

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555806	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/17/2024
NAME OF PROVIDER OR SUPPLIER  Glenbrook		STREET ADDRESS, CITY, STATE, ZIP CODE  1950 Calle Barcelona Carlsbad, CA 92009	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46982</p> <p>Based on interview and record review, the facility failed to ensure one resident ' s (Resident 1) written care plan for transfers was consistently implemented. Resident 1 had an unwitnessed fall while transferring into a chair.</p> <p>Findings:</p> <p>A review of the Admission Record for Resident 1 reflected Resident 1 was admitted to the facility on [DATE] with diagnoses that included: unspecified dementia (a condition of decline in thinking ability and memory); diabetic neuropathy (a severe condition caused by high blood sugar, and symptoms can include sensations of pain, numbness or burning, loss of balance or weakness).</p> <p>On 9/20/24 an unscheduled visit was made to the facility in response to a report of Resident 1 falling and fracturing her left wrist.</p> <p>On 9/20/24 at 12:10 P.M. Resident 1 was interviewed in her room. Resident 1 is sitting up in bed, with a clean cast on her left wrist. Resident 1 stated her arm and cast is very awkward, and needs extra care. Resident 1 stated she was still working with therapy as much as she could, since she wanted to be independent. Resident 1 recalled the incident: (The facility) was showing a movie and I wanted to see it. I was helped to the community room by the girl who was helping me and was going to lead the exercises for us. Resident 1 stated, they tell me that I reached back and missed the arm of the chair, and the girl was distracted and didn ' t make sure I got the arm of the chair. My hand slipped off and down I went. I guess neither of us did our job. I don ' t remember the fall, just that all of a sudden, I was on the floor.</p> <p>On 9/20/24 at 1:10 P.M. Certified Nursing Assistant (CNA) 2 was interviewed. CNA 2 stated Resident 1 walked with her walker until recently. Resident 1 now needs assistance for everything except eating, and gets around in a wheelchair pushed by staff. CNA 2 stated he would see Resident 1 walk with her walker and transfer herself without problems, it seemed ok. CNA 2 stated he has access to (any) resident care plan to review for changes or updates in care. CNA 2 stated he used the information from the nurses and other CNA ' s.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555806	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/17/2024
NAME OF PROVIDER OR SUPPLIER  Glenbrook		STREET ADDRESS, CITY, STATE, ZIP CODE  1950 Calle Barcelona Carlsbad, CA 92009	
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>On 9/20/24 at 1:30 P.M. CNA 3 was interviewed. CNA 3 stated Resident 1 was always walking with someone when CNA 3 saw her. Also, staff was there to remind her to reach back when sitting, or Resident 1 would forget. CNA 3 stated, without a reminder, Resident 1 would keep both hands on the walker and sit.</p> <p>On 9/20/24 at 1:50 P.M. a joint interview and record review was conducted. The Director of Therapy (DPT) was interviewed, and recent therapy notes (Physical Therapy Treatment Encounter Notes and Occupational Therapy Treatment Encounter Notes) dated 9/1/24 through 9/5/24, and 9/8/24 were reviewed. The DPT stated Resident 1 prior to her fall needed to be assisted by 1 person when walking and transferring for supervision, reminders, and light touching assistance, if needed, for her safety. The DPT also stated Resident 1 was not walking safe or transferring by herself, nor any other Activities of Daily Living, such as bathing, dressing, and undressing.</p> <p>On 9/20/24 Resident 1's record was reviewed. Resident 1's Occupational Therapy Treatment Encounter Notes dated 9/2/24 and 9/4/24 reflected that Resident 1 needed education and reminders to feel for the chair with the back of her legs, lock her walker brakes, and reach back before sitting to increase safety.</p> <p>On 9/20/24 the nursing note dated 9/11/24 timed, 5:59 P.M. was reviewed. The note reflected Resident 1 was found lying on the floor in the sunroom with her walker next to her. The CNA stated she walked to the sunroom with the resident before finding Resident 1 on the floor. The activities assistant stated she saw Resident 1 try to sit down and slip and fall to the floor.</p> <p>On 9/20/24 the Care Plan for Resident 1 was reviewed.</p> <p>The Focus of .Dementia reflected the staff are to provide cuing, and reorientation as needed.</p> <p>The Focus of .risk for falls or injury. noted prior falls on 8/10/24 and 8/12/24.</p> <p>On 8/13/24 the care plan was revised for staff to provide partial to maximum assistance with ADL ' s (bathing, dressing, transfers, etc.).Offer toileting every contact to resident to be able to assist and avoid the tempt [sic] of self-transferring to toilet.be at standby assist to prevent fall and injuries.</p> <p>The Focus of ADL self-care deficit . : Staff assistance is listed as: TRANSFER: the resident (1) requires limited assistance by (1) staff to move between surfaces.</p>		