

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555609	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Glendale Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1208 S. Central Ave 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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop a person-centered care plan (a treatment plan that focused on the needs and preferences of a resident or individual) for one of two sampled residents (Resident 1) reviewed for anticoagulant (a medicine that prevented blood clots from forming in the bloodstream) and antiplatelet (a type of medicine that prevented platelets [a type of blood cell] from sticking together and forming a blood clot) medication by failing to implement a care plan for apixaban (also known as Eliquis, a type of medicine known as a blood thinner) and clopidogrel bisulfate (also known as Plavix, a medicine that prevented blood clots by making your blood cells [platelets] less sticky). These deficient practices had the potential for a lack of individualized care and to affect the quality of services provided to Resident 1. During a review of Resident 1's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), atherosclerotic heart disease of native coronary artery (when plaque [a waxy buildup of fat, cholesterol, and other substances] forms in the arteries that supply the heart muscle with blood) and other specified disorders of veins (medical conditions that impair the normal function of the body's veins, leading to symptoms like swelling, pain, discoloration, and potentially serious complications like blood clots). During a review of Resident 1's Order Summary Report dated 9/3/2025, the Order Summary Report indicated apixaban oral tablet 2.5 milligram (mg, unit of weight), one tablet to be administered by mouth two times a day for cerebrovascular accident (CVA [also known as a stroke], when blood supply to a part of the brain was suddenly cut off, causing brain cells to die) prophylaxis (PPX, prevention or protective treatment). During a review of Resident 1's Order Summary Report dated 9/3/2025, the Order Summary Report indicated clopidogrel bisulfate oral tablet 75 mg, one tablet to be administered by mouth one time a day for coronary artery disease (CAD, a condition where the heart's arteries become hardened and narrowed). During a review of Resident 1's Skin assessment dated [DATE], the Skin Assessment indicated the resident had skin discoloration on the inner right upper arm and the top of the resident's left hand. The Skin Assessment indicated the resident had skin discoloration to the right and left lower extremities. During a review of Resident 1's Comprehensive (complete) Care Plan dated 9/3/2025, there was no Care Plan initiated to indicate Resident 1 was on the medication apixaban. During a review of Resident 1's Comprehensive Care Plan dated 9/3/2025, there was no Care Plan initiated to indicate Resident 1 was on the medication clopidogrel bisulfate. During a review of Resident 1's History and Physical (H&P) dated 9/4/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 9/8/2025, the MDS indicated the resident had moderate cognitive impairment (a person was experiencing noticeable and significant difficulties with thinking, learning, remembering, and other cognitive skills that impact their daily life). The MDS indicated Resident 1 was receiving an anticoagulant and an antiplatelet medication. During a concurrent interview and record review on 9/16/2025 at 4:46 PM, with licensed vocational nurse (LVN) 1, LVN 1 stated Resident 1 did not have a resident specific care plan initiated for the use of apixaban. LVN 1 stated without a care plan, there would not be a goal or specific interventions regarding the use of the specific medication, and the facility could not provide specific care required for Resident 1. LVN 1 stated Resident 1 could potentially bleed out and die. During a concurrent interview and record review on 9/16/2025 at 4:48 PM with LVN 1, LVN 1 stated Resident 1 did not have a resident specific care plan initiated for the use of clopidogrel bisulfate. LVN 1 stated without a care plan, there would not be a goal or specific interventions regarding the use of the specific medication and the facility would be lacking care since care was not resident specific. LVN 1 stated Resident 1 could potentially bleed out and die. During a concurrent interview and record review on 9/16/2025 at 5:14 PM, the Director of Nursing (DON) stated Resident 1 did not have a resident specific care plan for apixaban. The DON stated the resident should have had an apixaban care plan because Resident 1 was receiving that medication and the resident was at risk for bruising and discoloration. During a concurrent interview and record review on 9/16/2025 at 5:17 PM, the Director of Nursing (DON) stated Resident 1 did not have a resident specific care plan for clopidogrel bisulfate. The DON stated the resident should have had a clopidogrel bisulfate care plan because Resident 1 was receiving that medication and the resident was at risk for bruising and discoloration. During a review of the facilities policy and procedure (P&P) titled Care Plans - Comprehensive Person-Centered dated 3/2022</p>		