

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 09/27/2024
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 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prepare residents for a safe transfer or discharge from the nursing home.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44372</p> <p>Based on interviews and record reviews, the facility failed to ensure a sufficient preparation and orientation (sufficient preparation and orientation means the facility informs the resident where he or she is going and takes steps under its control to minimize anxiety) to a safe and orderly discharge was conducted for one of four sampled residents (Resident 1), who had fluctuating capacity to understand and make decisions and required continuous use of oxygen due to chronic obstructive pulmonary disease (COPD- lung disease causing restricted airflow and breathing problems). The facility did not provide adequate discharge planning for Resident 1, resulting in an unsafe discharge against medical advice on 9/25/2024.</p> <p>On 9/27/2024 (two days after the resident was discharged home), Resident 1 was transferred to the General Acute Care Hospital [GACH] due to severe shortness of breath, acute COPD exacerbation and acute hypercapnic [a life-threatening emergency of having too much carbon dioxide in the blood respiratory failure. In the GACH Emergency Department [ED], the GACH report indicated Resident 1 ' s oxygen saturation was 56% (normal range above 90%, [oxygen level 56% is life threatening and require immediate medical attention]) upon arrival at the GACH ED. The GACH ED Report indicated Resident 1 had been out of medications for the past three days and reported chest tightness, severe shortness of breath and wheezing. Resident 1 was subsequently transferred to the Intensive Care Unit [ICU] due to acute hypoxia. Resident 1 stayed in the GACH from 9/27/2024 to 9/30/2024.</p> <p>Findings:</p> <p>During a review of Resident 1's admission record indicated the facility admitted the resident on 12/08/2023 and readmitted on [DATE] with diagnoses including COPD, pneumonia (a lung infection that causes the air sacs in the lungs to fill with fluid or pus, making breathing difficult), and heart failure (occurs when the heart muscle doesn't pump blood as well as it should. When this happens, blood often backs up and fluid can build up in the lungs, causing shortness of breath). Resident 1's admission record indicated Resident 1 is self responsible and his primary language as [foreign language].</p> <p>During a review of Resident 1 ' s care plan dated 12/09/2023, indicated Resident 1 was at risk for respiratory distress related to COPD and Asthma as manifested by shortness of breath and low oxygen saturation. The care plan interventions included to monitor for shortness of breath [SOB], irregular respiration, wheezing, crackles, rhonchi, excessive secretion, cough, and inform the MD promptly.</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 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s care plan dated 7/29/2024 indicated the resident was risk for elopement due to diagnosis of dementia, resident paces and wanders outside of the facility. The care plan goal indicated Resident 1 will have no incident of elopement on a daily basis, including the resident will have no incident of wandering outside of facility property on daily basis. The care plan interventions included frequent visual checks of resident ' s whereabouts, giving reminders regularly and as needed, encouraging to be involve in activity of choice.</p> <p>During a review of Resident 1's History and Physical (H&P) dated 8/24/2024, indicated Resident 1 has fluctuating capacity to understand and make decision.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/18/2024, the MDS indicated Resident 1 ' s cognition (thought process) was intact. The MDS indicated the resident ' s preferred language is a [foreign language]. The MDS also indicated Resident 1 need and want an interpreter to communicate with the doctor or the health care staff. The MDS indicated Resident 1 was on oxygen and ambulate using a wheelchair. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and or touching/steadying and/or contact guard assistance as a resident completes activity) for eating, oral hygiene, toileting hygiene, and toilet transfer (an ability to get on and off the toilet).</p> <p>During a review of Resident 1 ' s Social Service Supervisor (SSS) record, dated 7/18/2024, the SSS record indicated Scheduled phone call with Ombudsman was made at 10:00 AM with Administrator and SSD. A number of concerns were discussed for the purpose of gaining feedback and guidance from the Ombudsman to best serve this resident's needs. Resident 1 was granted Out on Pass (OOP) (temporary permission of a Resident from a facility granted by medical director or physician), the Medical Director in May 2024 for 8 hours. It was stated that the Medical Director also revoked the OOP and suggested the resident should be seen by the Psychiatrist. Resident has the right to a second opinion of another physician. Resident has the right to refuse or ignore any written order or document, but the facility should make sure it is acting within its written/stated policy. Schedule IDT/Care Plan meeting with the resident, family, dietary, activities, rehab director, psychologist, psychiatrist and/or Medical Director, and SSD to address concerns that may lead to constructive discharge planning and purposeful goals for Resident 1.</p> <p>During a review of Resident 1 ' s Order Summary Report, the report indicated an order dated 8/22/2024, for the resident to receive oxygen at 1 to 2 liter per minute via nasal canula continuously for the diagnosis of COPD.</p> <p>During a review of Resident 1 ' s nurses notes dated 9/18/2024 and timed at 4:10 PM, the nurses ' notes indicated Resident left facility for OOP against medical advice in wheelchair and oxygen tank in stable condition.</p> <p>During a review of Resident 1 ' s nurses notes dated 9/19/2024 and timed at 4:30 PM documented Resident left facility for OOP against medical advice in wheelchair and oxygen tank in stable condition.</p> <p>During a review of Resident 1 ' s nurses notes dated 9/20/2024 and timed at 4:11 PM, the nurses ' notes indicated Resident left facility for OOP [out on pass] against medical advice in wheelchair and oxygen tank in stable condition.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s nurses notes dated 9/22/2024 and timed at 10:49 AM, the nurses ' notes indicated Resident OOP in stable condition.</p> <p>During a review of Resident 1 ' s nurses notes dated 9/23/2024 and timed at 4:15 PM, the nurses ' notes indicated Resident left facility for OOP against medical advice in wheelchair and oxygen tank in stable condition.</p> <p>During a review of Resident 1 ' s nurses notes dated 9/24/2024 and timed at 10:35 AM, the nurses ' notes indicated Resident went out on OOP in stable condition.</p> <p>During a review of the facility document titled Temporary leave of absence from 6/18/2024 to 9/26/2024 indicated Resident 1 was out of the facility almost every day for more than 3 hours. The facility document titled Temporary leave of absence, indicated Resident 1 ' s information for signing in and out of the facility from 9/18/2024 to 9/26/2024:</p> <ul style="list-style-type: none"> -Date out 9/18/2024, Time out 2:30 PM- Date Return 9/18/2024, time return was 8:00 PM. -Date out 9/19/2024, Time out 3:00 PM- Date Return and time return was blank. -Date out 9/20/2024, time out 2:00 PM- Date Return and time return was blank. -Date out 9/21/2024, time out 3:00 PM- Date Return9/21/2024, time return was 9:00 PM. -Date out 9/22/2024, time out 10:30 AM- Date Return9/22/2024, time return was 9:00 PM. -Date out 9/23/2024, time out 4:00 PM- Date Return 9/23/2024, time return was 10:30 PM. -Date out 9/24/2024, time out 10:00 AM- Date Return9/24/2024, time return was 8:00 PM. -Date out 9/25/2024, time out 9:30 AM- Date Return9/25/2024, time return was 7:30 PM. -Date out 9/26/2024, time out 8AM- Date Return and time return was blank. <p>During a review of the facility document titled Leave Hospital Against Advice, dated 9/25/2024, signed by Resident 1 and witnessed by RN 1 and RN 2 indicated, and information typed in English, This is to clarify that I, Resident 1, a resident in the facility am leaving the hospital against the advice of attending physician and hospital administration. I acknowledge and I have been informed of the risk involved and hereby release the attending physician, and the hospital from all responsibility and any ill effects which may result from this action.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s GACH records titled After visit summary indicated Resident 1 was discharged from the GACH to home on 9/30/2024.</p> <p>During a review of Resident 1 ' s nurses notes dated 9/25/2024 and timed at 7:42 PM, documented by RN 3, indicated that Staff call my attention that Resident 1 is already outside the parking lot, doorbell the door to tried to get inside the facility and kept banging the exit door with his wheelchair. We open the exit door and resident is very agitated, yelling and screaming to the staff and stated that his not an animal. I explained to him nicely the risk and benefits that he cannot get inside the facility due to he already signed the discharge against medical advice form. Resident was still very agitated and kept shouting that his not an animal and force his wheelchair to get into the dining area. Tried to call the [physician]. The DON was also notified regarding the situation and advice to call the police. Call the [local] Police and reported that resident is very agitated and trying to explain to him that he is no longer a patient here due to him signing AMA. [Local] Police did their investigation and call the family. [FAM 1] came and demanded right away a copy of the AMA papers that his father signed. One of the police ask me if the resident could stay the facility for tonight so FAM 1 could figure out tomorrow for the place to stay and said that they will also call the Ombudsman to ask if they will agree to stay the resident for tonight. The DON was notified again and said that ' s okay to let him stay tonight and they will have an IDT team meeting tomorrow for the discharge plan. Resident was readmitted again to the facility and to resume all the orders. Will continue to monitor the resident's behavior [sic].</p> <p>During an interview on 9/27/2024 at 8:32 AM, FAM 1 stated Resident 1 does not fully understand and speak English. FAM 1 stated for the past 3 to 4 months, Resident 1 was leaving the facility everyday morning and returning back to the facility at nighttime. FAM 1 stated Resident 1 is on continuous oxygen and using a wheelchair. FAM 1 stated that on 9/25/2024, at around 2 PM, FAM 1 received a call from RN 1 informing her that Resident 1 signed documents and left the facility. FAM 1 stated RN 1 did not inform her that Resident 1 signed the AMA form. FAM 1 stated that on 9/25/2024 at around 7:30 PM, FAM 1 received a call from Resident 1 that he was in front of the facility, and the facility staff would not let him back inside the facility. FAM 1 stated she went to the facility and observed Resident 1 in distress, inside the facility and the police was interviewing him.</p> <p>During an interview on 9/27/2024 at 8:51 AM, Resident 1 stated he understand very limited English and requested a translator to communicate with staff and providers. Resident 1 stated for more than 3 months everyday he was leaving the facility wheel himself while on oxygen 2 L nasal cannula continuously to coffee place and come back to facility few hours later. Resident 1 stated everyday he would sign a log when he leaves and sign again when he gets back to facility. Stated on 9/25/2024 around 8 AM request to leave the facility, a nurse ask him to sign a document. Stated he signed the document and left the facility. Stated the nurse did not explain what he was signing, and he was speaking English. Stated when he came back on 9/25/2024 around 7:30 PM the facility door was closed and he had to bang on the door, but staff refused to take him in, stated he was having shortness of breath and difficulty breathing since his oxygen tank was empty. Stated he was yelling and begging staff to let him in while he was on wheelchair, a nurse let him in and few minute later police and FAM 1 came. Resident 1 stated that FAM 1 had informed him that the paper he signed on 9/25/2024 was AMA that meant he would not be allowed to return to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/27/2024 at 9:46 AM, LVN 1 stated he was familiar with Resident 1, able to verbalize his needs in English and foreign language. LVN 1 stated if a resident request to sign AMA, the licensed nurse needs to notify the physician, explain the risks and benefits and have the resident sign the AMA form in the resident ' s preferred language. LVN 1 stated that if the resident requested to have the information explained to him in his foreign native langue, the document should be in his native foreign language, or the facility staff should get an interpreter to explain the AMA process to the resident. LVN 1 stated if a resident wants to leave a facility on a therapeutic leave, the staff should obtain an Out on Pass order with the resident ' s physician.</p> <p>During an interview and record review of Resident 1 ' s Social Service Supervisor Note dated 8/14/2024 and timed at 9:46 AM, on 9/27/2024 at 11:15 AM, the Social Service Supervisor stated the discharge plan was to discharge Resident 1 to home, however Resident 1 was transferred to the acute hospital on 8/22/2024, due to chest pain. The SSS stated he did not have any other discharge plans or IDT note for Resident 1 ' s current discharge plans or issues with going out of the facility, after 8/14/2024.</p> <p>During an interview on 9/27/2024 at 11:42 AM, the DON stated Resident 1 had been going out of the facility almost every day, in the morning and come back to the facility in the afternoon or evening, for more than 3 months, without having an out on pass order from the physician. The DON stated, Resident 1 ' s PCP discontinued the resident ' s out of pass order on 5/5/2024 and the facility ' s Medical Director revoked the resident ' s out on pass order on 7/18/2024. The DON stated Resident 1 continued to go out of the facility. The DON stated Resident 1 receives oxygen continuously with 1 to 2 liters via NC. The DON stated that on 9/25/2024 at around 8 AM, Resident 1 requested to go out and since he did not have an out on pass order, RN 1 asked him to sign the AMA form. The DON stated that Resident 1 signed the AMA form, which was in English, and then he left the facility. The DON stated RN 1 did not use a translator to explain to Resident 1 what he was signing. The DON stated he does not have any documented evidence that RN 1 used a translator. The DON stated that on Resident 1 ' s Face Sheet, it indicated that Resident 1 primary language was a foreign language other than English, however he was able to communicate with English. The DON stated RN 1 should have used a translator to translate the AMA form for Resident 1 the AMA. The DON stated if a resident requests to go OOP there should be a physician ' s order.</p> <p>During an interview on 10/02/2024 at 7:46 AM, FAM 1 stated Resident 1 was discharged to home from the GACH on 9/30/2024, however, the GACH 1 physician nor the ICU physician did not refill/gave prescriptions for Resident 1 ' s ordered routine medications and advised the resident to get his medications from his own primary care provider. FAM 1 stated Resident 1 missed all his GACH discharge medications for a few more days. FAM 1 stated she had to find a new primary care provider that could provide the prescriptions for Resident 1 ' s GACH discharge medications because Resident 1 ' s previous primary physician was the attending physician at his previous skilled nursing facility.</p> <p>During an interview and record review of Resident 1 nurses Note from 9/1/2024 to 9/26/2024 on 9/27/2024 at 11:55 AM, the DON stated that according to the nurses ' notes, Resident 1 had been going OOP every day for a few hours against medical advice. The DON stated Resident 1 did not have the AMA form signed when Resident 1 would leave the facility previously. The DON stated the only AMA form that Resident 1 had signed was the form dated 9/25/2024, signed by Resident 1 and witnessed by RN 1 and RN 2.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and record review of Resident 1 ' s active care plans on 9/27/2024 at 12:03 PM, the DON stated the facility staff failed to develop a care plan to address Resident 1 ' s concerns of leaving the facility every day for the last three months with no order for Out on Pass and leaving the facility against medical advice. The DON stated the plan was to discharge the patient to home with family or find a different placement. The DON stated he could not provide documented evidence of Resident 1 ' s Discharge Plan, after Resident 1 was readmitted to the facility on [DATE]. The DON stated the facility did not conduct any IDT meeting or care plan conference with the patient and family about Resident 1 ' s issues/concerns of frequently leaving the facility OOP with no physician orders. The DON stated a safe discharge for Resident 1 would be to provide the patient with supplemental oxygen, arrange for home health services, and provide his prescription medications.</p> <p>During an interview on 10/02/2024 at 11:14 AM RN 3 stated she had received a report that Resident 1 had signed the AMA form and no longer a resident at the facility. RN 3 stated that on 9/25/2024, at around 7:30 PM, he was upset and requesting to come into the facility and does not feel good. RN 3 stated Resident 1 went inside the facility and stayed in the Dining Room, RN 3 notified the DON, then called the police. RN 3 stated the police and FAM 1 came to the facility. According to FAM 1, Resident 1 speaks a foreign language. The police asked if Resident 1 could stay for the night and the DON agreed for the resident to stay for the night. RN 3 stated the resident was readmitted to the facility for the night. RN 3 stated she did not check if the resident ' s oxygen tank to see if it was empty or not that night and did not check Resident 1 ' s vital signs. RN 3 stated, that Resident 1 did not have an order for OOP, but the facility staff would always let him go out on pass prior to that night [9/25/2024].</p> <p>During a review of the facility ' s policy and procedure (P&P) titled Discharge Summary and Plan, revised October 2022, the P&P indicated As part of the discharge summary, the nurse reconciles all pre-discharge medication with the resident's post-discharge medications. The medication reconciliation is documented. The post-discharge plan is developed by the care planning/interdisciplinary team with the assistance of the resident and his or her family and includes: where the individual plans to reside; arrangements that have been made for follow-up care and services; a description of the resident's stated discharge goals; the degree of caregiver/support person availability, capacity and capability to perform required care; how the IDT will support the resident or representative in the transition to post-discharge care; what factors may make the resident vulnerable to preventable readmission how those factors will be addressed.</p> <p>During a review of the facility ' s P&P titled Discharging a Resident without a Physician ' s Approval, revised October 2012, indicated A physician's order should be obtained for all discharges, unless a resident or representative is discharging himself or herself against medical advice. If the resident or representative (sponsor) insists upon being discharged without the approval of the attending physician, the resident and/or representative (sponsor) must sign a release of responsibility form. Should either party refuse to sign the release, such refusal must be documented in the resident's medical record and witnessed by two staff members. The director of nursing services, or charge nurse, shall inform the resident, and/or representative (sponsor) of the potential hazards involved in the early discharge of the resident and shall request that the resident remain in the facility until such time as the isolation/precautionary period has ended.</p> <p>(continued on next page)</p>		

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