STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555605	A. Building B. Wing	09/12/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 44372 Based on interview and record review, the facility failed to ensure residents received treatment care and services, in accordance with professional standards of practice, for one of three sampled residents (Resident 1) by: 1. Failing to honor Resident 1 ' s request to transfer to the acute hospital on 9/6/26 due to a change in condition for more than 4 hours. 2. Failing to assess, recognize, intervene, after Resident 1 had a change of condition on 9/6/24. 3. Failing to document Resident 1 ' s condition in the facility forms titled SBAR (Situation, Background, Action, Respond). These deficient practices had the potential to delay in the delivery of necessary care and services for Resident 1 and negatively affect Resident 1 ' s psychosocial wellbeing. Findings: During a review of Resident 1's Face Sheet (admission record), the Face Sheet indicated the facility admitted the resident on 8/30/2024 with diagnoses including chronic obstructive pulmonary disease(lung disease causing restricted airflow and breathing problems), respiratory failure (a serious condition that makes it difficult to breathe on your own which develops when the lungs can't get enough oxygen into the blood), and generalized anxiety disorder(a mental disorder that causes people to experience excessive, uncontrollable, and irrational worry that interfered with their daily living). During a review of Resident 1's History and Physical from the GACH (Generalized Acute Care Hospital) 1 H&P dated 8/29/2024, indicated Resident 1 is alert, cooperative, no distress. During a review of Resident 1's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) dated 9/03/2024, the MDS indicated the resident ' s cognition (thought process) was intact. The MDS indicated Resident 1 is able to express idea and wants and make self-understood, able to understand others. Resident 1 does not have inattention and disorganized thinking. The MDS indicated Resident 1 does not hallucinate and does not have delusions. During a review of Police Report dated 9/06/2024 and timed at 1:28 AM, indicated Responsible Party is the medical power of attorney of Resident 1 who is requesting to go to hospital. (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: 555605	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the Police Report dated 9/06/2024 and timed at 2:29 AM, documented Resident 1 short of breath and chest pain. Paramedics arrived and will transport. During a review of Resident 1's GACH 2 records dated 9/6/2024 and timed at 2:33 AM, indicated Resident 1 presented to the GACH 2 emergency room with chest pain. Began 4 hours prior to arrival. Presents from nursing facility. Vitals signs are reviewed and are notable for the following: Tachycardia (fast heart rate more than 100), respiratory rate 24 (normal 12 to 20 breaths per minute), elevated D-dimer (a blood test that can indicate that a person has a blood clotting condition which can lead to serious health conditions, including stroke (a medical condition that occurs when there is a disruption to blood flow in the brain, causing brain cells to die). Resident 1 alert and oriented x4, moving all extremities, no drift, no neurological deficit. During a review of Resident 1 ' s Progress Notes dated 9/06/2024 and timed at 3:00 AM, documented by LVN (Licensed Vocational Nurse) 1, indicated, at around 12:30 AM Resident 1 ' s Emergency Contact [EC 1] walked through the facility ' s front door and stated that he wanted to drive Resident 1 to GACH 1. The Progress Notes indicated EC 1 was informed by LVN 1 that there was a process to follow to release resident. The Progress Note indicated that Resident 1 was not in any distress at that time. The Progress Notes indicated that EC 1 stated he was going to call the police, police called and arrived quickly. The Progress Notes indicated the police heard what was happening and said they could not do anything and asked EC 1 and Resident 1 if they could it wait until the morning staff arrived . The Progress Notes indicated EC 1 said no, so LVN 1 called the DON (Director of Nursing) and the Administrator, but was unreachable. The Progress Notes indicated LVN 1 placed a call to Resident 1 ' s Physician and was instructed to call the DON. The Progress Notes indicated that EC 1 and Resident 1 was provided with the Against Medical Advice [AMA] paper to sign, but Resident 1 refused to sign. The Progress Notes further indicated that EC 1 was on phone screaming and screamed Resident 1 ' s chest hurt, asked resident did her chest hurt and she said yes, 911 called immediately. During a review of Resident 1 ' s Care Plan dated 9/06/2024 indicated Accommodation of Needs Plan and as intervention indicated provide information as to how preferences and accommodation will be incorporated in care, incorporate preferences in daily care and schedule of resident while in the facility, involve family and significant others as needed to determine preferences, periodically interview resident to determine if there are changes in preferences, provide assistance with daily care to meet accommodation requests and needs and as goal indicated staff will accommodate the needs and preferences. During an interview on 9/12/2024 at 10:55 AM, EC 1 stated on 9/5/2024 between 10 PM to 10:30 PM he visited Resident 1 at the facility and observed Resident 1 in distress, crying, reporting chest pain and begging staff to transfer her to hospital. EC 1 stated he asked LVN 1 to transfer Resident 1 to the acute hospital or let EC 1 take Resident 1 to the acute hospital, but LVN 1 did not take any action and told him Resident 1 cannot be transferred to the acute hospital. EC 1 stated he called 911 emergency services and police came however they were not able to assist. EC 1 stated LVN 1 was unaware how to handle the situation. EC 1 stated that LVN 1 told him, she was new to the facility and already contacted the DON and ADM but did not receive any response. EC 1 stated they offered him the AMA papers to sign but he did not sign. EC 1 stated eventually around 2:30 AM Resident 1 was transferred to GACH 1. (continued on next page)

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/12/2024 at 11:32 AM, Resident 1 stated on 9/5/2024 starting 10:30 PM, she was having chest pain, hard time breathing, and crying and asked LVN 1 to transfer her to the acute hospital but LVN 1 told her she had to stay, and they cannot transfer her. During an interview on 9/12/2024 at 11:53 AM, LVN 1 stated she was assigned to care for Resident 1 on 9/5/2024, during the 11 PM to 9/6/2024 at 7 AM shift. LVN 1 stated she was from a Nursing Registry, and it was her first-time taking care of Resident 1. LVN 1 stated she was the only Licensed Nurse at the facility during the shift. LVN 1 stated that on 9/6/2024, at around 12 AM, EC 1 wanted to take Resident 1 to the acute hospital. LVN 1 stated Resident 1 also requested to go with him. LVN 1 stated based on her assessment Resident 1 was not on any distress that time. LVN 1 stated she was not aware of the protocol of the facility, and she was not aware how to handle the situation, so she texted the DON and ADM to get instructions. LVN 1 stated she could not recall the exact time but stated sometime before 1 AM 9/6/2024. LVN 1 stated she did not receive any response. LVN 1 stated she also contacted Resident 1 ' s Physician but was instructed to consult with the DON. LVN 1 stated she asked Resident 1 to sign the AMA form, but EC 1 did not sign. LVN 1 stated on 9/6/2024 around 2:30 AM, Resident 1 reported chest pain and that is the time she called 911 and transferred Resident 1 to the acute hospital. LVN 1 stated she received a text message around 5 AM from the DON after Resident 1 was transferred to the acute hospital. LVN 1 stated she did not create an SBAR and only documented under the progress notes. During an interview on 9/12/2024 at 12:08 PM, LVN 2 stated if a resident reports chest pain, discomfort after assessing Resident will call 911 and transfer Resident to the hospital. LVN 2 stated the licensed nurse should document findings in the SBAR and create a care plan. During an interview on 9/12/2024 at 1:02 PM, the DON stated on 9/6/2024 at around 1:30 AM, the DON received a text message from LVN 1, who was from a Nursing Registry, and it was her first shift at the facility. The DON stated that EC 1 wanted to transfer Resident 1 to the acute hospital. The DON stated that she received another text message on 9/6/2024 at 2:36 AM that indicated Resident 1 reported chest pain and was transferred to the acute hospital. The DON stated he replied to the text message on 9/6/2024 at 5:14 AM. The DON stated if a resident requests to be transferred to the acute hospital, the licensed nurse needs to contact the physician, if there was no answer the licesed nurse needs to contact the medical director and if no answer, the licensed nurse should have the resident sign AMA and if refused to sign AMA, have 2 nurses sign the AMA form and call 911. The DON stated based on his job description the DON must be available 24 hours 7 days a week. During an interview and record review of Resident 1 medical records on 9/12/2024 at 1:07 PM, the DON stated LVN 1 did not create an SBAR form which is a standard of practice for the facility. During a review of the facility ' s policy and procedure (P&P) titled Protection of Resident, dated December 2017, indicated The facility will provide a safe resident environment from abuse that will protect and monitor residents. To monitor effects of abuse and ensure protection of residents and ensure that all staff are trained and are knowledgeable in how to react and respond appropriately to resident behavior. Identified facility characteristics hat could increase the risk of abuse include but are not limited to: Lack of administrative oversight, staff burnout, and stressful working conditions; poor or inadequate preparation or training for care giving responsibilities. Neglect, means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P&P) titled Exercise of Resident Rights, dated November 2017, indicated The facility protects and promotes the rights of each resident. It is the facility's policy to ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. The facility must not hamper, compel, treat differentially, or retaliate against a resident for exercising his/her rights. Facility behaviors designed to support and encourage resident participation in meeting care planning goals as documented in the resident assessment and care plan are not interference or coercion. During a review of the facility ' s policy and procedure (P&P) titled Discharge Against Medical Advice (AMA, dated December 2016, indicated The signed AMA form releases the facility from legal responsibility for any medical problems the resident may experience after leaving the facility against the advice of their physician problems the resident may experience after leaving the facility against the advice of their physician. When a resident or family member demands discharge against medical advice, notify the physician immediately. If the resident or family member refuses to sign the AMA form, do not detain the resident. Document their refusal to sign on the AMA form and enter your signature with date. 1.Obtain signatures on the AMA release form. 2. Complete the Post Discharge Plan of Care. 3. Document the incident in the Interdisciplinary Progress Notes. Record in the resident's medical record: date, time and reason for leaving-resident's physical and mental condition-the mode of departure-method of transportation-the reason, if any, for refusing to sign the AMA form. Complete the Interdisciplinary Discharge Summary and obtain a Physician Discharge Summary. Record transfer on the 24-Hour Report. Complete an In House Communicator to notify other departments of the discharge. During a review of the facility ' s policy and procedure (P&P) titled Director of Nursing dated May 2017, indicated The Director of Nursing has 24-hour accountability and is responsible for the delivery of high-quality and cost-effective health care while achieving positive clinical outcomes, and patient family and employee satisfaction. He/she is responsible for the overall operations, integration, coordination and direction of nursing and patient care within the Facility. Additionally, he/she ensures that care delivery is consistent with the mission, vision, values and policies of facility and in accordance with accepted standards of practice, state and federal regulations and licensing requirements. During a review of the facility ' s policy and procedure (P&P) titled Change of Condition, dated August 2017, indicated It is the facility's policy that it shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). The purpose of this policy is to establish and explain change of condition documentation guidelines when it occurs from admission to discharge in long term care. The Director of Nurses (DON) and/or its designee shall be responsible for implementation and enforcement of this policy. Using the Interact Tool SBAR - notify physician for all signs and symptoms manifested by the patient. The form will be used to initiate change of condition documentation for any decline or improvement. The Staff Developer will conduct and provide educational training upon hire and yearly thereafter and/or as needed. A consultant may be utilized to provide training to the staff.

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F 0726

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.

44372

Based on the interview and record review, the facility failed to ensure that LVN (Licensed Vocational Nurse)1 who was from a Nursing Registry [a business or agency that provides nursing staff to hospitals], demonstrated the necessary competency to provide adequate care for one of three sampled residents, (Resident 1).

This deficiency had the potential to negatively impact Resident 1's psychosocial well-being and delay the delivery of critical care.

Findings:

During a review of Resident 1's Face Sheet (admission record), the Face Sheet indicated the facility admitted the resident on 8/30/2024 with diagnoses including chronic obstructive pulmonary disease(lung disease causing restricted airflow and breathing problems), respiratory failure (a serious condition that makes it difficult to breathe on your own which develops when the lungs can't get enough oxygen into the blood), and generalized anxiety disorder(a mental disorder that causes people to experience excessive, uncontrollable, and irrational worry that interfered with their daily living).

During a review of Resident 1's History and Physical from the GACH (Generalized Acute Care Hospital) 1 H&P dated 8/29/2024, indicated Resident 1 is alert, cooperative, no distress.

During a review of Resident 1's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) dated 9/03/2024, the MDS indicated the resident ' s cognition (thought process) was intact. The MDS indicated Resident 1 is able to express idea and wants and make self-understood, able to understand others. Resident 1 does not have inattention and disorganized thinking. The MDS indicated Resident 1 does not hallucinate and does not have delusions.

During a review of Police Report dated 9/06/2024 and timed at 1:28 AM, indicated Responsible Party is the medical power of attorney of Resident 1 who is requesting to go to hospital.

During a review of Police Report dated 9/06/2024 and timed at 2:29 AM, documented Resident 1 short of breath and chest pain. Paramedics arrived and will transport.

During a review of Resident 1's GACH 2 records dated 9/6/2024 and timed at 2:33 AM, indicated Resident 1 presented to the GACH 2 emergency room with chest pain. Began 4 hours prior to arrival. Presents from nursing facility. Vitals signs are reviewed and are notable for the following: Tachycardia (fast heart rate more than 100), respiratory rate 24 (normal 12 to 20 breaths per minute), elevated D-dimer (a blood test that can indicate that a person has a blood clotting condition which can lead to serious health conditions, including stroke (a medical condition that occurs when there is a disruption to blood flow in the brain, causing brain cells to die). Resident 1 alert and oriented x4, moving all extremities, no drift, no neurological deficit.`

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Progress Notes dated 9/06/2024 and timed at 3:00 AM, documented by LVN (Licensed Vocational Nurse) 1, indicated, at around 12:30 AM Resident 1 ' s Emergency Contact [EC 1] walked through the facility ' s front door and stated that he wanted to drive Resident 1 to GACH 1. The Progress Notes indicated EC 1 was informed by LVN 1 that there was a process to follow to release resident. The Progress Note indicated that Resident 1 was not in any distress at that time. The Progress Notes indicated that EC 1 stated he was going to call the police, police called and arrived quickly. The Progress Notes indicated the police heard what was happening and said they could not do anything and asked EC 1 and Resident 1 if they could it wait until the morning staff arrived . The Progress Notes indicated EC 1 said no, so LVN 1 called the DON (Director of Nursing) and the Administrator, but was unreachable. The Progress Notes indicated LVN 1 placed a call to Resident 1 ' s Physician and was instructed to call the DON. The Progress Notes indicated that EC 1 and Resident 1 was provided with the Against Medical Advice [AMA] paper to sign, but Resident 1 refused to sign. The Progress Notes further indicated that EC 1 was on phone screaming and screamed Resident 1 ' s chest hurt, asked resident did her chest hurt and she said yes, 911 called immediately. During an interview on 9/12/2024 at 10:55 AM, EC 1 stated on 9/5/2024 between 10 PM to 10:30 PM he visited Resident 1 at the facility and observed Resident 1 in distress, crying, reporting chest pain and begging staff to transfer her to hospital. EC 1 stated he asked LVN 1 to transfer Resident 1 to the acute hospital or let EC 1 take Resident 1 to the acute hospital, but LVN 1 did not take any action and told him Resident 1 cannot be transferred to the acute hospital. EC 1 stated he called 911 emergency services and police came however they were not able to assist. EC 1 stated LVN 1 was unaware how to handle the situation. EC 1 stated that LVN 1 told him, she was new to the facility and already contacted the DON and ADM but did not receive any response. EC 1 stated they offered him the AMA papers to sign but he did not sign. EC 1 stated eventually around 2:30 AM Resident 1 was transferred to GACH 1. During an interview on 9/12/2024 at 11:32 AM, Resident 1 stated on 9/5/2024 starting 10:30 PM, she was having chest pain, hard time breathing, and crying and asked LVN 1 to transfer her to the acute hospital but LVN 1 told her she had to stay, and they cannot transfer her. During an interview on 9/12/2024 at 11:53 AM, LVN 1 stated she was assigned to care for Resident 1 on 9/5/2024, during the 11 PM to 9/6/2024 at 7 AM shift. LVN 1 stated she was from a Nursing Registry, and it was her first-time taking care of Resident 1. LVN 1 stated she was the only Licensed Nurse at the facility during the shift. LVN 1 stated that on 9/6/2024, at around 12 AM, EC 1 wanted to take Resident 1 to the acute hospital. LVN 1 stated Resident 1 also requested to go with him. LVN 1 stated based on her assessment Resident 1 was not on any distress that time. LVN 1 stated she was not aware of the protocol of the facility, and she was not aware how to handle the situation, so she texted the DON and ADM to get instructions. LVN 1 stated she could not recall the exact time but stated sometime before 1 AM 9/6/2024. LVN 1 stated she did not receive any response. LVN 1 stated she also contacted Resident 1 ' s Physician but was instructed to consult with the DON. LVN 1 stated she asked Resident 1 to sign the AMA form, but EC 1 did not sign. LVN 1 stated on 9/6/2024 around 2:30 AM, Resident 1 reported chest pain and that is the time she called 911 and transferred Resident 1 to the acute hospital. LVN 1 stated she received a text message around 5 AM from the DON after Resident 1 was transferred to the acute hospital. LVN 1 stated she did not create an SBAR and only documented under the progress notes. (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/12/2024 at 12:08 PM, LVN 2 stated if a resident reports chest pain, discomfort after assessing Resident will call 911 and transfer Resident to the hospital. LVN 2 stated the licensed nurse should document findings in the SBAR and create a care plan. During an interview on 9/12/2024 at 12:42 PM, the Director of Staff Development (DSD) stated if a resident ' s condition was an emergency, the LVN should assess the resident, inform the physician and the family to call 911 and transfer the resident to the acute hospital. The DSD stated the LVN should document the assessment and findings in the SBAR form. The DSD stated if the resident requests to leave the facility and is not under distress, the LVN will have the resident sign the AMA form, and if refused to sign the AMA form, the LVN will explain the risks and benefits of staying and leaving AMA. The DSD stated that two nurses would sign the AMA form before the resident can leave the facility. The DSD stated the DON is the one who is in charge of license staff to make sure staff are competent. During an interview on 9/12/2024 at 1:02 PM, DON stated on 9/6/2024 at 1:30AM, the DON stated he does not have any documentation that LVN 1 who was from a Nursing Registry had completed the facility ' s nursing competency checklist prior to working at the facility. The DON stated the facility provides annual competency for each licensed staff each year to make sure staff have enough knowledge to take care of the residents. There was no policy and procedure as well, for Staffing Competency. During an interview and record review of Resident 1 medical records on 9/12/2024 at 1:07 PM, the DON stated LVN 1 did not create an SBAR, which is a standard of practice for the facility.