STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555806	A. Building B. Wing	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenbrook	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)
F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on interview and record review the facility failed to ensure three of four sampled residents (Residents 2, 44 and 11) knew the location of the survey results binder.This failure had the potential to keep residents, family members, and visitors from easily reviewing the most recent survey results and the facility's plan of corrections, which were essential for making informed decisions about living at the facility.During an interview on 9/17/25 at 2:30 PM, three of four residents polled at the resident council meeting did not know the location of the survey results binder.During a concurrent observation of the facility and interview with the Administrator (ADM) on 9/17/25 at 4:37 PM. The ADM verified the three locations of the survey results binders and confirmed there was no sign at one of the sites in the facility indicating where to find it. ADM stated that the facility did not have a policy and procedure regarding posting and accessibility of survey results. A review of the State of California-Health and Human Services Agency, Attachment F Resident [NAME] of Rights, Section 72527 Skilled Nursing Facilities indicated .g) Examination of survey results. A resident has the right to (1) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents and must post notice of their availability.

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to initiate nonpharmacological or behavioral intervention before initiating antipsychotic medications (medication to treat psychosis [mental disorder characterized by disconnection from reality]) for two of five sample residents (Residents 31 and 49).This deficient practice had the potential for Resident 31 and 49 to receive unnecessary antipsychotic medication or inappropriate dose for behavioral treatment.Findings:1. A review of Resident 31's admission Record indicated the resident was readmitted on [DATE] with diagnoses which included Alzheimer's disease (a progressive brain disorder that causes memory and other cognitive decline), dementia (loss of mental function such as thinking, memory and reasoning skills), delusional disorders (false belief of reality), depression, mild cognitive impairment and disorientation.A review of Resident 31's History and Physical (H&P), dated 2/12/25, indicated Resident 31 was alert to person and not to place and time.A review of Resident 31's quarterly Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/11/25 Section C, Cognitive Pattern, indicated Resident 31's Brief Interview for Mental Status (BIMS) score was 10 out of 15 which indicated Resident 31 had moderate cognitive impairment. MDS section N, Medications, indicated Resident 31 was receiving antipsychotic medication.A review of Resident 31's Order Summary Report, indicated an active physician's order dated 2/28/25 for Olanzapine (generic name of medicine to treat schizophrenia [a severe brain disorder in which people interpret reality abnormally) tablet 2.5 mg (mg [milligrams-unit of dose]) to be given one tablet by mouth in the evening for psychosis manifested by paranoia that staff had conspiracy against her. A review of Resident 31's psychiatry notes dated 3/2/25 and 9/15/25, indicated to continue with Olanzapine 2.5 mg every evening. During an interview with the Director of Nursing (DON) on 09/17/25 at 9:47 AM. DON stated Resident 31 had no non-pharmacological or behavior intervention done before giving the Olanzapine medication. DON also stated, We are supposed to do that. During a concurrent interview and review of Resident 31's behavior monitoring sheet on 9/18/25 at 10:20 AM with Licensed Vocational Nurse (LVN 3). LVN 3 confirmed there that the behavior monitoring from 3/1/25 to 9/17/25 indicated no documented behaviors. A review of Resident 31's Medication Administration Record (MAR), from 3/1/25 to 9/17/25, indicated Olanzapine 2.5 mg was documented as given with no refusal recorded. During a concurrent interview and record review of Resident 31's progress notes on 9/18/25 at 3:20 PM with DON. DON confirmed no documentation of non-pharmacological or behavioral monitoring done before initiating the Olanzapine antipsychotic medication. DON also confirmed that the psychiatrist did not look at the nurse's behavior monitoring documentation when retaining or adjusting the dose of Olanzapine for Resident 31. 2. A review of Resident 49's admission Record indicated the resident was readmitted on [DATE] with diagnoses which included Parkinson's disease (neurological disorder that affects movement, balance and coordination), dementia and psychosis. A review of Resident 49's H&P, dated 1/31/25, indicated Resident 49 was alert and oriented to name only and did not have the capacity to make his own decision. A review of Resident 49's quarterly MDS dated [DATE], Section C, Cognitive Pattern, indicated Resident 49's BIMS score was 10 out of 15 which indicated Resident 49 had moderate cognitive impairment. MDS section N, Medications, indicated Resident 49 was receiving antipsychotic medication and no attempted gradual dose reduction was coded for Quetiapine Fumarate (generic name of medicine to treat mental disorder). A review of Resident 49's Order Summary Report indicated an active physician's order dated 1/31/25 for Quetiapine Fumarate tablet 25 mg. Take 25 mg by mouth at bedtime for hallucinations manifested by looking for his daughter because he was on plane and it was sinking and needed to evacuate. A review of Resident 49's new neurologist orders dated 5/14/25, indicated that Quetiapine Fumarate 0.5 mg tablet by mouth give one time a day for hallucinations. A review of Resident 49's MAR, from 7/1/25 to 9/17/25, indicated Quetiapine Fumarate was documented as given and no refusal was recorded. During an interview with the DON on 9/17/25 at 9:47 AM. DON stated Resident 49 had no non-pharmacological or behavior intervention done before giving the Quetiapine Fumarate medication. DON also stated, We are supposed to do that. During a concurrent interview and record review of Resident 49's behavior monitoring sheet on 9/18/25 at 10:25 AM with LVN 3. LVN 3 confirmed the behavior monitoring from 6/1/25 to 9/17/25 for Resident 49 indicated no documented behaviors. During a concurrent interview and record review with DON on 9/18/25 at 11:45 AM. DON was unable to find non-pharmacological or behavioral intervention prior to initiating Resident 49's Quetiapine Fumarate medication on his readmission on [DATE]. A review of the facility's policy and

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the Office of the Long-Term Care (LTC) Ombudsman (an advocate for residents of nursing homes) before discharge for two of four sampled residents (Resident 5 and 7). This deficient practice had the potential to leave residents unprotected from improper discharge and deny them access to an advocate for their options and rights.1.During a review of Resident 7's History and Physical (H&P), dated 9/2/25, the H&P indicated Resident 7 was sent to the hospital on 8/24/25, and came back to the facility on 8/30/25. During an interview with the SSD on 9/18/25, at 10:11 AM. She stated the facility must send written notification to the ombudsman when resident was discharged or transferred. Medical records staff must send the notification. During a concurrent interview and record review with the (MRD) on 9/18/25, at 10:21 AM, MRD confirmed there was no written notification of transfer sent to the ombudsman. A review of the facility's policy and procedure titled Record Content.Transfer and Discharge Notice dated October 2024, indicated,. Section III – 38 . A written discharge notice must be provided to the residents and resident representative with a copy to the State Long Term Care (LTC) Ombudsman at least 30 days prior to discharge or as soon as possible. The copy of the notice to the Ombudsman must be sent at the same time notice is provided to the resident and resident representative. 2.During a review of Resident 5's admission Record dated 9/18/25, the admission Record indicated Resident 5 was admitted on [DATE], due to a fall resulting in left femur fracture (a complete or partial break in a bone, often caused by excessive force, an accident, or repetitive stress). During a review of Resident 5's History and Physical (H&P), dated 9/18/25, the H&P indicated Resident 5 had the capacity to make his own healthcare decisions. During a review of Resident 5's Interdisciplinary Discharge Summary – Social Services, dated 9/11/25, the Discharge Summary indicated Resident 5 was discharged to home on 9/15/25, with a discharge reason of met functional goals. There was no documented evidence in Resident 5's clinical record regarding the notification of the Ombudsman. During an interview on 9/18/25, at 4:42 PM, with the Social Services Director (SSD), SSD stated that Medical Records held the responsibility for notifying the Ombudsman of discharges. SSD stated being unaware of the specific timing required for such notifications. During a concurrent interview and records review on 9/18/25 at 5:10 PM, with Medical Records Director (MRD), the facility's policy and procedure (P&P) titled, Transfer and Discharge Notice was reviewed. The P&P indicated, .a. a written notice of discharge must be sent to the resident and resident representative and a copy to the State LTC Ombudsman at least 30 days prior or as soon as possible. MRD stated that no specific timeframe to when the Ombudsman gets notified.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to properly identify and provide necessary assistive devices for repositioning for one of the sampled residents (Resident 27).This failure had the potential to cause accident and injury to Resident 27.During a concurrent observation and interview with Resident 27 on 9/16/25 at 9:28 AM, Resident 27 was observed holding on to the bedside drawer while turning to their side. Resident 27 expressed difficulty repositioning in bed. Resident 27 had been using the bedside table drawer to assist in turning to their side.A review of Resident 27's admission Records dated 9/18/25, indicated Resident 27 was admitted on [DATE].A review of Resident 27's History and Physical (H&P), dated 9/5/25, indicated a chief complaint of fall which resulted in right femur fracture (a complete or partial break in a bone, often caused by excessive force, an accident, or repetitive stress). The H&P also indicated Resident 27 had the capacity to make own healthcare decisions.A review of Resident 27's Minimum Data Set (MDS - a standardized assessment tool) Section GG - Functional Abilities dated 9/5/25, indicated Resident 27 needed substantial/maximal assistance for bed mobility. During an interview on 9/16/25 at 9:40 AM with Certified Nurse Assistant 1 (CNA1), CNA1 stated Resident 27 was assisted with repositioning every 3 to 4 hours. CNA 1 further stated that Resident 27 would grab bedside table drawer when turning. CNA1 stated that it was not safe practice, and it could cause injury to Resident 27.During an interview on 9/18/25 at 9:12 AM, Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated Resident 27 did not have assistive device for positioning.During an interview with the Director of Nursing (DON) on 9/18/25 at 12:40 PM, DON stated that staff were expected to monitor safety and report incidents to LVN, Registered Nurse, and DON to address residents' needs. The DON confirmed that Resident 27's use of the bedside drawer when turning was not reported, and Resident 27's need was not addressed.A review of the facility's policy and procedure (P&P) titled Accidents and Incidents - Investigating and Reporting Procedure, dated 7/22/19, indicated: 1. An incident/accident report may be completed for the following: .Inappropriate use of devices for residents.