

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 07/12/2024
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48219</p> <p>Based on observation, interview, and record review, the facility failed to ensure a safe environment free of environmental hazards and provide adequate supervision to prevent accidents for one of three sampled residents (Resident 1).</p> <p>These deficient practices resulted in Resident 1 sustaining repeated falls, a total of two falls from 3/30/2024 to 7/10/2024 and was identified with injuries on one fall as follows:</p> <p>On 7/10/2024, Resident 1 fell in Shower room [ROOM NUMBER] and sustained 2 centimeters (cm) vertically X 0.5 cm head wound laceration (a deep cut or tear in skin or flesh). Resident 1 was transferred to the General Acute Care Hospital (GACH) via 911 emergency services on 7/10/2-24 and came back on the same day with five staples in the head.</p> <p>Findings:</p> <p>A review of Resident 1 ' s Admission Record indicated the facility admitted the resident on 1/21/2020 with diagnoses including dementia (impaired ability to think and remember interfering with doing everyday activities), wandering (to go from place to place usually without a plan or purpose), cervical disc disorder (age related wear and tear affecting the spine and neck).</p> <p>A review of Resident 1 ' s History and Physical dated 3/1/204, indicated Resident 1 lacked the capacity to understand and make decisions.</p> <p>A review of Resident 1 ' s Morse Fall Scale form (a rapid and simple method of assessing a patient ' s likelihood of falling) dated: 1/01/2023, 3/30/20224, and 7/10/2024, indicated Resident 1 had a history of multiple falls within the last six months and based on the answers to fall risk assessment is a high risk for falls.</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS - an assessment and screening tool) dated 5/4/2024, indicated the resident was able to make self-understood but able to do so with prompting. The MDS indicated the resident required supervision and contact guard assistance as resident completes activity with bed mobility, transfer, walking in the room, dressing, toilet use, and personal hygiene. The MDS further indicated Resident 1 has had falls since admission/entry or reentry to the facility.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1 ' s Interdisciplinary Resident Screen dated 7/12/2024, indicated Resident 1 required constant assistance for all functional mobility.</p> <p>A review of Resident 1 ' s care plan initiated on 1/31/2020 and re-evaluated on 04/03/2024, indicated Resident 1 was at risk for fall related to unsteady balance, weakness, impaired cognition, and use of antidepressant medication. The care plan goals indicated Resident 1 will not have any fall incident. The care plan interventions indicated to assist with ambulation and transfer as needed.</p> <p>A review of Resident 1 ' s Progress nursing note, dated 7/10/2024 at timed at 10:30 am, indicated Resident 1 had an incident of fall while in the Shower Room when the CNA (CNA1) assigned quickly went to the resident ' s room. Resident was found lying flat on the floor, crying, bleeding from back of head.</p> <p>A review of Resident 1 ' s Progress nursing note, dated 7/10/2024 timed at 1:14 pm, indicated Resident 1 had an incident of fall while in Shower room [ROOM NUMBER] when the CNA (CNA1) assigned quickly turned her back to get something in the linen cart. Resident 1 was found lying flat on the floor, crying, bleeding from back of head.</p> <p>A review of Resident 1 ' s emergency room notes from the GACH dated 7/10/2024, indicated Resident 1 presented to the Emergency Department (ED) after an apparent fall in the shower. Resident 1 was discovered in the facility's shower room after she had fell . The GACH ED clinical impression indicated the resident sustained a 6 cm laceration, requiring 5 staples.</p> <p>During an interview on 7/12/2024 at 4:05 pm with Quality Assurance (QA) Nurse, the QA nurse stated the incident occurred on 7/10/2024 at approximately 10:00AM. QA Nurse stated Resident 1 fell in Shower room [ROOM NUMBER] and was found lying on her back with her head towards shower. The QA Nurse stated CNA1 had turned her back from Resident 1 to get a towel from the linen cart. When CNA 1 turned her back, this is when Resident 1 fell to the ground. The QA Nurse stated staff should never turn their back to a resident who was assessed at high risk for falls. The QA Nurse stated Resident 1 had behaviors such as trying to stand on her own and staff turning their back on residents could lead to accidents and falls.</p> <p>During an interview on 7/12/2024 at 5:16 pm with CNA 3, CNA 3 stated Resident 1 was unsteady when walking and required her arm to be held and stand by assistance.</p> <p>During an interview on 7/15/2024 at 11:53 am with CNA 2, CNA 2 stated if she was assigned to a resident who was at high-risk for falls, CNA 2 would not leave the resident to get a towel. CNA 2 stated she would call for assistance and have some one else get the towel. CNA 2 stated that was the facility protocol for showering residents. CNA 2 stated the facility staff should not leave the resident alone because one never knows if the residents are going to get up and could lead to falls and injury.</p> <p>During an interview on 7/15/2024 at 12:03 pm with RN 2, RN 2 stated when showering a resident, the CNA should bring everything they need prior to taking the residents to the shower room. RN 2 stated the CNA should have their needed items within reach and should not leave residents unattended. RN 2 stated if the resident is left unattended the resident could fall and injure themselves.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/15/2024 at 12:15 pm with RN1 supervisor, stated Resident 1 had an unsteady gait and was at high risk for falls. RN 1 supervisor stated CNA 1 was trying to get a towel from the linen cart. RN 1 supervisor stated when showering a high- risk resident, the CNAs must never leave the resident unattended.</p> <p>During an interview on 7/15/2024 at 1:25 pm with LVN 1, LVN 1 stated knowing Resident 1, and that Resident 1 was a highly impulsive resident and high risk for falls. LVN 1 stated all staff were taught to not leave a resident unattended for safety and to prevent injuries during showers.</p> <p>During an interview on 7/16/2024 at 10 am, CNA1 stated Resident 1 stood up and fell on the floor of Shower room [ROOM NUMBER] when she turned her back to get a towel. CNA 1 stated she tried to prevent the fall, but Shower room [ROOM NUMBER] ' s floor was very slippery. CNA 1 stated she believed Resident 1 fell due to the floor of Shower room [ROOM NUMBER] being very slippery. CNA 1 stated she fears falling in Shower room [ROOM NUMBER] whenever she uses Showe room [ROOM NUMBER] for residents.</p> <p>During a concurrent observation of Shower room [ROOM NUMBER] and interview with CNA 1 on 7/16/2024 at 10:01 am, CNA 1, stated the whole floor and pathway to the exit in Shower room [ROOM NUMBER] was wet and slippery.</p> <p>During an interview on 7/16/2024 at 10:25 am, the current Maintenance Supervisor (MS 2) stated that he was not aware of the slipperiness of Shower room [ROOM NUMBER] floor tiles. MS 2 stated the tiles installed in this shower room were designed for showers. MS 2 stated that the previous maintenance supervisor (MS 1) had not brought this issue to his attention.</p> <p>During another interview on 7/16/2024 at 11 am, CNA 1 stated she had informed the maintenance supervisor of Shower room [ROOM NUMBER] being very slippery when wet. CNA 1 stated sometime in June 2024, she informed the maintenance supervisor of the hazard she noticed in Shower room [ROOM NUMBER]. CNA 1 stated she had almost slipped and fell herself in Shower room [ROOM NUMBER]. CNA 1 stated the maintenance supervisor informed her he would fix the issue.</p> <p>A review of the facility ' s current policy and procedure titled, Hazardous Areas, Devices and Equipment, revised July 2017, indicated it was the policy of the facility to ensure resident safety and reduce the risk of accidents hazards to the extent possible. The following identification of Hazards shall include but are not limited to Irregular floor surfaces. Assessment and analysis of hazardous areas and equipment will include resident - specific information including identification of vulnerable residents. Any element of the resident environment that has the potential to cause injury and that is accessible to vulnerable resident is considered hazardous. Interventions once identified will address the specific hazards identified and may be facility - specific or resident - specific with monitoring to ensure recommendation are implemented consistently and correctly.</p> <p>A review of the facility ' s current policy and procedure titled, Safety and Supervision of Residents revised July 2017, indicated it was the policy of the facility to ensure that the facility strives to make the environment as free from accidents and hazards as possible. Providing supervision and assistance to prevent accidents and resident safety are facility wide priority. Systems approach to safety indicated the facility - oriented and resident - oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly.</p> <p>(continued on next page)</p>		

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<p>F 0689</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 current policy and procedure titled, Bath, Shower/Tub revised February 2018, indicated it was the policy of the facility to promote cleanliness, and provide comfort to the resident. Guidelines including but not limited to staying with the resident throughout the bath/ shower and to never leave the resident unattended in the tub or shower. To use the emergency call signal for assistance, if needed.</p>