STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055523	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Post Acute Center	250 N. Verdugo Road Glendale, CA 91206

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48219 Based on interview and record review, the facility failed to ensure 3 of 3 sampled residents (Residents 2, 6, and 7) residing at the facility were free from sexual abuse (non- consensual [something is not agreed to by one or more of the people involved] sexual contact) from Resident 1, who had a diagnosis of Alzheimer ' s disease ((a brain condition that causes a progressive decline in memory, thinking, learning and organizing skills), by failing to: 1. Protect Resident 6 from nonconsensual sexual contact (any physical contact with another person of a sexual nature without effective consent) when Resident 1 grabbed Resident 6 ' s left arm and pulled down Resident 6 ' s sleeve on [DATE]. 2. Protect Resident 7 from nonconsensual sexual contact, in accordance with the facility ' s policy and procedures (P&P) on Abuse Prevention Program, when Resident 1 swiped his open palms across Resident 7 ' s breasts on [DATE], as witnessed by an unknown group of residents in the facility ' s Activity Room. 3. Protect Resident 2 from nonconsensual sexual contact when Resident 1 grabbed/cupped Resident 2 ' s left arm tightly and left breast with both hands, as witnessed by Housekeeper (HK) 1, on [DATE]. Resident 2 complained of pain when Resident 1 grabbed her left breast with both hands. 4. Protect and prevent further nonconsensual sexual contact of Resident 1 to other residents when the facility failed to develop a comprehensive, resident specific care plan on [DATE], in accordance with the physician order dated [DATE], to monitor Resident 1 ' s behavior episodes of mood disorder (a mental health condition that affects a person ' s emotional state of long periods of extreme feelings) of inappropriately touching females (residents and staff) in a sexual manner. 5. Ensure the Interdisciplinary Team (IDT - of professionals plan, coordinate and deliver you personalized health care) implement safeguards to prevent further potential sexual abuse, in accordance with the facility ' s policy and procedure on Abuse Prevention Program, when female facility staff reported having knowledge of Resident 1 ' s sexually inappropriate behaviors (for an unknown period of time) among female residents and staff such as grabbing arms, breasts, kissing, and asking for oral sex. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	6. Ensure to have a system in place to implement care plan interventions that are relevant to Resident 1 ' s behavioral needs, diagnosis and sufficient staff assigned to manage behaviors and effectively monitor/supervise the resident ' s whereabouts throughout the shifts to protect other female residents from non-consensual sexual contact, in accordance with the facility ' s P&P titled Behavioral Health Services. As a result, Resident 7 verbalized being in a state of shock after Resident 1 swiped his open palms across her breast on [DATE], and Resident 2 reported pain to the left arm and breast after Resident 1 grabbed her left breast with both hands on [DATE]. Resident 2 expressed feeling of sadness, embarrassed, upset, worried, and afraid that the incident of Resident 1 grabbing her by the arm and breast may happen again. Resident 6 verbalized being upset when Resident 1 grabbed her left arm and pulled her (gown) sleeve down. These deficient practices placed other female residents at risk for sexual abuse or non-consensual sexual contact from Resident 1 and cause psychosocial (covers a person's mental, emotional, social, and spiritual health) distress, physical injuries, hospitalization , and death. On [DATE] at 6:25 PM, while onsite at the facility, the California Department of Public Health (CDPH) identified an Immediate Jeopardy situation (IJ, a situation in which the provider ' s noncompliance [not following rules] with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) regarding the facility ' s failure to ensure Residents 2, 6, and 7 were free from non-consensual sexual contact against Resident 1. The survey team notified the Administrator (ADM) and the Director of Nursing (DON) of the IJ situation on [DATE] at 6:25 PM, due to the facility ' s failure to protect Residents 2, 6, and 7 against non-consensual sexual contact against Resident 1. On [DATE] at 1:40 PM, the Administrator (ADM) provided an acceptable IJ Removal Plan (a detailed plan to address the IJ findings). On [DATE] at 5:02 PM, while onsite and after the surveyor verified/confirmed the facility ' s full implementation of the IJ Removal Plan through observation, interview, and record review, and determined the IJ situation was no longer present, the IJ was removed onsite, in the presence of the ADM and the DON. The IJ Removal Plan included the following information: -On [DATE] at 9 AM, the facility ADM reported to CDPH an allegation of sexual abuse by Resident l towards Resident 2 manifested by inappropriate touching. -A changed of condition form was completed on [DATE], by a licensed nurse on Resident l and Resident 2 ' s records notifying their respective physician and responsible parties. -Resident 2 was evaluated by her primary physician on [DATE] with no new orders made. -Resident l and 2 were seen and evaluated by the psychiatrist (a medical practitioner specializing in the diagnosis and treatment of mental illness) on [DATE]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Resident 2 and 6 ' s psychology (the scientific study of the human mind and its functions, especially those affecting behavior) consult referral was made on [DATE], by the ADM and scheduled on [DATE] at 10 AM. -Resident l was placed under a one-to-one supervision and monitoring on [DATE] utilizing the one-to-one Observation daily monitoring form to document supervision and monitoring effective [DATE], to provide a safe environment for Resident 1 and other residents, indefinitely for two shifts (7 AM to 3 PM and 3 PM to 11 PM) while residents are awake and modified into 3 shifts (7AM to 3PM, 3 PM to 11 PM and 11 PM to 7 AM) on [DATE], until an appropriate placement is identified for the resident. -The one-to-one sitter [staff that are immediately at hand can help prevent a fall or redirect a patient from engaging in a harmful act] was written in the physician order on [DATE] indicating the one-to-one sitter for behavior monitoring and clarified physician order on [DATE] to reflect one-to-one sitter for monitoring and supervision for all shifts. The one-to-one sitter was indicated in the assignment sheet each shift and Resident l ' s care plan revision on [DATE]. -An in-service education was provided by the Director of Staff Development [DSD] on [DATE], surrounding one-to-one sitter as intervention for Resident 1 to nursing staff. -The Social Service Director [SSD] conducted a visit to Resident l on [DATE], to provide psychosocial support (a type of support that helps people meet their mental, emotional, social, and spiritual needs). -The SSD conducted a visit to Resident 2 and 6 on [DATE], to provide psychosocial support and identify any psychosocial distress (unpleasant emotions) or concerns with no other findings noted. - The SSD completed a wellness visit with Resident 2 at bedside noting resident resting in bed with appropriate affect and a clearer thought content and direct eye contact than previous day and offered psychological support. -Resident 6 was reassessed by a licensed nurse on [DATE], for any signs of psychosocial distress from an incident that happened on [DATE], and noted resident feel safe, happy and no other concerns identified at this time. -Resident 6 ' s allegation of physical altercation towards Resident l on [DATE], was reported to CDPH, ombudsman (serves as an advocate for patients and help settle complaints within an organization/facility) and law enforcement by the facility ADM. -Resident 6 and 1 ' s allegation of physical altercation reported on [DATE], was again reviewed by the new facility ADM on [DATE] surrounding interviews, investigations and conclusions. -Resident 7 is no longer a resident of the facility and expired on [DATE]. The facility ADM initiated review of the previous investigation records on [DATE], and unable to locate written facility interviews and summaries. -Resident l ' s plan of care was reviewed and updated on [DATE], by a licensed nurse to reflect current needs and action plan surrounding the resident ' s behavior. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-The IDT met with Resident 1 ' s responsible party with the following attendees: Interim Director of Nurses (DON), ADM, SSD, DSD to discussed resident ' s plan of care with emphasis on the on-to-one sitter for supervision and monitoring in all shifts and family agrees with the resident ' s plan of care. An in-service education was provided by the DSD to nursing staff regarding Resident I ' s plan of care. -Resident 2 and 6 ' s plan of care was reviewed and updated by a licensed nurse on [DATE] to reflect current needs and plan surrounding previous allegation of abuse incidents on [DATE] and [DATE]. -A Quality Performance Improvement (QAPI) was developed surrounding Abuse Management on [DATE] at 1 PM that will include the IJ received on [DATE], with emphasis on inappropriate touching towards female residents by a male resident. -The IDT members conducted an interview and observation to all 57 female residents on [DATE] to [DATE], utilizing the Resident Centered Care Room Rounds tool regarding potential concerns surrounding abuse with emphasis on inappropriate touching and or sexual inappropriateness from a male resident and no other concerns identified. -The ADM and the DSD conducted an interview with the facility staff to identify any information surrounding potential residents affected by Resident I ' s behavior of inappropriate touching with no identified concerns noted on [DATE] to [DATE]. - A Resident Council Meeting was conducted and attended by 12 residents including the resident council president by the Regional Nurse Resource on [DATE] at 2:15 PM, with no concerns identified surrounding abuse with emphasis on inappropriate touching. -The DSD provided the initial in-service education to nursing staff (Certified Nurse Assistants and Licensed Nurses) on [DATE] and [DATE] regarding Abuse prohibition and Management. The In-service re-education will continue until 100% is achieved by [DATE]. The IDT with the involvement of the Medical Director reviewed the abuse investigation process to include internal guideline procedures ensuring that the Residents are free from any type of abuse such as sexual, mental, financial, isolation, neglect and misappropriation of properties on [DATE] to be effective immediately. -The IDT and the Medical Director discussed the abuse investigation process to include internal guideline procedures ensuring that the Residents are free from any type of abuse such as sexual, mental, financial, isolation, neglect and misappropriation of properties during the Emergency Quality Assurance Committee meeting on [DATE]. -The Abuse investigation process Internal guideline in-service was provided by the DSD on [DATE] to the nursing staff to be made aware of such procedure -The IDT will review all residents upon admission/re-admission during clinical meetings Mondays to Fridays to identify any existing behaviors/conditions that may affect other residents and develop plan of care interventions surrounding supervision, monitoring and medication management that provides resident psychosocial needs and wellbeing. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-The Department Managers will conduct a Resident Care Room Rounds utilizing the Resident Care Room Rounds form daily Monday to Friday and will discuss findings during daily stand-up meeting. - The licensed nurses will conduct verbal huddle endorsement daily at the start of each shift with licensed nurses and Certified Nurse Assistants (CNAs) and as needed to discuss and identify any potential concerns surrounding abuse prohibition that may potentially affect other Residents. -The ADM and/or Designee will conduct random observation rounds weekly and as needed to validate compliance on abuse prevention and management. -The SSD and or Social Service Assistant [SSA] will conduct resident council meeting monthly and as needed replacing the current Activity department presiding the meeting in-order that the SSD will have a direct engagement and communication to the resident on any feedback being gathered during the meeting and to validate and identify further opportunities surrounding abuse prohibition and signs of being affected by other residents' behaviors. An invite will be provided to any families acting as responsible parties willing to attend pending approval by the Resident council president. Any findings during resident council meetings will be shared with the facility administrator and/or Designee for further follow-up. -The SSD is made aware of the new expectations of conducting the Resident Council meeting monthly and as needed on [DATE], provided by the Regional Resource Nurse. Monitoring was put in place to sustain compliance. Findings: 1. During a review of Resident 1 ' s Admission Record [AR] indicated the facility admitted the resident on [DATE], with a diagnosis of Alzheimer ' s Disease. During a review of Resident 1 ' s Change of Condition [COC] evaluation dated [DATE], indicated Resident 1 was having episodes of Inappropriate sexual behavior towards the staff. During a review of Resident 1 ' s Care Plan dated [DATE], indicated a care plan was developed on Resident 1 ' s episodes of inappropriate sexual behavior (did not indicate specific sexual behavior) toward staff. The care plan interventions included was to assign a male CNA to reduce behavior episodes, monitor for episodes of inappropriate sexual behavior towards staff. During a review of Resident 1 ' s Order Summary Report dated [DATE], indicated to monitor behavior episodes of grabbing random things and staff every shift. During a review of Resident 1 ' s History and Physical [H&P - a comprehensive physician ' s note regarding the assessment of the patient ' s health status) dated [DATE], indicated the resident did not have the capacity to understand and make decisions. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 1 ' s Minimum Data Set (MDS; a care assessment screening tool) dated [DATE], indicated the resident had severely impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated the resident required supervision or touching assistance providing verbal cues while assisting resident to complete activities of daily living (eating, oral hygiene, toileting hygiene, showering and bathing). During a review of Resident 1 ' s COC evaluation dated [DATE], indicated Resident 1 had altercation becoming verbally and physically aggressive pulling at the sleeves of a female resident [Resident 6]. During a review of Resident 1 ' s care plans dated [DATE], the care plan indicated the resident ' s physical behavior and poor impulse control (difficulty controlling actions or reactions) as evidenced by Resident 1 grabbing sweater sleeve of female resident and pulling it down. The care plan interventions included to intervene prior to agitation escalating (increasing rapidly) and to walk calmly away. During a review of Resident 1 ' s COC evaluation dated [DATE], the COC evaluation indicated Resident [1] brushed his arm against another resident ' s chest. The COC evaluation indicated the physician recommended for the resident to be followed by social service, Psychologist and Psychiatrist. During a review of Resident 1 ' s care plan dated [DATE], the care plan indicated Resident 1 brushing his arm against another resident ' s chest, with interventions included, for staff to closely monitor Resident 1 for inappropriate behaviors such as inappropriate grabbing, touching, brushing, kissing, hugging and other behaviors that may be deemed inappropriate. During a review of Resident 1 ' s Psychiatric Follow up note dated [DATE], the Psychiatric Follow up note indicated Resident 1 had an adjustment disorder [a recognized short-term health condition that occurs when one goes through a change in life and has difficulty adjusting to it], with disturbance of conduct - inappropriate sexual advances towards women. During a review of Resident 1 ' s Order Summary Report for [DATE], indicated a physician order dated [DATE], to monitor Resident 1 ' s behavior episodes of mood disorder (a mental health condition that affects a person ' s emotional state of long periods of extreme feelings) which indicated touching females sexually inappropriately and count/document every shift for Trileptal (mood stabilizer medication) usage. During a review of Resident 1 ' s COC evaluation dated [DATE], the COC evaluation indicated Resident 1 had episodes of inappropriate behavior of touching another resident's hand and breast. The COC Evaluation findings suggested that the resident had the ability to understand and follow simple instructions but due to Alzheimer ' s disease shows unpredictable behavior. During a review of Resident 1 ' s care plan dated [DATE], the care plan indicated Resident 1 had episodes of inappropriate physical behavior of touching left hand and breast of another resident. The care plan interventions included to inform the responsible party of Resident 1 ' s behavior, monitor behavior every shift, and report to the physician, if persistent. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 1 ' s Order Summary Report for [DATE], indicated a physician order dated [DATE], to monitor behavior episodes of mood disorder which included touching females sexually inappropriately, every shift. 2. During a review of Resident 7 ' s AR indicated the facility admitted the resident on [DATE], with diagnoses that included radiculopathy (pinched nerves which cause pain, weakness and numbness). During a review of Resident 7 ' s H&P dated [DATE], the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 7 ' s MDS dated [DATE], the MDS indicated the resident was cognitively intact. During a review of Resident 7 ' s Police Report dated [DATE], the Police Report indicated the police officer ' s interview with Resident 7 while in the facility, on [DATE]. The Police Report indicated that according to Resident 7, Resident 1 was known to be touchy-feely (touching and holding people more than usual, often in a way that makes other people uncomfortable), explaining that Resident 1 grabs female residents by the hand, including herself (Resident 7), and tells them he loves them. The Police Report indicated Resident 7 verbalized Resident 1 has Alzheimer ' s disease but has periods of reality. The Police Report indicated Resident 7 stated that on [DATE], while she was in the Activity group, Resident 1 swiped his open palm across her breasts. The Police Report indicated Resident 7 verbalized being in shock, including the other residents who were present in the Activity group and witnessed Resident 1 swiping his open palm across Resident 7 ' s breasts. The Police Report further indicated, Resident 7 stated she was in the facility for her Physical disability [any physical limitations or disabilities that inhibit the physical function] and is in complete control and awareness of her mental faculty [the abilities or capacities of the mind, including the ability to think clearly, reason, and understand]. 3. During a review of Resident 2 ' s AR indicated the facility admitted the Resident on [DATE], with diagnoses that included cerebral infarction (blood flow to brain is blocked causing tissue death). During a review of Resident 2 ' s H&P dated [DATE], indicated the resident had the capacity to understand and make decisions. During a review of Residents 2 ' s MDS, dated [DATE], indicated the resident was cognitively intact (has sufficient judgment, planning, organization, self control and able to manage the normal demands of environment). During a review of Resident 2 ' s Social Service [SS] Note dated [DATE], timed at 6:58 PM, the SS note indicated the resident appeared to still be upset regarding the incident with Resident 1. The SS Note indicated while Resident 2 was on her way to a smoke break, Resident 1 followed her in his wheelchair, took her by the arm and grabbed/cupped her left breast. The SS Note indicated Resident 2 stated he should not have done that and that she told him Please don't do that. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of the facility ' s written Final Investigation Report regarding Resident 1 and Resident 2 ' s sexual abuse allegation, (undated), signed by the facility ' s ADM. The Report indicated that on [DATE], HK 1 witnessed Resident 1 touched [Resident 2 ' s] left breast while in the facility ' s hallway. The Report indicated HK 1 told Resident 1 to stop. The Report indicated HK 1 reported the incident to the charge nurse. The Report indicated Resident 1 denied Resident 2 ' s allegations and instead stated that Resident 2 was the one who put Resident 1 ' s hand on Resident 2 ' s breast. The Report indicated a one-to-one sitter was assigned to Resident 1 on [DATE] (two days after Resident 2 ' s allegation of inappropriate touching was made against Resident 1). The Report indicated the facility would continue to monitor Resident 1 ' s behaviors. During a review of Resident 2 ' s SS Note dated [DATE] timed at 10:32 AM, the SS Note indicated a Follow up wellness visit [a visit from a professional to detect potential concerns early] to Resident 2 indicated the resident was doing well but the incident left her feeling embarrassed. 4. During a review of Resident 6 ' s AR, the AR indicated the facility admitted the resident on [DATE], with diagnoses that included history of ischemic attack (mini stroke) and cerebral infarction (a stroke that results in death of brain tissue). During a review of Resident 6 ' s Health Status Note dated [DATE], the Note indicated that at around 11:50 AM, Resident 1 was witnessed roaming around the facility in his wheelchair in the Activity Room, then engaged in a verbal and physical altercation with Resident 6 and suddenly grabbed the left arm and pulled Resident 6 ' s sleeve down. During a review of Resident 6 ' s COC evaluation dated [DATE], the COC evaluation indicated Resident 1 was witnessed grabbing Residents 6 ' s arm and pulling her (gown) sleeve down. Resident 6 was encouraged to verbalize feelings at that time. The COC evaluation indicated Resident 6 stated she was upset at this time. During a review of a facility document titled Incident Summary dated [DATE], the incident summary indicated Resident 1 admitted to pulling down the sleeve of Resident 6 and acknowledged the inappropriateness of his actions. During a review of Resident 6 ' s MDS dated [DATE], the MDS indicated the resident had moderate cognitive impairment (a condition where a person ' s intellectual functioning is significantly below average, along with significant deficits in behavior) requiring moderate assistance with transfers from chair to bed, shower to chair. During an interview with Resident 2 on [DATE] at 11:30 AM, Resident 2 stated than on [DATE] while she was rolling her wheelchair down the facility hallway going to the Smoking Area, Resident 1 came out of his room and started rolling in his chair towards her. Resident 1 stated that when Resident 1 was closer to her, Resident 1 grabbed her left arm tightly and said, I love you. Resident 2 stated she had told Resident 1 No! Please let go of me! Resident 2 stated after that Resident 1 grabbed her left breast with both hands. Resident 2 stated It was painful and i was embarrassed. I feel afraid and worried because I think it might happen again. Resident 2 stated We are supposed to feel safe in a place like this, I should not worry. Resident 2 stated that after the incident with Resident 1, the facility did not tell her anything about what the facility was going to do to keep her safe or how the facility staff would make sure Resident 1 does not hurt her again. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with the SSD on [DATE] at 2:40 PM, the SSD stated that the current interventions in place for Resident 1 ' s behaviors to prevent Resident 1 from touching other residents are not working. The SSD stated the interventions the facility currently had in placed, were to provide constant education and try to redirect Resident 1 from his inappropriate behaviors (inappropriate touching other female residents). During a telephone interview with Family Member 2 (F2 [Resident 6 ' s family member]) on [DATE] at 9:16 AM, F2 stated she was notified by the facility over the phone that there was a verbal and physical altercation between another resident and Resident 6. F2 stated the facility staff said another resident had grabbed Resident 6 by the arm and the facility staff had made a police report. F2 stated the facility did not mention anything about inappropriate behavior was made towards Resident 6. F2 stated Resident 6 had several strokes in the past, making it difficult for Resident 6 to communicate. F2 stated Resident 6 was able to understand simple phrases or words but struggled to verbally respond to questions or to make all needs and feelings known. During a random resident interview with another resident [Resident 8] on [DATE] at 3:18 PM, Resident 8 stated he was familiar with Resident 1 ' s behavior of reaching out to touch female staff and residents from the behind. Resident 8 stated he had witnessed Resident 1 speaking rudely to female staff and residents as well. Resident 8 stated he witnessed Resident 1 swinging (to try to hit someone or something by moving something, such as a fist) at Resident 7 in the past. During a concurrent interview and record review on [DATE] at 3:46 PM, with the DON, Resident 1 ' s care plan dated [DATE] was reviewed. The DON stated no care plan had been developed for Resident 1 ' s mood behaviors which included touching females sexually on [DATE] and [DATE]. The DON stated the facility should have developed a comprehensive resident centered care plan for Resident 1 ' s behavior that was geared towards females in general that included female residents and not just female staff to manage the resident ' s behaviors and protect the residents and staff. During a concurrent interview and record review on [DATE] at 3:50 PM with the ADM, Resident 1 ' s IDT meetings dated [DATE], was reviewed. The ADM stated she was unable to find documented evidence that the IDT, developed interventions specific to safeguard and protect female residents from potential further sexual non-consensual contact from Resident 1. When sked what did the facility do on [DATE] at 9 AM, to ensure not only was Resident 2 safe but all female residents were free from further non-consensual sexual contact from Resident 1, the ADM stated frequent monitoring was initiated to be documented once a shift, by the LVN in the resident ' s progress notes. The ADM stated the SSD was to visit Resident 2 for five days and stated the facility staff separated Residents 1 and 2. The ADM stated there was no physician order, IDT interventions or developed care plan to indicate the frequency or duration of Resident 1 ' s additional interventions that included frequent monitoring. During a concurrent interview and record review on [DATE] at 3:50 PM, Resident 1 ' s care plans dated [DATE], of inappropriate physical behavior of touching left hand/breast of another resident and Resident 1 ' s care plan dated [DATE], when the resident brushed his arm against another resident ' s chest were reviewed with the ADM. The ADM stated the care plans did not indicate resident specific interventions how facility staff would monitor or managed Resident 1 ' s behaviors specified in the care plans ([DATE] and [DATE]). (continued on next page)

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	055523	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Post Acute Center	250 N. Verdugo Road Glendale, CA 91206

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview with another family member [(F1) - Family member of Resident 7], on [DATE] at 10:49 AM, F1 stated Resident 7 passed away about two months ago, but F1 remembered Resident 7 ' s incident with Resident 1 of inappropriate touching, very well. F1 stated she was notified by Resident 7, when Resident 1 swiped Resident 7 ' s breasts with his open palms on [DATE] in front of facility staff and other[TRUNCATED]

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48219 Based on interview and record review the facility failed toensure one of three sampled residents (Resident 3) was free from misappropriation of property (the unauthorized, improper, or unlawful use of funds or other property for purposes other than for which intended) by failing to: 1. Protect Resident 3 ' s personal belonging/ valuables. Resident 3 ' s wallet was not accounted for on the Residents ' Clothing and Possession Form (inventory list), and Resident 3 was missing debit cards, two hundred dollars cash and a watch. 2. Accurately document on Resident 3 ' s Clothing and Possession Form personal belongings and valuables brought into the facility by Resident 3 and revise the form upon readmission and as needed. 3. Immediately report and investigate Familymember2 ' s (FM2) allegation of abuse of Resident 3 ' s missing personal belongings/valuables. 4. Implement the facility ' s Policy and Procedure on Investigating Incidents of theft and /or Misappropriation of Resident Property. These deficient practices resulted in the misplacement of Resident 3 ' s wallet, two hundred dollars cash, debit cards, and watch and placed other residents at risk for misappropriation of property. Findings: During a review of Resident 3 ' s Admission Record indicatedthe facility admitted the resident on 06/10/2024 with diagnoses of Malignant Neoplasm (Cancerous tumor) of lung. During a review of Resident 3 ' s Minimum data Set (MDS, a standardized resident assessment and care screening tool) dated 6/17/2024, indicated Resident 3 had severe cognitive impairment (problems with ability to think, learn, remember, and use judgment) and was not able to complete the staff assessment for mental status. During a review of Resident 3 ' s Clothing and Possession form, dated 6/10/24, the form indicatedResident 3 had following in his possession upon admission to the facility: a. one pair of glasses b. one nightgown c. one pajama d. one shirt e. one slipper f. one sock (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g. one t-shirt h. one yellow watch. There was no documentation on Resident 3 ' s Clothing and Possession form indicating facility staff accounted for Resident 3 ' s wallet, debit card, or two hundred dollars cash. There was no other Clothing and Possession form completed or revised upon Resident 3 ' s readmission to the facility on [DATE]. During a review of Resident 3 ' s Nursing Progress Notes, dated 6/27/2024 at 2:15 PM, the Note indicated Family Member (FM) 2 could not locate Resident 3 ' s wallet and watch after Resident 3 passed away. The Note indicatedfor F2 to follow up with social services in the morning. There was no indicationon the progress notes indicating Resident 3 ' s missing belongings (wallet and watch) were located. During an interview on 8/26/2024 at 1:02PM, with the Business Office Manager (BOM), the BOM stated when a resident had belongings or valuables, it was the responsibility of the social service department to ensure residents belonging were safeguarded and secured. During an interview on 8/26/2024 At 1:47PM with SocialService Director (SSD), SSD stated certified nursing assistants (CNA) were responsible forcompleting residents Clothing and Possessions form upon admission and discharge. During an interview on 8/26/2024 at 2:10PM, with FM2, FM2 stated Resident 3 ' s personal belongings were requested from the facility after Resident 3 passed away. FM2 stated receiving from the facility Resident 3 ' s wallet, however FM2 stated Resident 3 ' s wallet was missing two hundred dollars cash, debit cards, and Resident 3 ' s watch. During an interview on 8/26/2024 at 3:08PM, with the Administrator (ADM), the ADM stated when a resident was admitted to the facility it was the responsibility of the Licensed Vocational Nurse (LVN) or Registered Nurse (RN) for ensuing that residents Clothing and Possession form was completed and documented by the CNA. The ADM further stated when a resident had valuable personal propertyin the facility, licensed nurses (LN) should keep residents ' valuables locked up for safekeeping in the absence of the SSD. The ADM stated LN ' swould then give the residents valuables to the SSD who was ultimately responsible for securing and locking up residents ' valuables for safeguarding. The ADM stated FM2 notified the facility that Resident 3 ' s gold watch and two hundred dollars cash and debit cards were missing. The ADM stated the facility could not locate Resident 3 ' s watch or two hundred dollars cash/debit cards and statedthe facility should have secured and protected Resident 3 valuables. During a follow up interview on 8/26/24 at 3:08 PM with the ADM, the ADM statedResident 3 ' s watch was worn on Resident 3 when Resident 3 was transferred to the GACH 6/19/24, however upon Resident 3 ' s return from the GACH, Resident 3 was no longer wearing the watch. The ADM statedreaching out to the GACH and the transport team, however Resident 3 ' s watch could not be located. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/26/2024 at 3:45PM with ADM, the facility's policy and procedure (P&P) titled, Investigating Incidents of Theft and /or Misappropriation of Resident Property Revised August 2021 was reviewed. The Policy indicatedwhen an incident of theft and / or misappropriation of resident property was reported, the administrator was to investigate the incident, review the residents ' personal inventory record to determineif the missing items were recorded on the report. The policy indicatedto interview staff member on all shifts having contact with the resident during the past 48 hours, interviewing resident ' s roommate, family members, and visitors, and perform a search of general useareas for the missing item including the resident's room for missing items. The ADM statedafter FM2 informed the ADM of Resident 3 ' s missing wallet, debit card, two hundred dollars cash and missing watch, the ADM initially statedthat Resident 3 ' s wallet was locked inside the medication cart, however, was unsure the actual location of Resident 3 ' s items. The ADM statedafter being informed of the allegation from FM2, the ADM did report the allegation to the Department of Public Health, nor did the ADM file a report to the police department or investigate regardingResident 3 ' s missing personal property/ valuables. During an interview on 8/26/24 at 4PM with CNA 2, CNA 2 stated completing Resident 3 ' s Clothing and Possession form, however, could not recall if Resident 3 had a wallet, cash/ debit card. During an interview on 8/26/2024 at 5:10PM with the Director of Staff Development (DSD), the DSD stated upon admission to the facility, residents ' belongings were documented by the CNA on the Resident ' s Clothing and Possessions form. The DSD stated when a resident had valuables, the SSD would secure the valuables locked away, however if the SSD was not there at the time, the nursing supervisor would lock up residents ' valuables until the SSD was returned to the facility. During an interview on 6/26/2024 at 6:00PM with Social Service Director Assistant (SSDA), SSDA stated an unnamed CNA gave Resident 3 ' s personal belongings/valuables to SSDA after Resident 3 was transferred to the general acute care hospital (GACH). SSDA stated placing Resident 3 ' s personal belongings/valuables in an unlocked drawer in the SSD ' s office. SSDA stated not documenting the belongings on Resident 3 ' s Clothing and Possession form, nor could statewhat items for Resident 3 were placed in the unlocked drawer, nor had the SSDA notified the SSD of Resident 3 ' s personal belongings/valuables stored in the SSD ' s unlocked drawer. During an interview on 8/26/2024 at 6:15PM with the ADM, the ADM stated SSDA should have documented the belonging of Resident 3 on the Clothing and Possessions form once received by the unnamed CNA. The ADM statedproper documentation was necessary to ensure Resident 3 ' s valuables were safeguarded, and to ensure accountability for facility staff receiving residents ' personal belongings/valuables to ensure Residents ' belonging are safeguarded. During an interview on 8/27/2024 at 1:38PM with Activity Director (AD), AD statedonly being informed of Resident 3 ' s missing wallet during a morning huddle (a short meeting, where a team of nurses and other healthcare professionals share and discuss important information). AD statedcalling for the maintenance supervisor to unlock the SSD ' s office, since typically that was where residents ' valuables were stored. AD statedResident 3 ' s wallet was found in the SSD ' s office in an unlocked drawer. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s undated policy and procedures, titled investigating Incidents of theft and /or Misappropriation of Resident Property, dated 8/2021, indicatedall reports of exploitation, theft or misappropriation of resident property are promptly and thoroughly investigated. The policy interpretation and implementation indicateresidents have the right to be free from exploitation, theft and / or misappropriation personal property. Furthermore, indicating the facility shall exercises reasonable care to protect the resident from property loss or theft including: Implementing policies that strictly prohibit, and pursue to the full extent of the law, staff or employee theft or misappropriation of resident property; providing measures to safeguard resident valuables from easy public access; inventorying resident belongings upon admission; promptly responding to and investigating complaints of theft or misappropriation of property. A review of the facility ' s policy and procedure (P&P) titled, Abuse investigation and reporting revised 8/2021, indicated all reports of resident abuse, neglect, exploitation, misappropriation of residents property, mistreatment and /or injuries of unknow source(' abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Further indicating An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of Unknown source and misappropriation of resident property) will be reported immediately, but not later that two hours if the alleged violation involves abuse or has resulted in serious bodily injury; or twenty - four hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 48219 Based on observation, interview and record review, the facility failed to report an allegation of misappropriation of property (the illegal use of the property or funds of another person for one ' s own use unauthorized purpose) for one of three sampled residents (Resident 3) to the California Department of Public Health (CDPH), within two hours by telephone and written report, in accordance with the facility ' s Policy and procedure titled Abuse investigation and reporting - Investigation Incidents of theft and or misappropriation of resident Property. This deficient practice had the potential to result in unidentified abuse in the facility and the risk of further abuse to residents. Findings: A review of Resident 3 ' s Admission Record indicated the facility admitted the resident on 6/19/2024, with diagnoses that included but not limited to Malignant neoplasm (Cancerous tumors) of lung. A review of Resident 3 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 6/17/2024, indicated Resident 3 had serve cognitive impairment (severe issues with thinking, communication, understanding or memory). During an interview on 8/26/2024 at 2 PM with Family member (F2), F2 stated on the day her father passed away (6/26/2024), F2 called the facility and spoke to the administrator (ADM) to request his personal belongings, which included Resident 3 ' s wallet, watch, debit card, and two hundred dollars cash. F2 stated the facility could not locate Resident 3 ' s personal belongings/valuables. During a review of Resident 3 ' s Nursing Progress Notes, dated 6/27/2024 at 2:15 PM, the Note indicated F2 could not locate Resident 3 ' s wallet and watch after Resident 3 passed away. The Note indicated for F2 to follow up with social services in the morning. There was no indication on the progress notes indicating Resident 3 ' s missing belongings were located. During an interview on 8/26/2024 at 3:45PM with the ADM, the ADM stated she was informed by F2, after Resident 3 passed away on 6/26/24, that Resident 3 ' s wallet, debit card, and two-hundred-dollars cash was missing. The ADM stated Resident 3 ' s personal items could not be located. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/26/ 2024 at 3:45PM with the Administrator, the policy and procedure (P&P) titled, Investigating incidents of Theft and /or Misappropriation of Residents Property dated August 2021 was reviewed. The P&P indicated, if an alleged or suspected case of theft, exploitation or misappropriation of resident property is reported, the facility administrator, or his/ her designee, notifies the following persons or agencies with twenty - four hours of such incident, as appropriate: a. state licensing and certification agency (CDPH); b. Ombudsman; c. Resident representative; d. Adult protective services; e. law enforcement officials. The Administrator stated on 6/26/2024, Resident 3 ' s F2 notified the facility regarding Resident 3 ' s missing gold watch and other personal belongings/valuables. The ADM stated not notifying CDPH after F2 reported the missing belongings of Resident 3, nor filing a report to the police department, nor had the facility conducted an investigation to locate Resident 3 ' s belongings. A review of the facility ' s policy and procedure (P&P) titled, Investigating Incidents of the Theft and /or Misappropriation of Resident Property revised August 2021, indicated all reports of exploitation of misappropriation of resident property are promptly and thoroughly investigated. Policy interpretation and implementation indicated residents have the right to be free from exploitation, theft and / or misappropriation of personal property. Further indicating if an alleged or suspected case of theft, exploitation or misappropriation of resident property is reported, the facility administrator, or his /her designee, notifies the following persons or agencies within twenty-four (24) hours of such incident, as appropriate: a. State licensing and certification agency; b. Ombudsman; c. Resident representative; d. Adult protective services; e. Law enforcement officials. A review of the facility ' s policy and procedure (P&P) titled, Abuse investigation and reporting revised 8/2021, indicated all reports of resident abuse, neglect, exploitation, misappropriation of residents property, mistreatment and /or injuries of unknow source (' abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Further indicating An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of Unknown source and misappropriation of resident property) will be reported immediately, but not later that two hours if the alleged violation involves abuse or has resulted in serious bodily injury; or twenty - four hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury.

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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** 48661 Based on observation, interview, and record review, the facility failed to provide safety to one of two sample residents (Resident 1) who was at high risk for injury as indicated in the facility ' s policy and procedure titled Falls and Fall Risk, Managing and resident ' s care plan by failing to: 1. Ensure Resident 1 was assisted by two persons while performing activities of daily living (ADL). While Certified Nursing Assistant (CNA) 3 assisted Resident 1 to change clothes, Resident 1 turned to scratch the back and started to slide down the bed. CNA 1 grabbed Resident 1 under the neck and back and eased Resident 1 to the floor. 2. Implement fall precautions immediately by monitoring the resident for low bed position and safety after Resident 1 ' s fall on 8/20/24. These deficient practices resulted in Resident 1 ' s all with injuries which included a left distal tibia-fibula fracture (a serious injury that occurs when the tibia and fibula, the two long bones in the lower leg, break due to too much pressure) during an assisted fall (when a patient begins to fall and is helped to the ground by another person, such as a medical professional), and the potential for Resident 1 to have a repeat fall with serious injury that could require another hospitalization and resident to experience pain and discomfort. Findings: A review of Resident 1 ' s Admission Record indicated the facility admitted the resident on 2/12/2019 and readmitted on [DATE], with diagnoses including dementia (loss of cognitive functioning - thinking, remembering, and reasoning interferes with a person ' s daily life and activities), hemiplegia (one-sided muscle paralysis or weakness) affecting left side, and abnormal posture (when the body was in a rigid position or moves in an abnormal way for a long time). A review of Resident 1 ' s Admission Fall Assessment, dated 2/12/2024 timed at 9:45 PM, indicated the Resident 1 did not have a history of falls within the last six months, had total incontinence (no control) of bowel (long, tube-shaped organ in the abdomen that completes the process of digestion) movement and bladder (a hollow organ in the lower abdomen that stores urine) for urination, and the assessment determined the resident was at risk for falls. A review of Resident 1 ' s History & Physical (H&P) dated 4/22/2024, indicated the resident did not have the capacity to understand and make decisions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1 ' s Minimum Data Set (MDS - a standardized resident assessment and care screening tool) dated 6/19/2024, indicated the resident had severe cognitive impairment (problems with a person ' s ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident was dependent (helper did all the effort and resident did none of the effort to complete the activity. Or the assistance of two or more helpers was required for the resident to complete the activity) on facility staff with oral/toileting/personal hygiene, showering, dressing, rolling to the left and right side, and transfers. The MDS indicated Resident 1 was always incontinent of bowel and bladder and had zero falls since admission/re-admission. The MDS indicated Resident 1 ' s active diagnoses included dementia and hemiplegia. A review of Resident 1 ' s Change of Condition (COC) dated 8/20/2024 at 5:27 AM, indicated the resident had an assisted fall while the Certified Nursing Assistant (CNA) was dressing the resident. The COC indicated vital signs (measurements of the body ' s basic functions, such as breathing rate, body temperature, pulse rate, and blood pressure) were checked, skin assessment was done by the Registered Nurse Supervisor (RNS) with no redness or skin discoloration noted, and the resident denied pain. The COC indicated the Resident ' s Representative, and the Physician were notified with no new orders. A review of Resident 1 ' s Post Fall Review dated 8/20/2024 at 7:37 AM, indicated Resident 1 had a witnessed fall in the resident ' s room. The Post Fall Review indicated the Interdisciplinary Team (IDT-a team of facility staff responsible in care planning for the residents) discussed recommendations for rehabilitation (the action of restoring someone to health through training and therapy a) to screen the resident and for the Social Services Director (SSD) to provide psychosocial visits as needed. A review of Resident 1 ' s Fall Risk assessment dated [DATE] at 8:06 AM, indicated Resident 1 was at was at risk for falls due to total incontinence of bowel and bladder, did not have a history of falls within the last six months. A review of Resident 1 ' s care plan titled Actual Fall Care Plan dated 8/20/2024, indicated a care plan goal ensure the resident was free from fall and injury and resume usual activities without further incident. The Care Plan interventions included to place the bed in a low position while the resident was in bed, ensure resident ' s call light was always within reach, and to monitor/document/report to the doctor for signs or symptoms of pain, bruises, change in mental status or new onset of confusion or sleepiness. A review of Resident 1 ' s IDT Review Progress Note dated 8/23/2024 at 10:22 AM, indicated reassessing safety precautions with bed positioning and utilization of side rails. The IDT Review Progress Note indicated re-education with nurses regarding safe handling of resident including needs in level of assistance. A review of Resident 1 ' s Physician ' s Order dated 8/25/2024 (5 days after the resident ' s fall), indicated fall precautions that included to keep bed on low position, monitor bed position for patient ' s safety every shift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the General Acute Care Hospital (GACH) Orthopedic Progress Note dated 8/25/2024 at 7:41 AM, indicated the Resident 1 had a left distal tibia-fibula fracture and surgical treatment was not recommended. The progress note indicated to convert resident ' s splint was to a CAM (Controlled Ankle Motion boot - orthopedic device that limits ankle and foot movement to help treat and stabilize injuries) boot when available. A review of Resident 1 ' s Medication Administration Record (MAR) dated 8/1/2024 to 8/31/2024, indicated the fall precautions included to put bed on low position, monitor bed position for patient ' s safety every shift was first documented on 8/26/2024. The progress notes had no documented evidence that Resident 1 ' s bed position for safety was observed on 8/1/24 to 8/25/24. During an observation on 8/26/2024 at 9:50 AM, Resident 1 was lying in bed with bilateral upper side rails raised and had a bolster (long pillow to offer support or strengthen) to the resident ' s upper left and right side. Resident 1 ' s bed was in a low position. During an interview on 8/26/2024 at 11:10 AM, the Administrator (ADM) stated CNA 1 was getting the resident ready for an appointment and when CNA 1 turned to get the resident ' s clothes, Resident 1 turned to scratch the residents back and started to slide down the bed. CNA 1 grabbed the resident under the neck and back and eased Resident 1 to the floor. During an interview on 8/26/2024 at 12:24 PM, CNA 1 stated all of Resident 1 ' s clothes were on the bedside table and when the resident turned and started to fall off the bed, CNA 1 dropped everything and tried to save Resident 1 by holding the resident ' s neck and back before the resident fell . CNA 1 stated the resident was heavy and was unable to hold Resident 1 with CNA 1 alone. CNA 1 stated Resident 1 required two persons assist when providing care, and even if Resident 1 needed two persons assistance with care, CNA 1 prepared Resident 1 to be in time for dialysis (a medical procedure with the use of a machine to remove excess fluid and toxins in the body) without calling for another staff member to help. CNA 1 stated the fall could have been prevented if there had been another staff member to assist the resident. During an interview on 8/26/2024 at 12:57 PM, Registered Nurse Supervisor (RNS) 1 stated Resident 1 required two persons assist because the resident had contractures (when muscles, tendons, joints, or other tissues tighten or shorten) and unable to turn without assistance. RNS 1 stated Resident 1 was heavy, and one staff member would not be able to catch the resident if a fall were to occur. RNS 1 stated the situation (regarding the fall) could have been prevented if there were two staff members that assisted Resident 1 during the fall incident. During an interview on 8/26/2024 at 3:16 PM, the Director of Nursing (DON) stated if a resident required two persons assist and was not provided two people, there was potential for an accident to occur. The DON stated the outcome of not providing two-person assist could affect the resident ' s safety and could potentially injure the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055523	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Post Acute Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/26/2024 at 3:40 PM, the DON stated every resident in the facility had a fall risk assessment done upon admission, quarterly, and after every fall. During a concurrent record review of Resident 1 ' s MAR, the DON reviewed the fall precautions that indicated to place the bed in low position, monitor bed position for patients ' safety every shift. The MAR indicated the order date was on 8/25/2024 and the first documentation was done on 8/26/2024. The DON stated the order was to monitor Resident 1 and should have been initiated right after the residents fall on 8/20/2024. The DON stated if the facility was not monitoring for safety the patient there was potential to cause another fall incident. A review of the facility ' s policy and procedure (P&P) titled Falls and Fall Risk, Managing dated 2/7/2024, indicated Based on previous evaluations and current data, the nursing staff would identify interventions related to the resident ' s specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The P&P indicated Resident conditions that may contribute to the risk of falls include delirium and other cognitive impairments, lower extremity weakness, poor grip strength, functional impairments, and incontinence. A review of the facility ' s P&P titled Activities of Daily Living (ADL), Supporting dated March 2018, indicated Appropriate care and services would be provided for residents who were unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care). The P&P indicated A resident ' s ability to perform ADLs would be measured using clinical tools, including the MDS. Functional decline or improvement would be evaluated in reference to the assessment reference date (ARD) and the following MDS definitions: Total Dependence - Full staff performance of an activity with no participation by resident for any aspect of the ADL activity.