

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  11/21/2024
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>46779</p> <p>Based on observation, interview, and record review, the facility failed to ensure certified nurse assistant (CNA) 3 was seated when assisting one of eight sampled Residents (Resident 2) during mealtime.</p> <p>This deficient practice had the potential to result in feelings of decreased self-esteem and self-worth for Residents 2.</p> <p>Findings:</p> <p>During a review of Resident 2's Admission Record indicated the facility originally admitted Resident 2 on 5/18/2016 and readmitted her on 9/10/2024 with diagnoses that included dementia (a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and hemiplegia (a condition that causes partial or complete paralysis on one side of the body).</p> <p>During a review of Resident 2's Initial History and Physical, dated 9/13/2024, indicated Resident 2 does not have the capacity to understand and make decisions.</p> <p>During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 9/14/2024, indicated Resident 2 was dependent with eating, oral hygiene, shower/bathe self, toilet hygiene, and chair/bed-to-chair transfer.</p> <p>During an observation on 11/18/24 at 12:43 PM, Resident 2 was observed seated on her bed in her room. CNA 3 was standing next to the head of the bed and facing the foot of the bed, on Resident 2 ' s right side. CNA 3 placed Resident 2 ' s meal tray onto the bedside table, located to the right of CNA 3. CNA 3 was observed standing and looking down at Resident 2 while feeding Resident 2.</p> <p>During an interview on 11/18/2024 at 12:44 PM, with CNA 3, CNA 3 stated standing over and feeding Resident 2. CNA 3 stated she should have obtained a chair and sat down next to Resident 2 so she could be at eye level with Resident 2 while providing feeding assistance.</p> <p>During an interview on 11/21/2024 at 1:06 PM, with the Director of Nursing (DON), the DON stated that staff should not stand over the resident while providing feeding assistance to preserve the resident's dignity.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure titled, Assistance with Meals, dated 4/2018, indicated Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example:</p> <p>a. not standing over residents while assisting them with meals.</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779</b></p> <p>Based on observation, interview and record review, the facility failed to accommodate the needs of three of three sampled residents (Resident 1, 9, and 45) by failing to ensure residents call light (a device used by residents to signal his or her needs for assistance) was within reach.</p> <p>These deficient practices had the potential for Resident 1, 9, and 45 not able to call the facility staff to ask for help or assistance.</p> <p>Findings:</p> <p>1. During a review of Resident 9's Admission Record indicated the facility admitted Resident 9 on 1/23/2024 with diagnoses that included dementia (a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and blindness of left eye.</p> <p>During a review of Resident 9's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 8/9/2024, indicated Resident 9 had severely impaired memory and cognition (ability to think and reason). The MDS indicated Resident 9 was dependent with oral hygiene, shower/bathe self, toilet hygiene, personal hygiene, and chair/bed-to-chair transfer.</p> <p>During a concurrent observation and interview on 11/18/2024 at 10:18 AM, with Certified Nursing Assistant (CNA) 4, observed Resident 9 lying in bed. The resident's touch pad call light (a touch pad call light enables individuals with limited movement to call for help) was observed tucked between the mattress and bed rail. CNA 4 stated Resident 9 was blind on the left eye and weak on both hands. CNA 4 stated Resident 9 would not be able to locate the call light and use the call light to call for assistance from facility staff.</p> <p>2. During a review of Resident 45's Admission Record indicated the facility admitted Resident 45 on 9/19/2024 with diagnoses that included dementia (a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and Parkinson ' s disease (a chronic brain disorder that affects movement, balance, and coordination).</p> <p>During a review of Resident 45's Initial History and Physical, dated 9/21/2024, indicated Resident 45 has the capacity to understand and make decisions.</p> <p>During a review of Resident 45's MDS, dated [DATE], indicated Resident 45 required substantial/maximal assistance with eating, oral hygiene, and personal hygiene, and was dependent with shower/bathe self, toilet hygiene, and chair/bed-to-chair transfer.</p> <p>During a review of Resident 45's Care Plan, dated 10/1/2024, indicated the Care Plan addressed assistance with activities of daily living and its intervention including placing call light always thing reach.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 11/18/2024 at 10:25 AM, with Resident 45, the resident was observed lying in bed with the touch pad call light placed at the top of the bed over the pillow. Resident 45 was observed with tremors (involuntary movement of one or more parts of the body) with his hands, and the resident was unable to lift arms over his head. Resident 45 stated he did not know where his call light button was.</p> <p>During a concurrent observation and interview on 11/18/2024 at 10:26 AM, the CNA 4, CNA 4 stated Resident 45's call light button was on top of the bed over his pillow and Resident 45 could not reach the call light button. CNA 4 stated call light should be within residents' reach so they could use it and asked for help for their needs and safety.</p> <p>During an interview on 11/21/2024 at 1:07 PM, with the Director of Nursing (DON), the DON stated the staff should put call light within residents' reach at all times to meet their needs and ensure their safety, especially emergent situation.</p> <p>47882</p> <p>3. During a review of Resident 1's Admission Record indicated the facility originally admitted Resident 1 on 3/24/2023 and readmitted on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - lung diseases that make it hard to breathe), anxiety disorder (a mental health condition that involves excessive and persistent feelings of fear, dread, and uneasiness), and generalized muscle weakness.</p> <p>During a review of Resident 1's MDS, dated [DATE], indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and or contact guard assistance as resident completes activity) with eating, partial/moderate assistance (helper does less than half the effort) with personal hygiene, dressing, and roll left and right, and dependent (helper does all the effort) with bathing and toileting.</p> <p>A review of Resident 1's Care Plan for risk for fall due to poor balance, weakness and poor safety awareness dated 3/27/2023, the care plan interventions included to keep the resident's call light within reach and answered promptly.</p> <p>A review of Resident 1's facility document titled Fall Risk Assessment, dated, 7/3/2024, and 9/27/2024, the document indicated Resident 1 was a high risk for fall.</p> <p>During a concurrent observation and interview on 11/18/2024 at 9:26 AM with Licensed Vocational Nurse (LVN) 3 in Resident 1's room, Resident 1 was in bed laying facing the left side of the bed with the resident ' s call light hanging on the right side of the bed the button pointing towards the floor, unreachable to Resident 1. LVN 3 stated, Resident 1 is able to use a call light, however, the call light needed to be reachable and not placed behind the resident. LVN 3 stated, as per policy, the call light should be within reach to call for assistance, especially for any type of emergency.</p> <p>During an interview on 11/19/2024 at 8:05 AM with the DON, the DON stated, residents call light should always be within reach as per policy. The DON stated, it is important for the call light to be within reach in order for residents to call for assistance and for any type of emergency such as a fall.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During review of the facility's policy and procedure (P&amp;P) titled, Answering Call Lights, dated 8/2017, indicated the call light will be placed within easy reach of the resident.</p> <p>During a review of the facility's P&amp;P titled, Answering Call Lights, dated 8/2017, the P&amp;P indicated; a) the purpose is to respond to the residents requests and needs when call lights are used, b) ensure when resident is in bed the call light will be placed within easy reach of the resident, and residents call light will be answered as soon as possible.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882</b></p> <p>Based on interview and record review, the facility failed to ensure an advance directive (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) and Physician Orders for Life Sustaining Treatment (POLST, a medical order form that tell medical staff what to do if you have a medical emergency and are unable to speak for yourself) was accessible in residents medical records (physical paper chart) for one of eight sampled residents (Resident 41).</p> <p>Resident 41's paper chart did not have a copy of the Advance Directive Acknowledgement and the original POLST.</p> <p>This deficient practice had the potential for Resident 41's medical treatment, provisions, to be delayed and/or not be carried out, according to the Resident 41's and/or Responsible Party's request during an emergency, which can negatively affect Resident 41's quality of care.</p> <p>Findings:</p> <p>During a review of Resident 41 ' s Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Dementia (a group of related symptoms associated with an ongoing decline of the brain and its abilities), seizures (a sudden burst of abnormal electrical activity in the brain that can cause temporary changes in a person's behavior, movements, feelings, and level of consciousness) , and urinary tract infections (UTIs) are common infections that affect the bladder, the kidneys and the tubes connected to them.</p> <p>During a review of Resident 41's History and Physical Examination (H&amp;P), dated 7/19/2024, indicated Resident 41 does not have the capacity to understand and make decisions. The H&amp;P indicated prognosis is from fair to serious.</p> <p>During a review Minimum Data Set (MDS, a resident assessment tool), dated 9/6/2024, indicated Resident 41's cognitive skills (ability to make daily decisions) was severely impaired. The MDS indicated Resident 41 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and or contact guar assistance as resident completes activity) with eating and required substantial/maximal assist (helper does more than half the effort) with personal hygiene, dressing, toileting, and bathing/showering.</p> <p>During a concurrent interview and record review, on 11/18/2024, at 12:01 PM, with Licensed Vocational Nurse (LVN) 4, Resident 41 ' s medical paper chart (Resident 41's medical records), (undated) was reviewed, the chart did not have a copy of Resident 41's advance directive and POLST. LVN 4 stated, it was the practice of the facility to ensure the advance directive and the POLST were in the physical paper chart, he did not know why it was not in Resident 41's chart. LVN 4 stated, it was important to have it in the chart so the nurses would know the care needed to provide in case of emergency, otherwise, it had the potential to delay the care.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review, on 11/18/2024, at 12:10 PM, with Registered Nurse (RN) 2, Resident 41's medical paper chart (Resident 41's medical records), (undated) was reviewed, the chart did not have a copy of Resident 41's advance directive and POLST. RN 2 stated, Resident 41's advance directive and the POLST should be in Resident 41's physical paper chart, it was the facility's protocol (rules or guidelines that everyone needs to follow to communicate or interact effectively). RN 2 stated, it was important that the advance directive and the POLST were in the physical paper chart so nurses can adhere to what care Resident 41 and/or the responsible party wanted in case of emergency, it was the first thing nurses checked during an emergency. RN 2 stated, not having the advance directive and the POLST in the physical paper chart can delay the process and/or affect Resident 41's quality of care.</p> <p>During an interview on 11/19/2024 at 8:05 AM with the Director of Nursing (DON), the DON stated, he expected resident's advance directive and POLST be in the resident's physical paper chart, it was the first item the nurses checked in case of emergency. DON stated, not having residents advance directive and POLST in the resident's physical paper chart had the potential to delay and/or negatively affect the resident ' s quality of care.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Advance Directive, dated 2/2017, indicated; a) the facility ' s copy of the advance directive must be filed in the resident ' s clinical record, b) the facility must document in a prominent part of the resident ' s clinical record whether the resident has issued an advance directive, and c) the facility will document provision of information for advance directive and will be maintained in the clinical record.</p> <p>During a review of the facility's P&amp;P titled, Physician Orders for Life Sustaining Treatment (POLST), dated 12/2016, indicated; a) a completed, fully executed POLST is a legal physician order, and is immediately actionable, b) once reviewed, the POLST should be copied, and the current original form placed in the front of the resident ' s chart, along with the resident ' s advance directive if he/she has one.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882</b></p> <p>Based on observation, interview, and record review, the facility failed to provide adequate supervision for two of two sampled residents (Residents 4 and 23) when:</p> <ol style="list-style-type: none"> <li>1. Resident 4, who was a high risk for fall, was observed in bed reaching for his drinks by the bedside table, without a floor mat as per plan of care to prevent injury from fall.</li> <li>2. Resident 23, who was a high risk for fall, and had a fall incident on 11/18/2024 in Room B (RB-not Resident 23's room) witnessed by a Resident in Room B (RRB), was not frequently monitored, or supervised as per plan of care.</li> </ol> <p>These deficient practices had the potential for to cause major injury from a fall and negatively affect Residents 4's and 23's quality of life.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of Resident 4 ' s admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included psychosis (symptoms that cause a person to lose touch with reality, or have a break in their thoughts and perceptions), anxiety disorder (a condition that causes excessive feelings of fear, dread, and worry that can interfere with daily life), and history of fall.</li> </ol> <p>During a review of Resident 4 ' s History and Physical, dated 7/30/2024, indicated Resident 4 does not have the capacity to understand and make decisions.</p> <p>During a review of Minimum Data Set (MDS, a resident assessment tool), dated 10/18/2024, indicated Resident 4 ' s cognitive skills (ability to make daily decisions) was severely impaired. The MDS indicated Resident 4 required partial/moderate assistance (helper does less than half the effort) with eating, substantial/maximal assist (helper does more than half the effort) personal hygiene and toileting, and dependent (helper does all the effort) with dressing and bathing.</p> <p>During a review of Resident 4 ' s facility document titled Fall Risk Assessment, dated 4/25/2024, 7/19/2024, and 10/21/2024, indicated Resident 4 was a high risk for fall.</p> <p>During a review of Resident 4 ' s care plan (CP) for risk for falls, injuries from falls related to history of falls, impaired safety awareness, revised 10/24/2024, the CP indicated Resident 4 had falls on 6/28/2023, 1/8/2024, and 3/11/2024, intervention included the use of left floor mat.</p> <p>During a concurrent observation and interview on 10/19/2024 at 10:20 AM with Licensed Vocational Nurse (LVN) 1 in Resident 4 ' s room, Resident 4 was lying in bed moving and reaching for his drinks on a bedside table left side of the bed, there was no floor mat next to the bed as per plan of care. LVN 1 stated, she was not aware Resident 4 was a fall risk and needed to have a floor mat next to the bed. LVN 1 stated, it was important to have a floor mat next to Resident 4 ' s bed in case of a fall it can minimize the potential for a major injury.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/19/2024 at 10:45 AM with Director of Nursing (DON), the DON stated, the facility did not implement the plan of care for Resident 4 to ensure there was a floor mat next to the bed. The DON stated, not having a floor mat next to the bed, for a high risk for fall resident, had the potential to cause major injury from a fall.</p> <p>2. During a review of Resident 23 ' s admission record indicated the resident was originally admitted to the facility on [DATE] with diagnoses that included psychotic disorder, anxiety disorder, abnormalities of gait and mobility (having problems with the way you walk or move around) and muscle weakness.</p> <p>During a review of Resident 23 ' s History and Physical, dated 10/4/2024, indicated Resident 4 does not have the capacity to understand and make decisions.</p> <p>During a review of the MDS, dated [DATE], indicated Resident 23 ' s cognitive skills was severely impaired. The MDS indicated Resident 23 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and or contact guard assistance as resident completes activity) with eating, partial/moderate assistance (helper does less than half the effort) personal hygiene, substantial/maximal assistance with dressing and toileting and dependent with showering/bathing.</p> <p>During a review of Resident 23 ' s CP for actual falls related to balance deficit, cognitive impairment, poor safety awareness, initiated 10/6/2024 and revised on 11/18/2024, indicated Resident 23 had a fall incident on 10/6/2024 in his room, 10/17/2024 in his room, and 11/18/2024 in Room B (RB) not his room. The CP indicated intervention initiated 10/6/2024 was frequent visual monitoring.</p> <p>During a review of Resident 23 ' s facility document titled SBAR Communication Form and Progress Note, dated 11/18/2024 timed at 6:45 PM, the document indicated Resident 23 had an unwitnessed fall in Room B at 5:40 PM out of his wheelchair and sustained a skin tear 1.5 cm x 1.5 cm on the right elbow and 1 cm x 0.8 cm on the right parietal area.</p> <p>During a review of Resident 23 ' s facility document titled Fall Risk Assessment, dated 10/6/2024, 10/17/2024, and 11/18/2024, indicated Resident 23 was a high risk for fall.</p> <p>During an observation on 11/19/2024 at 3:05 PM in front of the nurse ' s station by Resident 23 ' s room, Resident 23 on his wheelchair observed a small superficial skin tear on the forehead and the right elbow, Resident 23 was non-interview-able.</p> <p>During an interview on 11/19/2024 at 3:10 PM with Treatment Nurse (TN) 1, TN 1 stated, she was working the day of the fall incident on 11/18/2024, she was called to room B by the DON to do the skin treatment on Resident 23 ' s forehead and elbow, Resident 23 was already back on his wheelchair. TN 1 stated, she does not know who was monitoring Resident 23 and why Resident 23 was in another room.</p> <p>During an interview on 11/19/2024 at 3:20 PM with Registered Nurse (RN) 1, RN 1 stated, she was working the day of the fall incident on 11/18/2024, she was called to room B by the DON to help with the assessment, Resident 23 was already up on the chair. RN 1 stated, she does not know who was monitoring Resident 23 and why Resident 23 was in another room.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/19/2024 at 3:30 PM with Certified Nurse Assistant (CNA) 1, CNA 1 stated, he was working the day of the fall incident on 11/18/2024, he was called to room B by the DON, Resident 23 was already on the floor. CNA stated, the DON and himself assisted Resident 23 back in his wheelchair. CNA 1 stated, he does not know who was monitoring Resident 23, and added he was busy passing trays. CNA 1 stated, he does not know why Resident 23 was in room B, it is not his room.</p> <p>During an interview on 11/19/2024 at 3:40 PM with the DON, the DON stated, a family member in room B called that Resident 23 fell . DON stated, when he got there Resident 23 was on the floor lying on his right side and noted a skin tear on the forehead and the right elbow, he was the first nurse in the room. The DON stated, he does not know who was supposed to monitor Resident 23 and why Resident 23 was in room B.</p> <p>During a concurrent interview and record review, on 11/19/2024, at 3:50 PM, with the DON, Resident 23 ' s Electronic Health Records for the month of October and November was reviewed. The records did not indicate any type of documentation for frequent visual monitoring due to Resident 23 being high risk for fall. The DON stated, he cannot find any type of documentation of frequent visual monitoring for Resident 23, but he will initiate every hour monitoring and start a log. DON stated, no one seemed to be monitoring Resident 23 when had the fall, since a visitor was the one who saw him.</p> <p>During an interview on 11/20/2024 at 11:05 AM with Resident in Room B (RRB), RRB stated, she remembered Resident 23 ' s fall incident on 11/18/2024, a man in a wheelchair came in the room and tried to reach something on the floor and fell . RRB stated, there was no nurses/staff in the room.</p> <p>During an interview on 11/21/2024 at 8:15 AM with the DON, the DON stated, the facility does not have a policy for supervision, but residents should be supervised at least every hour especially for high fall risk residents to make sure they were safe and comfortable. The DON stated, not supervising high fall risk Residents had the potential to cause major injury from a fall.</p> <p>During a review of the facility ' s policy and procedure (P&amp;P) titled, Comprehensive Care Plan, dated 12/2016, indicated; a) comprehensive plan of care will include interventions to attempt to manage risk factors. , b) comprehensive plan of care will address the Resident ' s individual needs, and c) develop goals and approaches for each problem and /or condition that are realistic, specific, measurable, and include interventions/approaches that relate to each stated long and short term goal.</p> <p>During a review of the facility ' s P&amp;P titled, Fall Prevention Program, dated 12/2016, indicated; a) the facility will identify interventions related to the resident ' s specific risk and causes to try to prevent the resident from falling and to try to minimize complications from falling, b) if a resident is at risk for falls, it will be identified on the care plan, all precautions will be implemented to protect the resident according to the fall prevention and reduction program, and c) the care plan should include close observation and increased supervision.</p>		

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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)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>50203</p> <p>Based on observation, interview, and record review, the facility failed to attempt to use appropriate alternative interventions before the installation of bilateral 1/4 siderails (quarter bars that are attached to the side of the bed to help with safety and comfort) for one of four sampled residents (Resident 31).</p> <p>This failure had the potential for Resident 31 to be at risk for entrapment (when a resident can get caught by the head, neck, chest, or other body parts in tight spaces around the siderail) and physical injury.</p> <p>Findings:</p> <p>During a review of Resident 31 ' s Admission Record, the facility admitted Resident 31 on 6/22/2023 and readmitted Resident 31 on 12/28/2023 with diagnoses that included hypertensive heart (heart problems that occur because of high blood pressure over time) and chronic kidney disease (kidney damage over time) with heart failure (heart cannot pump enough blood to meet the body ' s needs) and muscle weakness (the muscle does not have enough strength to move normally).</p> <p>During a review of Resident 31 ' s History and Physical (H&amp;P, a comprehensive physician ' s note regarding the assessment of a resident ' s health status), dated 7/3/2024, Resident 31 does not have the capacity to understand and make decisions.</p> <p>During a review of Resident 31 ' s Minimal Data Set (MDS, a resident assessment tool), dated 9/27/2024, Resident 31 ' s cognition (a person ' s mental process of thinking, learning, remembering, and using judgement) was moderately impaired, was dependent (helper does all the effort and required two or more helpers for the resident to complete the activity) for transferring from bed to chair or toilet transfers, required moderate assistance (helper does more than half the effort) when moving from lying to sitting, and required moderate assistance (helper does less than half the effort) when rolling from side to side in bed. The MDS indicated that the bed rail was not in use.</p> <p>During a review of Resident ' s Order Summary Report (instructions that communicated the medical care that the resident received while in the facility), with an order start date of 07/02/2024, bilateral 1/4 siderails were placed for bed mobility and to assist Resident 31 in getting in and out of bed.</p> <p>During a review of Resident 31 ' s Side Rail/ Restraint/ Device Assessment, dated 10/02/2024, the assessment indicated Resident 31 had side rails for mobility aid to improve functional ability when in bed. The assessment indicated the alternates initiated included frequent monitoring, reminders to use call lights (a small button used to communicate with the nurses that a resident needed assistance), and restorative care (a program that focused on maximizing a resident ' s optimal level of function).</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 31 ' s care plan, revised on 10/19/2024, the care plan indicated Resident 31 used bilateral side rails when in bed for bed mobility. The care plan ' s interventions included re-assessing Resident 31 every three months or as needed for the use of side rails.</p> <p>During a review of Resident 31 ' s Consent for bilateral 1/4 siderails, dated 10/25/2024, the document indicated that Resident 31 had a fear of falling and the bilateral 1/4 side rails were placed with expected benefits including improved functional ability, reduced harmful behaviors, and increase mobility.</p> <p>During an observation on 11/18/2024 at 9:48AM in Resident 31 ' s room, Resident 31 was sleeping in bed with the bilateral 1/4 siderails up.</p> <p>During a concurrent observation and interview on 11/20/2024 at 8AM in Resident 31 ' s room, Resident 31 was lying in bed with the head of bed elevated and bilateral 1/4 side rails were up. Resident 31 stated, the side rails were up for my safety so nothing happens to me.</p> <p>During an interview on 11/20/2024 at 8:15AM with the Director of Nursing (DON), the DON stated that side rails may be used for residents who need assistance for mobility. The DON stated that residents would ask for side rails to assist with moving around in bed. The DON stated, if the side rails were used for mobility, and nursing staff were required to obtain a consent for the use of side rails. The DON stated, nursing would assess the resident to ensure resident safety while using side rails.</p> <p>During a concurrent observation and interview on 11/20/2024 at 3:30PM with the DON in Resident 31 ' s room, the DON stated Resident 31 ' s side rails were up. The DON stated that side rails could be a form of entrapment and can be a form of restraints (a device that limits a person ' s movement or actions).</p> <p>During a concurrent interview and record review on 11/20/2024 at 3:35PM with the DON, Resident 31 ' s Side rail/ Restraint/ Device Assessment, dated 10/2/2024, was reviewed. The Side rail/ Restraint/Device Assessment indicated the alternatives initiated prior to the use of side rails included frequent monitoring, reminders to use call light, and use of restorative care. The DON stated, no additional alternative interventions were implemented, prior to use of Resident 31 ' s side rails. The DON stated, Resident 31 ' s head, neck, and chest were not measured. The DON stated, the MDS nurse documented and completed the side rail/ restraint/ device assessment. The DON stated, the risk of not implementing appropriate interventions prior to installing side rails was that the immediate use of side rails could cause entrapment.</p> <p>During a review of the facility ' s policies and procedures (P&amp;P) titled Bedside Rail Assessment and Management, revised on 2/2017, the P&amp;P indicated the facility was to assess residents prior to implementation and use of bed/side rails to ensure appropriate protocols have been followed such as: the use of alternate methods have been attempts, the least restrictive measures were utilized, and ensure that the bed ' s dimensions were appropriate for the resident ' s size and weight. The P&amp;P indicated, the DON was responsible for implementing the bedside rail entrapment risk assessment.</p>		

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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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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882</b></p> <p>Based on observation and interview and record review the facility did not follow policy and procedure for Food Storage Principle, on food storage, and in accordance with professional standards for food service safety by failing to:</p> <ol style="list-style-type: none"> <li>1. Discard 15 ham sandwiches in a steel pan in the refrigerator with an expired used by date of [DATE].</li> <li>2. Label and date an open plastic bag with two hotdog buns in the refrigerator.</li> <li>3. Discard six breaded fish in an open plastic bag in the freezer with an expired used by date of [DATE].</li> <li>4. Label and date a pitcher of prune juice in the refrigerator.</li> </ol> <p>These deficient practices had the potential to result in food contamination, growth of microorganisms (disease causing organism) that could cause foodborne illness (food poisoning or food illness due to pathogens (harmful organism that cause illness such as bacteria, viruses, or parasites) and toxins that contaminate food and negatively affect the health of the residents who consumed it.</p> <p>Findings:</p> <p>During a concurrent observation and interview on [DATE] at 8:30 AM with the Dietary Service Supervisor (DSS) during an initial kitchen tour, observed:</p> <ol style="list-style-type: none"> <li>a) 15 ham sandwiches in a steel pan in the refrigerator with an expired used by date of [DATE].</li> <li>b) Two hotdog buns in a clear plastic bag in the refrigerator without a label and use by date.</li> <li>c) Six breaded fish in an open plastic bag in the freezer with an expired used by date of [DATE].</li> <li>d) A pitcher of prune juice in the refrigerator without a label and use by date.</li> </ol> <p>During the same interview, the DSS stated, foods in the kitchen should be labeled and with a use by date, also expired use by date food should be discarded immediately, not having label on the food and/or having an expired used by date foods, had the potential for foods to be old and/or contaminated and can negatively affect residents ' health who consumed it.</p> <p>During an interview on [DATE] at 8:05 AM with the Director of Nurses (DON), the DON stated, food in the kitchen should be labeled and with a current used by date as per policy, it was important so the kitchen staff would know when to get rid of it and not to be serve to the residents. The DON stated, it was important to follow these practices because, if not, it can cause food contamination, and cause food borne illnesses that can affect residents ' health.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility ' s policy and procedure (P&amp;P) titled, Food Storage Principle, dated ,d+[DATE], indicated; a) purpose is to preserve food quality before and after food is prepared, b)label each package, box, can etc. with the expiration date, date of receipt, or when the item was stored after preparation, c) discard foods that have exceeded their expiration date, and d) discard leftover foods that have not been used within 48 hours of preparation.</p> <p>During a review of the Food Code 2022, indicated ,d+[DATE].17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. Indicated READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES.</p>

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>47882</p> <p>Based on observation, interview, and record review, the facility failed to dispose garbage and refuse (food waste, scraps) properly by not covering one of one metal dumpsters (large trash container designed to be emptied into a truck) due to overflowing trash bags filled with garbage, and leaving additional trash bags, boxes, and an old mattress on the ground by the garbage area.</p> <p>This deficient practice had a potential to attract birds, flies, insects, pest, rodents, and possibly spread infection to residents and staffs in the facility.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 11/18/2024 at 10:55 AM with the Maintenance Supervisor (MS) in the facility's garbage area, one metal dumpster was observed with the lid open due to overflowing trash bags filled with garbage, and additional trash bags, boxes, and an old mattress on the ground by the garbage area next to the bin. The MS stated, the housekeeping supervisor was responsible of making sure the trash bin was empty, and the garbage area was clean. The MS stated, we were also responsible in making sure this area was clean, because these could lead to infestation of rodents, insects, and other pest that can negatively affect everyone in the facility.</p> <p>During an interview on 11/18/2024 at 10:58 AM with Dietary Service Supervisor (DSS), the DSS stated, the kitchen uses the same trash bin as the rest of the facility, it should be kept clean to prevent infestation of pest and rodents that could possibly get in the facility premises and negatively affect the health of the residents and staff.</p> <p>During an interview on 11/18/2024 at 11:00 AM with the Administrator (ADM), the ADM stated, the housekeeper was responsible to making sure the garbage area was clean, and she was not aware of the overflowing trash bin, with surrounding garbage and boxes. The ADM stated, she will address the trash in the garbage area immediately because it was a potential for pest and other insects ' infestation and can affect the residents and staff ' s health.</p> <p>During an interview on 11/18/2024 at 1:06 PM with the housekeeping supervisor (HS), the HS stated, she was responsible in making sure the garbage area was clean. The HS stated, she will request for an additional pickup date, and in-service all the staff to notify her and the administrator to request for a pickup when the trash bin is half full. The HS stated it was an infection control issue that could affect the health of everyone in the facility.</p> <p>During an interview on 11/19/2024 at 8:10 AM with the Director of Nursing (DON), the DON stated, it was not good to have an overflowing trash bin and garbage on the ground because it could attract pest, insects, and rodents, that could get inside the facility and cause infection to residents and staff.</p> <p>During a review of the facility ' s policies and procedures (P&amp;P) titled Dispose of Garbage and Refuse, dated 8/2017, indicated: a)all garbage and refuse will be collected and disposed of in a safe and efficient manner, b)ensure that the area surrounding the exterior dumpster area is maintained in a manner free of rubbish or other debris.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46779</p> <p>Based on interview and record review, the facility failed to maintain a complete and accurate medical records in accordance with the facility ' s policy and procedure (P&amp;P) titled, Documentation Guidelines, for two of four sampled residents (Resident 14 and Resident 50) by failing to:</p> <ol style="list-style-type: none"> <li>1. Ensure the Infection Preventionist document wound care treatment as provided to Resident 14 on 9/5/24. The IP stated she was covering for the treatment nurse and forgot to document it in the Treatment Administration Record (TAR).</li> <li>2. Document Resident 50 ' s discharge disposition (the location to which the resident was transferred to) in the resident ' s discharge record.</li> </ol> <p>These deficient practices had the potential to negatively impact the delivery of services to Resident 14 and had resulted in Resident 50 ' s discharge record to be inaccurate.</p> <p>Findings:</p> <p>1. During a review of Resident 14 ' s admission record indicated the facility originally admitted Resident 14 on 12/22/2021 and readmitted on [DATE], with diagnoses that included hemiplegia (a condition that causes partial or complete paralysis on one side of the body) and hypertension (high blood pressure).</p> <p>During a review of Resident 14 ' s History and Physical Examination (H&amp;P), dated 4/8/2024, indicated Resident 14 does not have the capacity to understand and make decisions.</p> <p>During a review of Resident 14's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 10/8/2024, indicated Resident 14 required setup or clean-up assistance with eating, and was dependent with oral hygiene, toileting hygiene, shower/bathe self, and personal hygiene. The MDS indicated Resident 14 had an unhealed stage four pressure ulcer (the most severe stage of a wound, where the damage extends through all layers of skin, reaching the underlying muscle, tendon, or bone).</p> <p>During a review of Resident 14 ' s Skin Weekly Assessment, dated 8/27/2024, indicated Resident 14 had a stage four pressure injury at right hip, measured 1.7-centimeter (cm, a unit of measurement) x 1.8 cm x 0.5 cm.</p> <p>During a review of Resident 14 ' s Physician Order, dated 9/3/2024, indicated the physician ordered treatment for the resident ' s right hip, started on 9/3/2024, as to cleanse with normal saline (a sterile solution of water and salt), pat dry, apply collagen (a substance that promote wound healing) then calcium alginate (a substance absorbs wound drainage and promote wound healing, covered with foam dressing every day shift for 21 days.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 11/20/2024 at 10:21 AM, with Treatment Nurse (TN) 1, Resident 14 ' s TAR dated 9/1/2024 to 9/30/2024, and the Progress Notes, dated 9/3/2024 to 9/17/2024, were reviewed. TN 1 stated the treatment for Resident 14 ' s right hip pressure injury on 9/5/2024 was not documented in the TAR and the Progress Notes. TN 1 stated she was off on 9/5/2024 and the licensed nurse who performed the treatment for Resident 14 should have documented on TAR. TN 1 stated it was important to document treatment on the TAR, so the other staff would know what and when the resident received the treatment.</p> <p>During an interview on 11/20/2024 at 10:40 AM, with the Infection Preventionist (IP) stated, the IP stated she was covering for TN 1, and she provided the wound treatment for Resident 14 on 9/5/2024, but she forgot to document it on the TAR and the Progress Notes. The IP stated it was important to document on the TAR after providing a wound treatment, so that the next shift nurse and other staff could know what treatment and when the treatment was provided to ensure consistency of the residents ' care.</p> <p>During an interview 11/21/2024 at 1:05 PM, with the Director of Nursing (DON), the DON stated the licensed nurses must document on the TAR after a wound treatment was provided to a resident because no documentation means it was not done. The DON stated it was important to document the administration of wound care treatment correctly to avoid confusion in the resident ' s care and to ensure consistency and continuation of care.</p> <p>During a review of the facility ' s P&amp;P titled, Documentation Guidelines, dated 11/2021, indicated the facility staff should document the name, dosage, and time of administration of all treatments. The P&amp;P indicated when the administration of treatment was not recorded, it will be presumed that the treatment has not been provided.</p> <p>49390</p> <p>2. During a review of Resident 50's discharge summary, dated 9/10/2024, the discharge summary indicated the Resident 50 was discharged to an assisted living facility.</p> <p>During a concurrent interview and record review on 11/21/2024 at 1:11 PM with Minimum Data Set Nurse (MDSN), Resident 50's Minimum Data Set (MDS-a resident assessment tool), dated 9/10/2024 was reviewed. The MDS indicated Resident 50 was discharged to a hospital. The MDSN stated, he made an error documenting the resident ' s discharge disposition and should have documented Resident 50 was discharged to an assisted living facility.</p> <p>During a review of the Facility's policy and procedure (P&amp;P) titled, Documentation Guidelines dated 11/2021, the P&amp;P indicated to record resident events accurately.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50203</p> <p>Based on observation, interview, and record review, the facility failed to implement the facility 's policy and procedure on infection control to prevent the spread of infection for 3 of 6 sampled residents (Resident 101, Resident 5, and Resident 39) by failing ensure Certified Nurse Assistant (CNA) 6 practice proper hand hygiene and wear gloves or gowns in Resident 5's contact precaution (a set of measures to prevent the spread of infectious agents through direct or indirect contact with individuals or an environment) room.</p> <p>These deficient practices had the potential to result in the spread of infection (a process when a microorganism, such as bacteria, fungi, or a virus, enters a person's body and causes harm).</p> <p>Findings:</p> <p>During a review of Resident 5's Admission Record, the facility admitted Resident 5 on 3/5/2021 and readmitted her on 10/4/2024 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD, a chronic lung disease causing difficulty in breathing), muscle weakness, and metabolic encephalopathy (a chemical imbalance in the blood that affects the brain).</p> <p>During a review of Resident 5's Minimal Data Set (MDS, a resident assessment tool), dated 8/6/2024, the MDS indicated Resident 5's cognition (a person ' s mental process of thinking, learning, remembering, and using judgement) was moderately impaired and required maximal assistance (helper does more than half of the effort) or dependent (the helper does all of the effort) for activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily) such as toileting hygiene, personal hygiene, dressing, and transferring from lying to sitting or from the bed to the chair.</p> <p>During a review of Resident 5's History and Physical (H&amp;P, a comprehensive physician's note regarding the assessment of a resident ' s health status), dated 10/4/2024, the H&amp;P indicated Resident 5 does not have the capacity to understand and make decisions.</p> <p>During a review of Resident 5's care plan, revised on 11/14/2024, the care plan indicated Resident 5 required contact precaution related to multi-drug-resistant organism (MDRO, a microorganism that was resistant to one or more classes of antibiotic or antifungal medications) infection. The care plan ' s interventions included providing education to Resident 5 that the providers and staff must follow contact precautions that included washing hands before and after entering and leaving the room, wearing gloves and gown during care activities.</p> <p>During a review of Resident 42's Admission Record, the facility admitted Resident 42 on 1/31/2024 and readmitted him on 10/14/2024 with diagnoses that included metabolic encephalopathy and an artificial opening of the urinary tract.</p> <p>During a review of Resident 42's MDS, dated [DATE], the MDS indicated Resident 42 ' s cognition was moderately impaired.</p> <p>(continued on next page)</p>		

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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	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 42's Order Summary Report, order start date on 10/25/2024, the report indicated Resident 42 had enhanced barrier precautions where the providers and staff must clean their hands, including before entering and when leaving the room.</p> <p>During an observation on 11/18/2024 at 11:03AM in front of Resident 5's room, there was a contact precaution sign posted by the doorway.</p> <p>During an observation on 11/18/2024 at 12:54PM in Resident 5's room, CNA 6 was inside Resident 5's room setting up her food tray and water cups without wearing a gown or gloves. CNA 6 was observed walking out of Resident 5's room without using alcohol-based hand rub or washing hands with soap and water and entered Resident 42 ' s room without using alcohol-based hand rub or washing her hands.</p> <p>During an interview on 11/18/2024 at 1:03 PM with CNA 6, CNA 6 stated, she walked into Resident ' s 5 room to deliver her lunch tray. CNA 6 stated, she did not recall seeing the contact precaution sign outside the door. CNA 6 stated, she did not use alcohol-based hand rub or was her hands with soap and water, and she did not wear a gown or gloves when walking into Resident 5 ' s room. CNA 6 stated, she did not recall practicing hand hygiene when she left Resident 5 ' s room to walk into Resident 42 ' s room. CNA 6 stated she should have worn gloves and gown before walking into Resident 16 ' s room and to practice hand hygiene before and after leaving a resident ' s room for patient safety as to not spread infections to other residents.</p> <p>During a review of the facility ' s policies and procedures (P&amp;P) titled, Transmission Based Standard, dated 6/2022, indicated the facility staff place signage that included instructions for the specific use of personal protective equipment (PPE, protective equipment that consists of gown, gloves, and masks to protect an individual from hazardous material) in a visible area outside the resident ' s room. The P&amp;P indicated the staff wears the appropriate PPE before entry into a resident ' s room placed on transmission-based precautions. The P&amp;P indicated for residents placed on contact precautions, staff should wear a gown and gloves for all interactions that may involve contact with the resident and the resident ' s environment.</p> <p>During a review of the facility ' s P&amp;P titled, Hand Hygiene, dated 8/2017, the P&amp;P indicated all employees who have direct resident contact will sanitize their hands between contacts with residents.</p>		

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50203</p> <p>Based on observation, interview, and record review, the facility failed to ensure resident ' s bedrooms measured at least 80 square feet (sq ft, a unit of measurement) per resident in multiple bedrooms for 12 of 16 rooms. Resident Rooms 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 14, and 15 measured less than 80 sq. ft per resident.</p> <p>This deficient practice had the potential to impact the ability to provide safe nursing care and privacy to the residents.</p> <p>Findings:</p> <p>During a review of the facility ' s Client Accommodation Analysis (CAA, a form used to identify the room sizes and number of beds in a room) form, dated 11/21/2024, the CAA form indicated 12 resident ' s bedrooms did not measure 80 sq. ft per resident as listed below:</p> <table border="1"> <thead> <tr> <th>Rooms</th> <th>Required</th> <th>Square Footage</th> <th>Square Footage</th> <th>Number of Beds</th> <th>Number of Residents</th> </tr> </thead> <tbody> <tr><td>2</td><td>160</td><td>155.68</td><td>2</td><td>2</td><td>2</td></tr> <tr><td>3</td><td>320</td><td>292</td><td>4</td><td>4</td><td>4</td></tr> <tr><td>4</td><td>160</td><td>155.68</td><td>2</td><td>2</td><td>2</td></tr> <tr><td>5</td><td>320</td><td>292</td><td>4</td><td>4</td><td>4</td></tr> <tr><td>7</td><td>320</td><td>292</td><td>4</td><td>4</td><td>4</td></tr> <tr><td>8</td><td>320</td><td>286.1</td><td>4</td><td>4</td><td>4</td></tr> <tr><td>9</td><td>320</td><td>292</td><td>4</td><td>4</td><td>4</td></tr> <tr><td>10</td><td>320</td><td>289.5</td><td>4</td><td>4</td><td>4</td></tr> <tr><td>11</td><td>320</td><td>292</td><td>4</td><td>4</td><td>4</td></tr> <tr><td>12</td><td>320</td><td>289.5</td><td>4</td><td>4</td><td>4</td></tr> <tr><td>14</td><td>320</td><td>286.1</td><td>4</td><td>4</td><td>4</td></tr> <tr><td>15</td><td>320</td><td>292</td><td>4</td><td>4</td><td>4</td></tr> </tbody> </table> <p>During an interview on 11/21/2024 at 9:50 AM with Resident 15 in Resident 15 ' s room, Resident 15 stated, the facility staff had enough room to care for him, and he had no issues with his room.</p> <p>(continued on next page)</p>	Rooms	Required	Square Footage	Square Footage	Number of Beds	Number of Residents	2	160	155.68	2	2	2	3	320	292	4	4	4	4	160	155.68	2	2	2	5	320	292	4	4	4	7	320	292	4	4	4	8	320	286.1	4	4	4	9	320	292	4	4	4	10	320	289.5	4	4	4	11	320	292	4	4	4	12	320	289.5	4	4	4	14	320	286.1	4	4	4	15	320	292	4	4	4
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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 11/21/2024 at 9:50 AM of rooms [ROOM NUMBER] with the Maintenance Supervisor (MS), the MS measured room [ROOM NUMBER], 7, and 11. The MS stated, room [ROOM NUMBER] was 155 sq. ft for two beds, room [ROOM NUMBER] was 292 sq. ft for four beds, and room [ROOM NUMBER] was 292 sq. ft for four beds.</p> <p>During an interview on 11/21/2024 at 9:50 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, she did not have any difficulty providing care for the residents for the abovementioned rooms. LVN 1 stated, the rooms had adequate room to move the resident with the wheelchair and to care for all four residents.</p> <p>During an interview on 11/21/2024 at 9:50AM with Certified Nurse Assistant (CNA) 5, CNA 5 stated, she did not have any issues caring for residents in the above mentioned rooms even those residents with the wheelchairs.</p> <p>During an interview on 11/21/2024 at 9:50 AM with Resident 41 in Resident 41 ' s room, Resident 41 stated, she did not have any issues with the space of her room.</p> <p>During the re-certification survey between 11/18/2024 and 11/21/2024, the above listed rooms had sufficient space for the residents ' freedom of movement. Each resident in the rooms listed above had individual bedside tables and over the bed tables. The rooms had adequate space to provide nursing care, privacy during care, and the ability to maneuver resident care equipment with the room. The room size did not present any adverse effect on the residents ' personal space, nursing care, and comfort.</p> <p>During a review of the facility ' s Room Waiver Request, dated 11/18/2024, the request indicated the Administrator (ADM) and the Director of Nursing (DON) will screen admissions and complete room rounds to ensure only the allowed capacity of residents were allowed in the rooms listed above. The Room Waiver Request indicated, the MS and the ADM inspected the rooms listed above to ensure that required medical equipment such as wheelchairs, guest chairs, and the Hoyer lift (a mechanical device used to lift and/or transfer a person) did not impact the delivery of care in the residents residing in the listed rooms.</p>