STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056317	A. BUILDING _____ B. WING _____	**07/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GLENOAKS CONVALESCENT HOSPITAL	**409 W. GLENOAKS BLVD. GLENDALE, CA 91202**

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 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise and update the care plans for one of two sample residents (Resident 1) after a fall. This deficient practice had the potential for the residents to receive inadequate care and services not individualized to prevent further falls. Findings: A review of Resident 1's Record of Admission indicated the resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/18/19, indicated Resident 1 had no cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) impairment and required limited staff assistance, with staff providing guided support for transferring, and toilet use. A review of the facility's investigation summary of Resident 1's fall dated 7/10/19, indicated Resident 1 slipped and fell on [DATE]. A review of Resident 1's Fall Risk care plan dated 6/18/19, indicated Resident 1 was at risk for falls. There no documentation the Fall Risk care plan was revised after Resident 1's fall on 6/29/19. On 7/17/19, at 2:12 p.m., during an interview and concurrent record review of Resident 1's care plans, the Director of Staff Development (DSD) stated, the Fall Risk care plan was last revised on 6/18/19, and was not revised after the fall on 6/29/19, to prevent further falls and injuries. A review of the facility's undated policy and procedure titled, Fall policy and procedure, indicated the resident's care plan after a fall required to be updated to minimize falls and prevent injury.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.