STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555911	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Adventist Medical Center Dp/Snf	1509 Wilson Ter Glendale, CA 91206

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. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555911	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Adventist Medical Center Dp/Snf	1509 Wilson Ter Glendale, CA 91206

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	Based on interview and record review, the facility failed to ensure one sampled patient (Resident 1) received Keppra (seizure [uncontrolled shaking, loss of body movement, function, and consciousness] medication), when Resident 1 was placed on NPO (nothing by mouth) by the physician and there was no communication between staff and physician regarding Resident 1's alternatives to receiving the medication.This deficient practice may have contributed to Resident 1 having a seizure the following morning, when Resident 1 did not receive Keppra for over 12 hours.Findings:During a review of Resident 1's History and Physical (H&P), dated 6/27/2025, the record indicated Resident 1 was admitted to the facility with a history of glioblastoma (brain tumor with symptoms such as headaches, seizure, mood changes, and speech difficulty).During a review of Resident 1's Gastroenterology (physician who specializes in stomach and intestine conditions) Consultation, dated 7/21/2025, the record indicated Resident 1 had gastrointestinal (GI, stomach) bleeding. The record indicated a plan for Resident 1 to have a Computed Tomography (CT, strong x ray that takes a more detailed image) of the abdomen.During a review of Resident 1's Clinical Note Nursing, dated 7/22/2025, the record indicated Resident 1could not receive anything by mouth (NPO) and would have a CT of the abdomen. During a review of Resident 1's Discharge Summary, dated 7/22/2025, the record indicated Resident 1 had a GI bleed and was transferred to the hospital.During an interview on 8/12/2025 at 4:43 p.m. with Registered Nurse (RN) 1, RN 1 confirmed patients in this facility could have intravenous (IV, medications and fluids into the vein) access. RN 1 stated whatever unit the patient was in, the nurse should give the medication. RN 1 stated the nurse should communicate to the other nurse on handoff report the patient's history, such as seizure, their medications, and treatment.During a concurrent interview and record review on 8/12/2025 at 4:58 p.m. with Director of Nursing (DON), Resident 1's Electronic Medical Record (MAR), dated 7/22/2025, was reviewed. DON confirmed Resident 1 did not receive Keppra on 7/22/2025 at the scheduled time of 9:00 a.m. because Resident 1 was NPO for the CT abdomen. Resident 1's Keppra was scheduled to be administered twice a day at 9:00 a.m. and 9:00 p.m.During a concurrent interview and record review on 8/26/2025 at 3:47 p.m. with DON, Resident 1's Transfer/Discharge Medication Review & Order Sheet, dated 7/22/2025, was reviewed. The Transfer/discharged Medication Review & Order Sheet indicated Resident 1 had an physician order of Keppra intravenous (IV, into the vein) 750 milligrams (mg, a unit of measure) every 12 hours.During an interview on 8/28/2025 at 10:43 a.m. with Registered Nurse (RN) 2, RN 2 stated nurses can notify the doctor and change oral medications to IV. RN 2 confirmed seizure medications could be given in the facility. RN 2 stated if the medication was already ordered it should be given. RN 2 stated if a resident missed their seizure medication, the resident could show seizure like activity or symptoms. RN 2 confirmed it would have been appropriate to call the doctor and ask if an oral med could be given if a resident was NPO. During an interview on 8/28/2025 at 11:48 a.m. with DON, DON stated if a medication was due and the resident was not discharged (released), the medication would have to be given. DON stated nurses were expected to clarify orders. DON stated on 7/22/2025 at 5:08 p.m., Resident 1 had an order for Keppra IV. DON stated 1 the order was reviewed by pharmacy at 5:14 p.m. and by the nurse at 5:36 p.m. DON stated they already got the order which meant it was due to be given.During an interview on 8/28/2025 at 12:15 p. m. with DON, DON confirmed the Resident 1 transferred to the hospital on 7/22/2025 at 8:31 p.m., and Resident 1 last received Keppra on 7/21/2025 at 9:14 p.m. (more than 12 hours since Resident 1's last Keppra dose).During the same interview on 8/28/2025 at 12:15 p.m. with DON, DON acknowledged Resident 1 should have received Keppra because it was important. DON stated, Any medication order by the doctor should be received by the patient. DON stated if there was an issue with an order or medication, nurses were expected to clarify with pharmacy. DON confirmed there was no note from nursing to physician about medications, nor was there a note to clarify with pharmacy about the medication order. DON stated nurses were expected to document any interventions and communication with pharmacy and the physician, and if there was no documentation, it was not done.During a review of the facility's policy and procedure (P&P) titled, Person-Centered Care Planning, undated, indicated Roles and Responsibilities Nursing Staff: Lead assessments, monitor health status, communicate changes, implement interventions.During a review of the facility's policy and procedure (P&P) titled, Charting, undated, indicated Aspects of resident care such as observations and assessments, administration of medications, and services or treatments performed must be documented in the resident medical record according to company policy