STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055288	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Hills Health Care Center	430 N.Glendale Ave 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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 48219 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was treated with dignity and respect in accordance with the facility ' s policy and procedure (P&P), titled Quality of life - Dignity while being assisted by certified nurse assistant (CNA)1, and ensure CNA 1 did not come in contact with Resident 1 after Resident 1 reported an incident that happened on 11/24/24, on 11/25/24 to the Administrator, when the Administrator brought CNA 1 to her room on 11/25/24, to make CNA 1 apologize to Resident 1 in accordance to the facility ' s P&P titled Abuse Prevention Program, and Abuse, Neglect, & Exploitation Prohibition. These deficient practices resulted in Resident 1 verbalizing feelings of being embarrassed and upset, and had the potential to place Resident 1 at risk for further abuse. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to facility on 11/12/2022, with a diagnosis of diabetes (a disease that occurs when your blood sugar is too high) with diabetic neuropathy (a nerve problem that causes pain and numbness). During a review of Resident 1 ' s Minimum Data Set (MDS- a resident assessment tool) dated 9/12/2024, the MDS indicated the resident ' s cognition (mental processes) was intact. The MDS indicated Resident 1 required set up assistance (helper sets up, resident completes activity) with eating, oral hygiene, and personal hygiene. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) for upper body dressing. The MDS indicated Resident 1 required substantial/maximum assistance (helper does more than half the effort) with toileting hygiene, shower/bathing/ lower body dressing, and putting on/taking off footwear. During a review of Resident 1 ' s Care Plan, titled, Mood State, dated 9/12/24, the care plan indicated to identify situations that might cause mood problem, and to monitor persistent mood. During a review of Resident 1 ' s Care Plan, tilted Self Care Deficit, revised on 9/30/24, the care plan indicated that Resident 1 was totally dependent on staff for all Activities of Daily living (ADL: task of everyday life). The Care plan indicated to provide assistance needed to the resident including continent care (the support and assistance provided to people who have bladder or bowel problems, or who are experiencing incontinence). (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Care Plan, tilted Self-Care Deficit, revised on 9/30/24, the care plan indicated that Resident 1 was totally dependent on staff for all Activities of Daily living (ADL: task of everyday life). The Care plan indicated to provide assistance needed to the resident including continent care (the support and assistance provided to people who have bladder or bowel problems, or who are experiencing incontinence). During a review of Resident 1 ' s Care Plan, titled, Behavioral Symptoms, dated 10/4/24, the care plan indicated an approach to encourage Resident 1 to verbalize feelings and to provide support by allowing Resident 1 to express self, and to monitor for behavior. During a review of Resident 1 ' s Care Plan, titled Isolation/Infectious Disease, Resident is confirmed Coronavirus 2019 (COVID-19: respiratory illness), dated 11/21/24, the care plan indicated to place Resident 1 in isolation and to provide in-room activities of choice. During a review of Resident 1 ' s Physician Order, dated 11/21/24, the order indicated Resident 1 was COVID-19 positive, and required isolation (a set of infection control measures implemented to prevent the spread of infectious diseases from an infected patient to healthcare workers, visitors, and other patients. During a review of Resident 1 ' s Care Plan, titled Resident claims certified nurse assistant (CNA) made an inappropriate joke such as a CNA put hard boil egg to his private area, dated 11/25/24, the care plan indicated the approach was for the administrator to investigate, notify the police department, and notify department of health services. During a review of Resident 1 ' s Progress Notes, dated 11/25/24 at 3:46 PM, the Progress Note indicated that Resident 1 verbalized being upset with CNA 1 to the ADM, regarding an inappropriate comment made by CNA 1 about a hard-boiled egg. The Note indicated the incident occurred on 11/24/24 and Resident 1 was assured by the ADM that the ADM would conduct an investigation, interview staff involved and any witnesses and take appropriate steps to protect resident rights. During a review of Resident 1 ' s Resident Interview Questions, dated 11/25/24 to 11/28/24 conducted by the Administrator (ADM) and Director of Nursing (DON), the questions indicated the following general questions: 1. Are you needs being met in this facility? 2. Are your certified nurse assistants and licensed nurses taking care of you 3. Are you afraid of anyone? 4. Do you feel safe in this building? 5. Is there anyone among the staff that you especially trust and confide in? The questions did not integrate or address monitoring of the psychosocial aspect, such as mood or behaviors of Resident 1, so Resident 1 could verbalize feelings and outcome as a result of the specific incident on 11/24/24. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the Nursing Assignments (Direct Care), dated 11/29/24 for the 3 PM to 11 PM shift, the nursing assignment indicated CNA1 was assigned to Resident 1. During an interview with Resident 1 on 12/10/24 at 9:55 AM, Resident 1 stated CNA 1 refused to perform task, such as providing Resident 1 with a fresh gown or changing Resident 1 ' s brief (diaper) when requested. Resident 1 stated on one occasion on 11/24/24, Resident 1 hurried to her meal tray as the meal tray arrived, and CNA 1 stated loudly, can ' t you wait for me to bring your food? This is not a one -to- one (individualized care to a resident) facility, you are not the only one I am assigned to! Resident 1 stated CNA 1 told Resident 1 you should be lucky CNA 1 agreed to take this assignment, and that no one wants this room. Resident 1 stated crying a lot since being told by CNA1 that facility staff did not want to assist Resident 1. During this same interview, Resident 1 stated on that same incident, on 11/24/24, when her meal tray arrived, there was a hard-boiled egg on the meal tray. Resident 1 stated her hard-boiled egg rolled off the tray and landed on Resident 1 ' s bed. After the egg was placed back on the meal tray by CNA 1, Resident 1 stated CNA 1 repositioned Resident 1 in bed, and then the egg rolled off the meal tray again, but this time onto the floor. Resident 1 stated when CNA 1 picked up the egg from the floor, CNA 1 held the egg in front of the area of CNA 1 ' s genital area and CNA 1 asked Resident 1 what to do with the egg that landed on the floor. Resident 1 stated feeling the comment that CNA 1 made regarding the egg and holding it in front of his genital area made Resident 1 stated feel disrespected to be treated this way, embarrassed and afraid. Resident 1 stated reporting the incident on 11/25/24 to the Administrator (ADM). Resident 1 stated not reporting the facility staff on 11/24/24, the day the incident occurred, since she was afraid because the ADM and the DON were not in the facility. Resident 1 stated after reporting the incident to the ADM, no one came to speak to me regarding my feelings or preferences or addressed any concerns I had regarding CNA 1. During the same interview on 12/10/24 at 9:55 AM with Resident 1, Resident 1 stated after the incident on 11/24/24, CNA 1 came into Resident 1 ' s room to obtain Resident 1 ' s blood pressure and blood sugar, which Resident 1 stated was strange. During an interview on 12/10/24 at 10:29 AM with the Administrator (ADM), the ADM stated conducting an interview with CNA 1 regarding the incident on 11/24/24 between Resident 1 and CNA 1 in Resident 1 ' s room. The ADM stated CNA 1 told Resident 1 that no one wanted to go in this room to accept the assignment only because Resident 1 was on isolation precaution (a set of infection control measures implemented to prevent the spread of infectious diseases from an infected patient to healthcare workers, visitors, and other patients), due to Resident 1 being positive for Coronavirus 2019 (COVID-19: respiratory illness). The ADM stated after the incident between Resident 1 and CNA 1, the ADM did not discuss with licensed nurses (LN) to conduct any follow up monitoring on Resident 1, or to evaluate Resident 1 ' s mood or behaviors. During an interview on 12/10/24 at 11 AM with Resident 1, Resident 1 stated the ADM had not followed up with Resident 1 on how Resident 1 felt after the incident between her and CNA 1 on 11/24/24. Resident 1 stated facility staff did not ask Resident 1 about her feelings regarding the incident, or towards CNA 1. Resident 1 stated not wanting CNA 1 to be assigned to her, and that Resident 1 was upset. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with on 12/10/24 at 11:10AM with CNA 1, CNA 1 stated telling Resident 1 that everyone in the facility was scared to be assigned to Resident 1 ' s room, since the resident was COVID-19 positive. CNA 1 stated that Resident 1 rushes CNA 1, so CNA 1 stated telling Resident 1 that she was not his only resident in the facility, and not the only resident that CNA 1 was assigned to. CNA 1 stated a few days after the incident on 11/24/24, CNA 1 assisted licensed vocational nurse (LVN) 1 to obtain Resident 1 ' s blood pressure and blood sugar. During an interview on 12/10/24 at 1:30 PM with the ADM, the ADM stated not conducting an in service to licensed nurses regarding abuse after the 11/24/24 incident between Resident 1 and CNA 1. The ADM stated not informing LN ' s to monitor Resident 1 for depression or sadness or any other changes in mood or behaviors after Resident 1 verbalized the alleged abuse from CNA 1. During a review of the facility ' s policy and procedure (P&P) titled, Quality of life- Dignity, undated, the P&P indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. Residents are to be treated with dignity and respect at all times. The facility culture was one that supports and encourages humanization and individuation of residents, and honors resident choices, preferences, values, and beliefs. The P&P indicated that staff would speak respectfully to resident at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist resident by promptly responding to a resident ' s request for toileting assistance. During a review of the facility ' s undated policy and procedure (P&P) titled, Quality of life- Dignity, the P&P indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. Residents are to be treated with dignity and respect at all times. The facility culture is one that supports and encourages humanization and individuation of residents, and honors resident choices, preferences, values, and beliefs. Further stating that staff speak respectfully to resident at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs. Demeaning practices and standards of care that compromise dignity is prohibited. Staff are expected to promote dignity and assist resident by promptly responding to a resident ' s request for toileting assistance. During a review of the facility ' s undated P&P, titled Abuse Prevention Program, the P&P indicated to investigate and report any allegations of abuse, and to protect residents during the abuse investigations. The P&P indicated to identify and assess all possible incidents of abuse. The P&P indicated to implement changes to prevent future occurrences of abuse. During a review of the facility ' s policy and procedure (P&P) titled, Abuse, Neglect, & Exploitation Prohibition dated 12/1/18, the P&P indicated the purpose of the P&P was for each resident to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The P&P indicated for staff to integrate monitoring of staff and residents which were indicative of high stress levels that may lead to abuse. The P&P indicated that the facility would conduct an investigation of any alleged abuse and would investigate all patterns, trends or incidents that suggest the possible presence of abuse. The P&P indicated that the facility would protect residents from harm during the investigation and to ensure protection of the resident.

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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. 48219 Based on interview and Record review, the facility failed to ensure one of three sampled residents (Resident 1), who had a diagnoses of type 2 diabetes mellitus (a chronic condition where the body does not use insulin properly or does not produce enough insulin to regulate blood sugar levels) and required blood sugar checks, was provided with care and services by the licensed nurse (LN) in accordance to the facility ' s policy and procedure (P&P) titled Blood Glucose Test. This deficient practice had the potential for Resident 1 ' s blood sugar results to not be obtained properly and resulting in an inaccurate reading. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to facility on 11/12/2022, with a diagnosis of diabetes (a disease that occurs when your blood sugar is too high) with diabetic neuropathy (a nerve problem that causes pain and numbness). During a review of Resident 1 ' s Minimum Data Set (MDS- a resident assessment tool) dated 9/12/2024, the MDS indicated the resident ' s cognition (mental processes) was intact. The MDS indicated Resident 1 required set up assistance (helper sets up, resident completes activity) with eating, oral hygiene, and personal hygiene. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) for upper body dressing. The MDS indicated Resident 1 required substantial/maximum assistance (helper does more than half the effort) with toileting hygiene, shower/bathing/ lower body dressing, and putting on/taking off footwear. During a review of Resident 1 ' s care plan, titled Risk for hypo(low) /hyper (high) glycemia (blood sugar) related to diabetes mellitus, revised on 9/30/24, the care plan indicated goals for Resident 1 ' s blood sugar level would remain stable. The care plan indicated for blood sugar checks as ordered and to monitor for signs and symptoms of high blood sugar. The care plan indicated to check blood glucose (sugar), and if the blood sugar was below 70 milligrams per deciliter (mg/dL: a unit of measurement), and if the patient was unconscious (a state of being unable to respond to stimuli and a part of the mind that influences behavior or vital signs were absent), then administer Glucagon (a hormone that raises blood sugar) intramuscular (IM: a technique used to deliver a medication deep into the muscles)and call 911. During a review of Resident ' s 1 Medication Administration History, dated Friday 11/29/24 at 4:45pm, the Medication Administration History indicated Resident 1 had a blood sugar of 133mg/dL documented and electronically signed by licensed vocational nurse (LVN) 1. During an interview on 12/10/24 at 9:55AM with Resident 1, Resident 1 stated certified nurse assistant (CNA) 1 had performed her blood sugar check. Resident 1 stated feeling strange since she has never had a CNA obtain her blood sugars before but was afraid to say anything. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/10/24 at 11:10AM with CNA 1, CNA 1 stated on 11/29/24 he was asked by LVN 1 to perform Resident 1 ' s blood sugar check since LVN 1 was busy. CNA 1 stated conducting Resident 1 ' s blood sugar check, and stated it was his first time performing a blood sugar check. During an interview on 12/10/24 at 1:30PM with the ADM, the Administrator stated the facility ' s practices for blood sugar checks were only performed by LN ' s. The ADM stated CNA 1 should not have performed Resident 1 ' s blood sugar check on 11/29/24. During an interview on 12/10/24 at 2:00PM with the Director of Staff Development (DSD), the DSD stated only licensed staff could perform blood glucose checks. The DSD stated CNA1 should not have performed Resident 1 ' s blood sugar check. During a telephone interview on 12/10/24 at 2:40PM with LVN1, LVN1 stated asking CNA1 to obtain Residents 1 ' s blood pressure and blood sugar check. LVN1 stated Resident 1 was in isolation room (a set of practices that prevent the spread of germs in hospitals by creating barriers between people and germs), so while CNA 1 obtained Resident 1 ' s blood pressure and blood sugar, LVN 1 stood at the doorway of Resident 1 ' s room and monitored CNA 1. LVN 1 stated asking CNA 1 to perform the blood sugar check on Resident 1because Resident 1 was in isolation and LVN 1 was busy. During a review of the facility ' s policy and procedure titled, Blood Glucose Tests, dated 12/22/23, the P&P indicated the purpose of policy was to detect or monitor resident ' s blood glucose levels, evaluate findings, and determine appropriate interventions. The P&P indicated licensed nurse administers the test, records the results, communicates with the physician, documents the resident ' s condition, and coordinates and manages the diabetic resident ' s condition.