STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555605	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenhaven Healthcare	212 West Chevy Chase Drive Glendale, CA 91204

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 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 44429 Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), who had a diagnosis of dementia (the loss of cognitive process) with combative behavior (aggressiveness/eagerness to fight) was free from physical restraints (any manual method, physical or mechanical device/equipment or material that limits a resident's freedom of movement and cannot be removed by the resident) for purposes of discipline or convenience, by failing to: 1. Protect Resident 1 from physical injury on 8/20/2024, when Licensed Vocational Nurse (LVN) 1 restrained Resident 1's right and left arms by crossing Resident 1's arms across the chest and above the head and pull/drag the resident from the resident's room to the Nursing Station when Resident 1 exhibited episodes of mood swings [a sudden or intense change in a person's emotional state]. 2. Implement Resident 1's care plan interventions on Dementia, and Communication Problem related to Language Barrier [a difficulty for people communicating because they speak different languages] by establishing rapport and eye contact with the resident, use appropriate words and gestures, listen carefully and attend to verbal/nonverbal expressions when LVN 1 physically restrained Resident 1's left and right arms with both of her hands, while the resident was exhibiting episodes of mood swings, anxiety and agitation on 8/20/2024. 3. Ensure the facility's Interdisciplinary Team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals for residents) develop a comprehensive care plan when Resident 1 exhibited (showed) new behaviors manifested by combativeness, punching, scratching, and kicking, chasing staff, including touching the roommate (Resident 2) on 6/9/2024, 7/7/2024, and 8/18/2024, in accordance with the facility's policy and procedure [P&P] titled Person Centered Plan of Care. 4. Develop care plan interventions on 8/22/2024, to address Resident 1's combative behavior and agitation and identify the root cause (the fundamental reason for the occurrence of a problem) of the resident's behavior symptoms (combativeness and agitation) to prevent further injury to Resident 1. 5. Prohibit the use of physical restraints, in accordance with the facility's policy and procedure titled Physical Restraint Management, when LVN 1 held Resident 1 down with both hands to prevent LVN 1 from being hit, kicked and spit on by Resident 1 and restrained Resident 1's right and left arms by crossing Resident 1's arms across the chest and above the head and pull/drag the resident from the resident's room to the Nursing Station, on 8/20/2024. (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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NAME OF PROVIDER OR SUPPLIER Glenhaven Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 212 West Chevy Chase Drive Glendale, CA 91204	

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	As a result, LVN 1 restrained Resident 1's freedom of movement and the resident sustained (continued over time) redness/bruising to the back of the left hand and verbalized pain to both hands and shoulders on 8/20/2024. On the same day, on 8/20/2024 timed at 7:48 PM, during a telemedicine (the use of electronic information and communications technologies to provide and support) visit with Psychiatrist 1, Resident 1 verbalized being scared. Resident 1 was unable to verbalize the reason for being scared. These deficient practices placed other residents with behavioral issues (acting in a way that causes harm) residing at the facility [24 residents], at risk for staff abuse and restraints and cause psychosocial (covers a person's mental, emotional, social, and spiritual health) decline, physical (relating to the body) injuries, hospitalization , and death. On 8/26/2024 at 6:22 PM, while onsite at the facility, the California Department of Public Health (CDPH) identified an Immediate Jeopardy situation (IJ, a situation in which the provider's noncompliance [not following rules] with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) regarding the facility's failure of unnecessary physical restraint for a resident (Resident 1) who had behavioral issues which included combativeness. The survey team notified the Administrator (ADM) and the Director of Nursing (DON) of the IJ situation on 8/26/2024 at 6:22 PM, due to the facility's unnecessary use of physical restraint for Resident 1, while in an agitated state. On 8/28/2024 at 1:46 PM, the ADM provided an acceptable IJ Removal Plan (a detailed plan to address the IJ findings). On 8/28/2024 at 5:15 PM, while onsite and after the surveyor verified/confirmed the facility's full implementation of the IJ Removal Plan through observation, interview, and record review, and determined the IJ situation was no longer present, the IJ was removed onsite, in the presence of the ADM and the DON. The IJ Removal Plan dated 8/28/2024, included the following: o The facility interviewed 30 interviewable residents on 08/26/2024 and screened for any incidents of being physically restrained during care by the Social Services Designee (SSD) and 12 non-interviewable residents received body check (examine the body) on 08/26/2024, to determine any unexplained bruising (blood pooling under the skin) or redness by licensed nurses and the DON. o The facility started Training and Education on 8/26/24 headed by the Nurse Consultant Director of Staff Education and the DON, regarding abuse (the act of causing harm) and physical restraints. The training on Managing Behavior and Care plan will be completed by 08/28/2024. o The facility started In-service (continuous) training for staff nurses on 8/26/24, regarding updating comprehensive care plans for residents that exhibit combative behaviors to be completed and to include on the care plan not to use any type of restraints. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o The facility started an In-service training for staff and nurses on 8/26/24, on managing residents that exhibit combative behaviors. Staff from nursing department (Registered Nurse (RN), LVN, Certified Nurse Assistants [CNA], Restorative Nurse Assistants [RNA]) Dietary Department, Housekeeping, Maintenance and Department Managers (Social Service, Medical Records staff, Rehabilitation Department, Minimum Data Set (MDS), DON, DSD, IPN, Business Office Manager [BOM]), have been trained and will continue training until all staff have attended. o The facility conducted an In-service training for staff (RN, LVN, CNA, RNA, Housekeeping, Dietary Department, Maintenance and Department Managers) on 8/26/24, on what constitutes a physical restraint and its definition. o The nurse consultant conducted an In-service to all RNs, LVNs, CNAs, and RNAs, Housekeeping, Maintenance staff, Dietary staff, and Department Managers on 08/28/2024, regarding Behavior Management, Abuse and Physical Restraints. o The SSD, DON and Activity Director (AD) will conduct interviews of alert residents to determine if they have been physically restrained during care at least daily for the next 3 days and weekly for two weeks and monthly thereafter. o CNAs will continue to conduct body checks for all residents to identify any unexplained redness or bruising during showers and will be reported to the Charge nurse/Treatment nurse (TN) 1 and/or to DON for further intervention and reporting. Findings: During a review of Resident 1's Admission Record [AR], the AR indicated the facility admitted the resident on 6/6/2024, with diagnoses that included dementia and encephalopathy (damage or disease that affects the brain). During a review of Resident 1's History and Physical Examination (HPE, a comprehensive physician's note regarding the assessment of the resident's health status) signed by the attending physician (Physician 1) on 6/7/2024, the HPE indicated Resident 1 had fluctuating (changing frequently) capacity to understand and make decisions. During a review of Resident 1's Post COC [Change in Condition]/SBAR [Situation, Background, Assessment, Recommendation] notes dated 6/9/2024 timed at 1:20 PM, the Post COC indicated Resident 1 became combative towards the end of the shift and was brought back to bed several times. During a review of Resident 1's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool) dated 6/12/2024, the MDS indicated the resident had moderately impaired cognition (thought process). During a review of Resident 1's Interdisciplinary Team [IDT] Conference Record dated 6/12/2024, indicated that Resident 1 did not present with any behavioral issues, needs encouragement to join activities of choice and enjoys music. The IDT Record indicated the facility did not use physical restraints and restraints were not recommended at this time for Resident 1. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's care plans initiated in June 2024, the care plans indicated the following information: -On 6/12/2024, the facility developed a care plan titled [Resident 1] has a communication problem related to language barrier. The care plan interventions included allowing adequate time to respond, face the resident when speaking, making eye contact and reducing environmental noise, and monitoring for physical/nonverbal indicators of discomfort or distress. -On 6/12/2024, the facility developed a care plan titled [Resident 1] has diagnosis of dementia, at risk for decline in communication and activity participation . The care plan interventions included establishing rapport and eye contact with the resident, use appropriate words and gestures, listen carefully and attend to verbal/nonverbal expressions, reducing environmental noise, and maintaining a calm, unhurried manner. During a review of Resident 1's SBAR (Situation, Background, Assessment, Recommendation) Communication Form and Progress Note dated 7/7/2024 timed at 12:47 PM, indicated that on 7/7/2024 at about 8 AM, Resident 1 began to swing fist (refers strictly to the action of throwing one's fist) at the CNA when Resident 1 was reoriented by the CNA not to pull on her roommates' (Resident 2) gown. The SBAR indicated Physician 1 ordered Ativan (medication for anxiety) 0.5 milligrams [mg- unit of measurement) by mouth every 12 hours as needed for agitation for 14 days on 7/7/2024. During a review of Resident 1's care plans, for July 2024, the care plan did not indicate documented evidence that a care plan for Resident 1's agitation was developed on 7/7/2024, to specify the goals and care plan interventions the facility staff needed to implement to manage the resident's agitation. During a review of Resident 1's Telephone Order (TO) dated 8/5/2024, indicated a physician's telephone order to administer Depakote (medication to treat episodes of mania [extreme changes in mood]) oral tablet to 125 mg, one tablet by mouth one time a day for mood swings manifested by outbursts (uncontrolled feelings) of anger. During a review of Resident 1's SBAR Communication Form and Progress Note dated 8/18/2024, timed at 3:22 PM, authored by LVN 3, the SBAR Form indicated Resident 1 attempted to touch Resident 2 and when Resident 1 was redirected, the resident shook her head in denial and punched LVN 3. The SBAR form indicated Resident 1 began to chase facility staff down the facility hallway attempting to punch and kick staff. The SBAR Form indicated Resident 1 was combative, punching, scratching, and kicking staff. The SBAR Form indicated that LVN 3 called 911 emergency services, and a police officer spoke to Resident 1 in her primary/native language and the police officer was able to redirect the resident to calm down and go back to her room. During a review of Resident 1's Progress Notes New dated 8/19/2024, timed at 5:52 PM, the Progress Notes indicated the physician ordered to increase the resident's medication [Depakote] 120 mg from once a day to two times a day as a result of the behavior manifested by the resident on 8/18/2024. During a review of Resident 1's TO dated 8/19/2024, the TO indicated to administer Ativan oral tablet 0.5 mg, one tablet by mouth, every 12 hours to the resident as needed for 14 days manifested by verbalization of nervousness. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's Medication Administration Record [MAR], the MAR indicated to give the resident one tablet of Ativan 0.5 mg starting 8/19/2024, by mouth every 12 hours for 14 days, as needed for anxiety manifested by verbalization of nervousness. The MAR did not indicate Ativan was administered as needed for anxiety, from 8/19/2024 or 8/20/2024. The MAR indicated an order to monitor behavior for anti-anxiety manifested by verbalization of nervousness and tally by hashmarks (a way to count and record count numerically), starting on 8/19/2024. The MAR did not indicate Resident 1's anxiety manifested by verbalization of nervousness was monitored and counted by the licensed nurses from 8/19/2024 through 8/27/2024. During a review of Resident 1's TO dated 8/19/2024, indicated Depakote oral tablets dosage was increased from the original dose that was ordered on 8/5/2024 from 125 mg, one tablet once a day to 125 mg, one tablet two times a day, for mood swings manifested by outbursts (uncontrolled feelings) of anger. During a review of Resident 1's MAR in August 2024, the MAR indicated for the Depakote medication, Resident 1's behavior issues of outbursts of anger was monitored and documented 16 days after the original order of the Depakote oral tablets was ordered on 8/5/2024 starting 8/21/2024. During a review of a Short Message Service [SMS - a text messaging service that allows users to send short text messages between mobile devices] sent via text message [TM] from LVN 1 to the Director of Nursing (DON) dated 8/20/2024 timed at 6:48 AM, the TM indicated Resident 1 keeps hitting other residents and LVN 1 was unable to physically control the resident. The TM indicated Resident 1 was very aggressive and LVN 1 had to hold Resident 1 to prevent Resident 1 from going back to Resident 1 and 2's room and from hitting and kicking LVN 1. The TM indicated the DON asking LVN 1 What prompted crossing her arms? Or dragging her [Resident 1] to the station with both arms/hands held? LVN 1's response indicated She [Resident 1] did not want to stop. Where else should she go if not the station. Holding her hands so she [Resident 1] doesn't hit me. The TM indicated the DON stating that Resident 2 denied being hit by Resident 1 and Resident 1 sustained injuries/bruising to both the right and left hand. During a review of Resident 1's SBAR Communication Form and Progress Note dated 8/20/2024 timed at 12:27 PM, the SBAR indicated Resident 1 was allegedly hitting the roommate, Resident 2 on 8/20/2024. The SBAR indicated the charge nurse, LVN 1, reported that Resident 1 hit Resident 2. The SBAR indicated that upon interview of Resident 1, Resident 1 denied hitting Resident 2. The SBAR indicated Physician 1 was made aware of the allegation that Resident 1 hit Resident 2, but no new orders were given by Physician 1, as a result of the allegation. During a review of Resident 2's SBAR Communication Form and Progress Note dated 8/20/2024, indicated Resident 2 was allegedly hit by the roommate (Resident 1). The SBAR Form indicated Resident 2 was interviewed and Resident 2 stated she was not hit by Resident 1. The SBAR Form indicated Resident 2 did not have any injuries or bruising upon body assessment of the licensed nurse. During a review of Resident 2's Progress Notes, dated 8/20/2024 and timed at 9:32 AM, the Progress Notes indicated Resident 2 was discharged back to home on 8/20/2024. During a review of Resident 1's Skin Observation Tool dated 8/20/2024, timed at 1:48 PM, the tool indicated that 2 centimeters (cm- unit of measurement) by 2 cm bluish discoloration was observed on the back of Resident 1's left hand. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's IDT Conference Record dated 8/20/2024, the IDT Record indicated the IDT team met with Resident 1 with the aid of translator services and asked Resident 1 if her injury (bruising to the left hand) caused by LVN 1 was hurting, Resident 1 did not respond. The IDT record further indicated that Resident 1 denied hitting Resident 2. During a review of Resident 1's care plan, titled [Resident 1] was involved with an alleged abuse, initiated on 8/20/2024, indicated a goal that Resident 1 would not display any further behavior (no specific behavior indicated) for one month. The care plan interventions developed on 8/20/2024, included visual monitoring hourly and a STAT (immediately) X-ray of Resident 1's bilateral (both) hands and shoulders due to pain. During a review of Resident 1's care plan titled [Resident 1] has a new behavior of punching, kicking, and scratching staff, attempting to touch and grab other residents indicated the care plan was initiated on 8/18/2024 and revised on 8/22/2024. The care plan interventions dated 8/18/2024, indicated to notify attending physician of significant changes in behavior, notify responsible party, and provide psychosocial support. The care plan did not indicate the care plan interventions added, when the facility revised the care plan on 8/22/2024. The revised care plan dated 8/22/2024, did not include resident specific interventions to address Resident 1's behavior symptoms of combativeness with staff, agitation, and outbursts of anger. During a review of Resident 1's Psychology [the scientific study of the human mind and its functions, especially those affecting behavior] Note, dated 8/20/2024, the Psychology Note indicated Resident 1 verbalized being scared. The Psychology Note indicated that when Resident 1 was asked why or what happened, Resident 1 was unable to reply. During a review of CNA 2's handwritten Investigation Statement dated 8/19/2024 (corrected by DON as 8/20/2024), indicated CNA 2 heard LVN 1 calling to get Resident 1 out of the room because Resident 1 was hitting Resident 2. CNA 2 wrote witnessing Resident 1 walking out of the room heading by the facility hallway towards the Nurses Station, at around 6 AM, CNA 2 wrote that before Resident 1 reached the Nurses Station, LVN 1 stopped Resident 1 and spoke with the resident through the translator services using the phone, however Resident 1 got mad when LVN 1 confronted her and was about to kick and spit on LVN 1. CNA 2 further wrote that to avoid the assault, [LVN 1] restrained Resident 1 by holding the [resident's] hands while [the resident] was still trying to kick and spit on LVN 1. CNA 2 wrote that Resident 1 was screaming and kept talking in her language while LVN 1 tried to sit the resident on a wheelchair. CNA 2 wrote that LVN 1 held Resident 1's hand hard that it left a red mark at the back of Resident 1's hand. During a review of CNA 4's Investigation Statement dated 8/20/2024, indicated CNA 4 (night shift CNA) stated she witnessed Resident 1, inside her room, tapped Resident 2's foot with an open hand trying to wake her (Resident 2) up, on 8/20/2024 at around 6:20 AM. The Investigation Statement indicated CNA 4 told Resident 1 to stop tapping Resident 2's foot and Resident 1 started talking in her primary/native language as Resident 2 woke up . (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of CNA 3's (night shift CNA) Investigation Statement dated 8/20/2024, indicated CNA 3 heard yelling coming from Resident 1's room and when she entered the room, CNA 3 observed Resident 1 yelling and standing by Resident 2's bed. The Investigation Statement indicated CNA 3 left the room and reported Resident 1 to LVN 1. The Investigation Statement indicated CNA 3 stated that LVN 1 was trying to calm down Resident 1 in the facility hallway and held Resident 1's hands to prevent LVN 1 from getting hit. The Investigation Statement indicated CNA 3 got a wheelchair and sat Resident 1 down while another CNA (CNA 1) arrived from the morning shift and started to talk to Resident 1 to calm her down. During an interview on 8/26/2024 at 10:34 AM with Housekeeper (HK) 1, HK 1 stated that on 8/20/2024 at around 6:40 AM, he heard arguing by the hallway, across the Nurses Station. HK 1 stated witnessing Resident 1 standing by the Nursing Station while LVN 1 was behind Resident 1 restraining Resident 1's left and right arms with both of her hands. HK 1 stated that Resident 1 right and left arms and hands were crossed and restrained for about 5 minutes. HK 1 stated while LVN 1 was restraining the resident, Resident 1 was screaming, yelling, and kicking. HK 1 stated LVN 1 was calling for someone to get a wheelchair, while LVN 1 was physically restraining Resident 1. HK 1 stated that CNA 1 from the 7 AM to 3 PM shift, came to help calm down Resident 1. HK 1 stated Resident 1 had calmed down when CNA 1 had spoken to her. HK 1 stated that Resident 1 was pointing and complaining of left-hand pain to CNA 1. HK 1 stated that CNA 1 applied an ice pack to Resident 1's left hand. During an interview on 8/26/2024 at 10:47 AM, CNA 1 stated she arrived at the facility at around 6:45 AM. CNA 1 stated that she witnessed Resident 1 screaming in front of the Nurses Station, sitting on the wheelchair while LVN 1 physically restrained Resident 1 by holding Resident 1's left and right hand and Resident 1's arms were crossed above her head. CNA 1 stated she was able to calm down Resident 1, so LVN 1 had stopped restraining Resident 1. CNA 1 stated she noticed Resident 1 had redness on the back of the left hand. CNA 1 stated after she applied an icepack on Resident 1's left hand, CNA 1 took Resident 1 back to her room. During an observation and interview on 8/26/2024 at 11:06 AM, in Resident 1's room, in the presence of another employee [Translator 1] translating for Resident 1, Translator 1 stated that according to Resident 1, it was hard to remember what happened on 8/20/2024, during the early morning, because it happened a while back. Resident 1 stated she did not have any pain anymore. Resident 1 had pointed to the back of her left hand with yellowish discoloration. During an interview on 8/26/2024 at 11:21 AM, the Treatment Nurse (TN 1) stated that Registered Nurse (RN) 2 reported to her that Resident 1 needed treatment on her left dorsal hand bruising, on 8/20/24. TN 1 stated that Resident 1 was pointing to her left hand when she went to assess the resident. TN 1 stated that Resident 1 had a 2 cm by 2 cm bluish discoloration to the resident's left dorsal (back of the hand) hand, with no swelling, on 8/20/2024. TN 1 stated that Resident 1's bruising to the left hand had now changed to yellowish discoloration with no pain or swelling. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/26/2024 at 11:36 AM, the ADM stated when she arrived at the facility on 8/20/2024 at 7:30 AM, HK 1 reported that he observed LVN 1 had physically restrained Resident 1 on 8/202024 at around 6:40 AM, at the Nurses Station. The ADM stated she had immediately started the abuse investigation. The ADM stated during the course of her investigation, LVN 1 physically restrained Resident 1 by holding Resident 1's left and right hands while inside her room and was forcefully pulled by holding both of her hands in a strong manner towards the Nurses Station. The ADM stated Resident 1 sustained bruising to the back of her left hand. The ADM stated CNA 4 reported to LVN 1 that Resident 1 had allegedly abused her roommate [Resident 2] by tapping her foot on 8/20/24 at around 6:20 AM, when CNA 4 was walking by Resident 1's room. The ADM stated that LVN 1 had communicated with the DON via TM regarding the incident with Resident 1. The ADM stated that LVN 1 texted to the DON the reason why she physically restrained Resident 1 was because she assumed that Resident 1 would hit Resident 2 while in the resident's room. The ADM stated LVN 1 restrained Resident 1's hands because she did not want to get hit by the resident. The ADM stated LVN 1 forcefully pulled Resident 1's left and right hand out of the room and pulled the resident to the Nursing Station. The ADM stated the DON requested LVN 1 to submit a written statement, but LVN 1 did not submit and respond to any further communication with the ADM or the DON. The ADM stated LVN 1 was suspended on 8/20/2024 and was later terminated on 8/23/2024. During an interview, on 8/26/2024 at 12:08 PM, the DON stated LVN 1 stopped communicating via text messages and LVN 1 did not call back or respond to her for a written statement of what occurred on 8/20/2024. The DON further stated that LVN 1 forcefully pulled Resident 1's right and left hand on 8/20/2024 towards the Nursing Station. The DON stated LVN 1 did not follow the facility policy on Restraint Management and did not use good nursing judgement to deescalate [to decrease difficulty of a situation] Resident 1's agitated state. The DON stated the physical force used by LVN 1 caused injury (bruising) to Resident 1's left and right hand and may have caused psychosocial distress (unpleasant emotions which negatively impacts quality of life) by making Resident 1 feel helpless. The DON stated LVN 1 should have talked to Resident 1 in a calm voice or walked away, and just monitor Resident 1 until she calmed down. During an interview on 8/26/2024 at 2:05 PM with LVN 2, LVN 2 stated she arrived at the facility around 6:50 AM, on 8/20/2024, and observed LVN 1 restrained Resident 1's left and right hands and crossed the resident's arms across the resident's abdomen/chest area with LVN 1's right hand. LVN 1 used her left hand to hold her cell phone while trying to call the translator services to communicate with Resident 1. LVN 2 stated Resident 1 had been restrained for about two minutes. During the same observation, on 8/26/2024 at 2:05 PM, LVN 2 stated Resident 1 was not agitated or combative. LVN 2 stated CNA 1 came to Resident 1 and started to speak with her to comfort her. LVN 2 stated after CNA 1 talked to Resident 1, LVN 1 released her hand from Resident 1. LVN 2 stated CNA 1 took Resident 1 back to her room and reported to LVN 1 about Resident 1's injury (bruising) to the left hand and CNA 1 placed an ice pack to Resident 1 left and right hand. LVN 2 stated that LVN 1 should have not physically restrained Resident 1. LVN 2 stated LVN 1 caused physical and psychological harm to Resident 1 because LVN 1 used force which led to Resident 1 getting injured physically. During a telephone interview on 8/26/2024 at 2:29 PM, Resident 2 was interviewed and stated that Resident 1 would wake up at night and just walk up and down the hallway. Resident 2 stated that Resident 1 never hit her and did not bother her. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555605	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Glenhaven Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 212 West Chevy Chase Drive Glendale, CA 91204	

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 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent interview and record reviews on 8/26/2024 at 3:10 PM, Resident 1's Nursing Progress Notes titled Post [COC] dated 6/9/2024 timed at 1:20 PM and SBAR Communication Form and Progress Note dated 7/7/2024 timed at 12:47 PM were reviewed with the DON. During the concurrent interview, the DON stated he was unaware of Resident 1's Post COC on 6/9/2024 that indicated Resident 1's combative behavior. The DON further stated that he was unaware of Resident 1's combative behavior exhibited on 7/7/2024, as indicated in the SBAR Form. The DON stated there was no resident specific care plan developed for Resident 1's combative behaviors prior to 8/18/2024, because there was no IDT conference conducted to address Resident 1's aggressive behavior since the resident's behavior symptoms were not reported to him [DON]. The DON stated the SBAR Form dated 7/7/2024, indicated the physician ordered Ativan 0.5 mg every 12 hours as needed for agitation. The DON stated Resident 1's aggressive behavior and the physician order for the use of Ativan should have been communicated and addressed to identify and manage Resident 1's behavioral issues to avoid abuse or physical restraints. During a concurrent interview on 8/26/2024 at 3:34 PM and record review of Resident 1's care plan titled [Resident 1] has a new behavior of punching, kicking, and scratching staff, attempting to touch and grab other residents, dated 8/18/2024 and revised on 8/22/2024 with the DON, the DON stated that Resident 1's care plan interventions for Resident 1's new behavior of punching, kicking and scratching staff were not specific to the Resident 1's behavioral needs. The DON stated the licensed nurses only developed three care plan interventions which included to notify the physician, notify Resident 1's family, and provide psychosocial support. The DON stated the care plan did not indicate how the staff would provide psychosocial support such as to talk to the resident so she could voice any concerns. The DON stated the care plan did not address triggers or root cause that may have been causing Resident 1 to touch other residents especially Resident 2, including punching, kicking, and scratching staff. The DON stated because the care plan on 8/18/2024 did indicate addressing the root cause of Resident 1's aggressive behavior, LVN 1 led to escalating Resident 1's aggressive behavior by physically restraining Resident 1 on 8/20/2024. The DON stated restraining Resident 1 was not the appropriate action to protect the resident and calm her down. The DON stated LVN 1 used physical force (on 8/20/2024) and led to Resident 1's increase in aggression. During the same interview, on 8/26/2024 at 3:34 PM, the DON stated the facility's IDT conference should have been conducted the next day, on 8/19/2024, when resident 1 had an episode of combativeness on 8/18/2024. The DON stated the IDT conference was not conducted the next day, 8/19/2024, because it was a weekend (Sunday). The DON stated the next incident happened on 8/20/2024, early morning, and should had been prevented if Resident 1's combative behaviors was addressed by the IDT on 8/19/2024. During a phone interview on 8/26/2024 at 4:40 PM, LVN 3 stated he worked on 8/17/2024 from 11 PM to 7 AM shift. LVN 3 stated he had cared for Resident 1 in the past and Resident 1 previously had behaviors of agitation when Resident 1 would get startled. LVN 3 stated after Resident 1 had been redirected back to her room, Resident 1 became aggressive and began making threatening gestures with her fist. LVN 3 stated Resident 1 slapped him across the face while trying to calm her down. LVN 3 stated after several attempts to redirect Resident 1, the resident began chasing staff in the hallway. LVN 3 stated when Resident 1 began chasing staff, he called 911 emergency services. LVN 3 stated police officers arrived in the early morning of 8/18/2024 at around 1 AM. LVN 3 stated there was an officer who speaks Resident 1's native language and was able to calm her down. LVN 3 stated Resident 1 went back to her room and told the police officer she was tired. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/27/2024 at 4:18 PM, with RN 1 stated she worked on 8/17/2024 from 3 PM to 11 PM shift and she did not see Resident 1 in an agitated state and was not chasing, yelling, and kicking staff but noticed the resident with episodes of anxiously pacing up and down the hallway. RN 1 stated Resident 1 would pace up and down the hallway but return to her room. RN 1 stated she did not know if Resident 1's behaviors (verbalization of nervousness and outburst of anger) was being monitored or counted in the resident's records. During a review of the facility's P&P titled Physical Restraint Management dated 3/2017, the P&P indicated physical restraints are not used for purposes of discipline or convenience, but only as required to treat the resident's medical symptoms. The P&P indicated physical restraints are defined as any manual method, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. The P&P indicated physical restraints include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties, or vests, lap cushions, and lap trays the resident cannot move easily. During a review of the facility's P&P titled Person Centered Plan of Care dated 12/2016 indicated It is the policy of this facility to provide each resident with a person-centered plan of care developed that includes goals, measurable objectives and timetables to meet their medical, nursing, mental, psychosocial needs identified during comprehensive assessment and preferences of residents as