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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055523 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/05/2024 |
| NAME OF PROVIDER OR SUPPLIER Glendale Post Acute Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 250 N. Verdugo Road 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854</p> <p>Based on interview and record review, the facility failed to implement the facility ' s policy and procedure titled Abuse Prevention Program and Abuse Investigation and Reporting by failing to protect Resident 1 during an abuse investigation when Certified Nursing Assistant (CNA) 1, who matched the description of an alleged abuser as described by one of three sampled residents (Resident 1), was not prevented from coming in physical contact with Resident 1 after Licensed Vocational Nurse (LVN) 1 was already informed of the allegation of abuse on 5/31/24 at 7:30 PM.</p> <p>This deficient practice had the potential to cause further abuse and negatively affect the psychosocial well-being of Resident 1.</p> <p>Findings:</p> <p>A review of Resident 1 ' s admission record indicated the resident was admitted to the facility on [DATE] with diagnoses that included Parkinson ' s Disease (brain disorder in which there is a lack of the chemical messenger dopamine, which helps control muscle movement; leads to muscle stiffness, weakness, and trembling), abnormal gait and mobility, and lack of coordination.</p> <p>A review of Resident 1 ' s History and Physical (H&P), dated 5/25/2024, indicated the resident has the capacity to understand and make decisions.</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool), dated 5/29/2024, indicated the resident has intact cognition.</p> <p>A review of Resident 1 ' s Change in Condition Evaluation (CIC), dated 6/1/2024, timed at 9:58 AM, signed by Licensed Vocational Nurse (LVN) 1, indicated Resident 1 ' s Family Member (FM) 1, stated Resident 1 did not feel safe and FM 1 wanted to stay the night with Resident 1. The CIC also indicated FM 1 stated Resident 1 said a dark-skinned man with a baseball cap came into [Resident 1 ' s] room and rolled [Resident 1] over and started sticking something into [Resident 1 ' s] butt.</p> <p>During a phone interview on 6/4/2024 at 1:31 PM with FM 1, FM 1 stated at around 7:30 PM on 5/31/2024, Resident 1 stated that on 5/29/2024 at approximately 3:30 AM, a man who was dark-skinned and was wearing a baseball cap, assaulted him when the CNA inserted a plastic thing in his anus, grabbed his penis, and masturbated him. FM 1 stated she immediately informed LVN 1 on 5/31/2024, of what Resident 1 reported to her, including the description of the man.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During the same phone interview on 6/4/2024 at 1:31 PM with FM 1, FM 1 stated about 30 minutes after she informed LVN 1 on 5/31/2024, CNA 1 went inside Resident 1 ' s room and started cleaning Resident 1. FM 1 stated when CNA 1 went out of the room and Resident 1 informed her that CNA 1 was the alleged CNA that assaulted him. FM 1 stated CNA 1 was wearing a baseball cap. FM 1 stated she immediately ran out of the room and informed LVN 1.</p> <p>During an interview on 6/5/2024 at 9 AM with LVN 1, LVN 1 stated on 5/31/24 at around 7:30 PM, FM 1 informed him that Resident 1 stated he did not feel safe in the facility and that a dark-skinned person in a baseball cap came into his room and turned him over and began sticking something inside of his butt. LVN 1 stated upon hearing FM 1 ' s statement, he immediately called the Administrator (ADM), the Director of Nursing (DON), and the physician. LVN 1 stated 30 minutes after he was informed by FM 1, FM 1 came back to the Nursing Station and informed him that Resident 1 ' s current CNA is the person that Resident 1 was reporting. LVN 1 stated he immediately went to Resident 1 ' s room and he saw CNA 1 coming into Resident 1 ' s room with a urinary catheter (tube inserted through the urinary tract to drain urine into a bag) strap in his hands. LVN 1 stated he informed CNA 1 to not go back inside Resident 1 ' s room.</p> <p>During an interview on 6/5/2024 at 10:46 AM with CNA 1, CNA 1 stated he was assigned to Resident 1 when he worked on 5/29/24 during the 11PM to 7AM shift and on 5/31/24 during the 3PM to 11PM shift. CNA 1 stated on 5/31/24 at 8 PM, he went inside Resident 1 ' s room to clean Resident 1. CNA 1 stated he went out of the room to get some supplies, including a strap for Resident 1 ' s catheter, and as he was coming back to the room, LVN 1 stopped him and instructed him not to go back into the room. CNA 1 stated he wears a baseball hat when he works.</p> <p>During another interview on 6/5/2024 at 3:35 PM with LVN 1, LVN 1 stated he did not investigate and find out who the person that FM 1 and Resident 1 was pertaining to because the alleged incident occurred two nights ago. LVN 1 stated when he spoke to the ADM, he was not given instructions to investigate the alleged abuse. LVN 1 stated only the ADM investigates allegations of abuse.</p> <p>During an interview on 6/5/2024 at 4:24 PM with the ADM, the ADM stated the nursing staff are usually the first to hear the reporting of an alleged abuse and it is important for the nursing staff to conduct initial interviews and investigations of an alleged abuse to prevent reoccurrence. The ADM stated staff must immediately separate the resident from the alleged abuser. The ADM stated on 5/31/2024, CNA 1 was wearing a baseball cap when he was interviewed regarding the allegation of abuse.</p> <p>A review of the facility ' s Summary of Investigation, undated, indicated CNA 1 was wearing a baseball cap before being interviewed by ADM.</p> <p>During a separate interview on 6/5/2024 at 6:24 PM with the ADM, the ADM stated LVN 1 should have conducted the initial investigation of the allegation of abuse on 5/31/2024 at 7:30 PM. The ADM stated LVN 1 could have prevented CNA 1 from coming in physical contact again with Resident 1 after LVN 1 was informed of the allegation of abuse. The ADM stated Resident 1 could become traumatized if they come in contact again with an alleged abuser.</p> <p>A review of the facility ' s Policy and Procedure (P&P) titled, Abuse Prevention Program, revised 8/2021, indicated a part of the facility ' s abuse prevention is to protect residents during abuse investigations. The P&P also indicated the facility will protect residents from abuse by anyone, including facility staff.</p> <p>(continued on next page)</p> | | |

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| <p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>A review of the facility ' s P&P titled, Abuse Investigation and Reporting, revised 7/2017, indicated the administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented. The P&P also indicated the administrator will assign the investigation to an appropriate individual. The P&P also indicated the administrator will suspend immediately any employee who has been accused of resident abuse.</p> | | |