat should have been placed on the right side of Resident 1's bed to prevent injury from fall. During an interview on 5/17/24 at 6:50 p.m. with the Administrator (ADM), the ADM stated that she could not find Resident 1's diagnosis of seizure and dementia in his admission record. The ADM confirmed that if Resident 1's seizure and dementia was addressed and monitored in the care plan and an IDT meeting was held within 72 hours after the fall to conduct a root cause analysis and further interventions, on 3/7/24 and 3/18/24, Resident 1's fall incident which resulted in bleeding from his head and a transfer to GACH 1 on 5/2/24 could have been prevented. A review of the facility's policy and procedure (P&P) titled, Seizure Precautions, dated 6/1/17, indicated that residents considered at high risk for seizure activity would have seizure precautions initiated, seizure pads will be placed on the resident's side rails. Floor mats may be used. A review of the facility's policy and procedure (P&P) titled, Fall Management Program, dated 6/1/17 indicated: -The Nursing Staff will develop a plan of care specific to the resident's needs with interventions to reduce the risk of falls. -The Interdisciplinary Team will routinely review the plan of care at a minimum of quarterly, with a significant change in condition, and post fall. Interventions will be implemented or changed based on the resident's condition and response. -Suggested measures that can be used in the prevention of falls included determine the safest use of side rails. -Post Fall: The IDT-Falls Committee will meet within 72 hours of a fall. The IDT-Falls Committee will review and document: Summary of event following a fall; root cause analysis; Referrals, as necessary; and Interventions to prevent future falls. The resident's Care Plan will be updated as necessary.