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	06/12/2025

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 - 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** Based on interview and record review, the facility failed to identify the provision of monitoring and supervision to prevent abuse and intoxication of illicit/recreational drugs ([street drugs] refers to the use and misuse of illegal and controlled drugs) for one of two sampled residents (Resident 1) reviewed for substance abuse, and with a recent history of taking recreational drugs by failing to: 1. Accurately assess, monitor, and develop interventions to provide additional monitoring and ensure the safety of Resident 1 who had a history of methamphetamine (meth - a powerful synthetic stimulant drug with a high potential for addiction) use for potential of continued meth use when Resident 1 tested positive for amphetamine as indicated in the General Acute Care Hospital (GACH 1) Toxicology Report (details the analysis of biological samples to identify and quantify the presence of drugs, poisons, or other chemicals in a person's system), on 4/25/2024. 2. Secure and prevent Resident 1 from keeping smoking items (cigarettes, glass pipe, and lighters) in his possession, when Resident 1 was assessed by the facility and documented as a non-smoker on 10/8/2024. 3. Develop and implement interventions to ensure the safety of Resident 1 and other residents when lighters were found present in Resident 1's room on 6/4/2025, who had orders to receive continuous oxygen daily. 4. Ensure the facility has a plan of action in place on how to care for residents who does not comply with the facility's smoking policy titled Smoking Policy - Residents that indicated oxygen use is prohibited in smoking areas and independent smoking privileges may not have or keep any smoking items, except under direct supervision. These failures resulted in Resident 1 experiencing tachycardia (rapid heart rate, defined as a heart rate exceeding 100 beats per minute [bpm]), oxygen (O2) desaturation (oxygen levels in the blood drop below normal for an extended period, normal blood oxygen level is 95 percent [%] to 100%), shortness of breath (SOB, difficulty breathing) and being transported by emergency medical services (EMS or 911) to General Acute Care Hospital (GACH) 2 on 6/4/2025 at 5:54 p.m. GACH 2 toxicology dated 6/4/2025, indicated Resident 1 tested positive for amphetamines (a synthetic, addictive, mood altering drug, used illegally as a stimulant and legally as a prescription drug) and methamphetamines upon arrival to GACH 2, requiring intubation (a way to secure the airway and support breathing, often in critical or emergency situations). (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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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 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/5/2025, the police report indicated police officer (PO) 1 was dispatched on 6/5/2025, regarding Resident 1's found property. The Report indicated narcotics, and a meth pipe were found in one of the resident's rooms (Resident 1). The Report further indicated under drug information that PO 1 found meth in clear baggie and candy dispenser, and was documented as amphetamines/ methamphetamines with quantity documented as 1 (one) gram (gm, unit of measurement by weight). Findings: During a review of Resident 1's admission Record (AR, contains demographic and medical information), the AR indicated the facility admitted Resident 1 on 7/12/2021 and readmitted on [DATE] with diagnoses that include paraplegia (the inability to voluntarily move the lower parts of the body), incomplete (some degree of movement and sensation may be retained below the injury site), Emphysema is a type of chronic obstructive pulmonary disease (COPD, a lung disease characterized by long-term poor airflow), Atrial fibrillation (Afib, irregular heart beat), Hypertensive heart disease (a group of heart conditions that develop as a result of prolonged high blood pressure) with heart failure (when the heart cannot pump enough blood and oxygen), and depression (a constant feeling of sadness and loss of interest). During a review of Resident 1's GACH 1 Toxicology Report, dated 4/25/2024, timed at 3:01PM, the Report indicated, Resident 1 tested positive for Amphetamine during a drug screen, urine test. During a review of Resident 1's History and Physical (H&P, a comprehensive physician ' s note regarding the assessment of the resident ' s health status), dated 5/1/2024, the H&P indicated, Resident 1 have the capacity to understand and make decisions. During a review of Resident 1's Interdisciplinary team (IDT- a group of professionals from different fields in the nursing facility that work together to address a patient's needs) note, dated 5/2/2024, at 11:15 a.m., the IDT note indicated, IDT spoke to resident regarding result of his urine drug screen that was completed while he was in the hospital. Urine drug screen read that he was positive for amphetamine . Explained to resident that taking recreational drugs is not tolerated in the facility. Provided education on risks and effects of taking recreational drugs, while taking other prescribed medications and resident's current health status. Informed resident that further investigation will be conducted regarding this matter .IDT met to discuss resident urine drug screen result of positive for amphetamine. IDT recommends continuing to educate resident on effect of recreational drug use while on prescribed medications, continue to provide education on the effects of recreational drug use based on his health status, remind resident that recreational drug use is not tolerated in the facility. There was no documented evidence to indicate that the facility staff had monitored Resident 1 for illegal substance use after Resident 1's urine tested positive for amphetamine in GACH 1. During a review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 3/19/2025, the MDS indicated Resident 1 ' s cognition (ability to think, remember, and reason) was intact. The MDS indicated Resident 1 needed supervision for eating and oral hygiene, partial assistance for personal hygiene, and substantial/maximal assistance to dependent on physical assistance by staff for toileting, bathing, dressing, and transfer from bed to wheelchair. (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 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's GACH 1 History and Physical (H&P) dated 6/30/2024, at 1:41 p.m., the H&P indicated, Social History .He does have a history of methamphetamine (a man-made [synthetic], highly addictive stimulant that speeds up brain and body functions and is illegal without a prescription) use. During a review of Resident 1 ' s Smoking Assessment, dated 10/8/2024, the form indicated Resident 1 does not smoke. During a review of Resident 1's Change of Condition [COC] Evaluation (details significant deviations from a resident's baseline status, including physical, cognitive, behavioral, or functional changes), dated 4/16/2025, at 1 p.m., Resident 1's COC indicated, Resident [1] noted with tachycardia and desaturation. Gave 15 L (liter, unit of measure by volume) of oxygen with his head elevated 90 degrees. Called paramedics immediately. Assessed by paramedics and recommended to transfer patient to hospital but resident strongly refused. MD notified . During a review of an Order Requisition for laboratory tests with collection date of 4/24/2025, the Requisition indicated Resident 1 refused laboratory draw and again on 4/28/2025. During a review of Resident 1's Nursing Progress Note, dated 4/30/2025, at 8:25 a.m., Resident 1's Nursing Progress indicated, Resident [1] refused laboratory (test) 3x (three times). Explained risk and benefits but still strongly refused. During a review of Resident 1's COC Evaluation, dated 6/4/2025, at 5:35 p.m., Resident 1's COC indicated, Resident [1] noted with SOB, desaturation 88% O2 at 2 LPM via NC, and tachycardia with a HR of 174 bpm. HOB (head of bed) elevated for comfort and for easily breathing. O2 given at 15 LPM via nonrebreather mask (NRB, a type of oxygen delivery device used in emergency situations to provide a high concentration of oxygen to a patient who can breathe on their own but has low blood oxygen levels). MD made aware with an order to transfer resident to GACH 2 via 911 for further evaluation. During a review of Resident 1's EMS Runsheet (a medical record for ambulance services), dated 6/4/2025, timed at 5:32 p.m., the EMS Runsheet indicated, Facility called EMS for a patient with respiratory distress. Facility stated patient pulse oximetry was 85 % on room air. Upon arrival, patient was sating at 88 % with NRB (non-rebreather mask) at 15 L per minute. Staff denied any recent illness or injury. Patient [Resident 1] complained of SOB for the past 10 minutes .history of methamphetamine use. They stated they found a lighter on the patient. During a review of Resident 1's GACH 2 ED (Emergency Department) Report, dated 6/4/2025, at 5:54 p.m., the GACH 2 ED Report indicated, Resident 1 arrived by ambulance .was having hypotension (low blood pressure) and shortness of breath at a nursing facility and was sent for further evaluation. Resident 1's ED Report indicated, Individual has a history of methamphetamine use. Patient arrived hypotensive. He is speaking gibberish .Diagnostics .methamphetamines - Presumptive Positive, Abnormal, dated 6/4/2025, at 8:25 p.m.Re-evaluation and Summary .admitted patient [Resident 1]. The patient's [Resident 1] condition required additional management, and care was escalated to admission .sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection) protocol was initiated. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Nursing Progress Note, dated 6/4/2025, timed at 9:09 p.m., Resident 1's Nursing Progress indicated, It was observed that resident has a long lighter on his table. This was identified as a fire hazard because the resident is using an oxygen concentrator, which increases the risk of fire in the presence of open flames or ignition sources. During a review of Resident 1's Case Management/ Social Worker (CM/SW) Screening, dated 6/5/2025, at 2:19 p.m., the Screening indicated, SW reviewed Pt's chart and noted that Pt (Resident 1) admitted to (GACH 2) on 6/4/2025 with initial dx (diagnosis) of Sepsis (the body's extreme reaction to an infection), per Facesheet .Per MD (physician), Pt [Resident 1] tested positive for Meth . Pt [Resident 1] is now intubated, unsure where Pt [Resident 1] received the drugs. During a review of Resident 1' s Order Summary Report (OSR), the OSR indicated active orders as of 6/6/2025, Resident 1 OSR included the following: 1. Admit to Skilled Nursing from general acute care hospital (GACH) 1, dated 4/30/2024 under the service of primary care physician (MD) 1 with the following diagnosis: Amphetamine abuse, septic shock, acute renal failure, multiple infected wounds and pressure sore. 2. Administer Oxygen at 2 (two) liters per minute (LPM) via nasal cannula continuously to keep the oxygen (O2) saturation at 92 percent (%), every shift for shortness of breath (SOB), with order dated 4/16/2025. 3. OK to go out on pass for 6 hours with responsible party, with order dated 4/30/2025. During a review of Resident 1's Care Plan (CP- a document that outlines a resident's needs, treatment, and expected outcomes), dated 6/5/2025, the care plan focus indicated, The resident tested positive for Methamphetamine in the hospital after being transferred by 911 for tachycardia, tachypnea (rapid and shallow breathing), SOB, and desaturation. During an interview on 6/6/2025, at 12:35 p.m., the facility Administrator (ADM) reported on 6/4/2025 Resident 1 had a fast heartbeat (tachycardia) and was moved to the hospital (GACH 2) via a 911 call (emergency service phone call). ADM stated the hospital informed the facility on 6/5/2025, that a drug test (toxicology screening) showed Resident 1 tested positive for amphetamine (a synthetic, addictive, mood-altering drug). The ADM noted that Resident 1 was not being monitored for the use of amphetamines or methamphetamines. ADM stated that after being notified of Resident 1's positive test result, staff found an open black bag in Resident 1's room. ADM stated that he took possession of the bag and discovered a glass meth (methamphetamine) pipe inside (a smoking device used for meth). ADM stated the local police were called, and an officer arrived on June 5, 2025, at 5 p.m. to remove the glass pipe for proper disposal (safe removal and discard). ADM stated Resident 1 shares a room with two other residents. The ADM added that Resident 1 is usually very quiet and private, which made this discovery surprising to the staff. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/6/2025, at 5:13 p.m., the Director of Staff Development (DSD) stated that the charge nurse, Licensed Vocational Nurse (LVN) 3, notified her that Resident 1 was experiencing tachycardia, with a fluctuating heart rate (HR) of 174 beats per minute (normal HR: 60-100 bpm) on 6/4/2025. The DSD stated that Resident 1 initially refused to go to the hospital. The DSD stated before Resident 1's change in condition (COC), the resident was playing games in his room. Additionally, the DSD stated she observed that Resident 1 had a lighter in his room and the DSD could not explain why Resident 1 would keep a lighter in his room. During a telephone interview on 6/6/2025, at 5:28 p.m., with the Director of Staff Development (DSD) present, LVN 3 was contacted. LVN 3 stated while was delivering evening medications to other residents in Resident 1's room, LVN 3 observed that Resident 1 was having difficulty breathing (shortness of breath, SOB). LVN 3 stated Resident 1 was receiving oxygen, looked pale, and was sweaty. LVN 3 stated she informed DSD and the Director of Nursing (DON) to reassess Resident 1. LVN 3 stated when Resident 1 began having trouble talking, 911 was called. LVN 3 stated, no evening medications were given to Resident 1. LVN 3 noted that this was the worst episode of breathing difficulty she had seen in Resident 1, even while on oxygen. She was not aware if Resident 1 was taking any medication from outside. LVN 3 stated Resident 1 orders food delivered to the facility and has a friend who brings groceries. LVN 3 stated that on Wednesday, June 4, 2025, she saw a long, orange and black lighter in Resident 1's room, and Resident 1 does not leave the room to smoke. During a review of the police report dated 6/5/2025, at 3:02 p.m., the police report indicated PO 1 was dispatched regarding found property. Report indicated upon arrival PO 1 spoke with the facility's ADM that stated he found narcotics and a meth pipe in one of his patient's (Resident 1) room. Report indicated, I collected the meth pipe and narcotics. I booked the narcotics for destruction and placed the meth pipe in the disposal bin property room. Police report indicated under drug information, found meth in clear baggie and candy dispenser, type was documented as amphetamines/ methamphetamines and quantity documented was 1 (one) gram (gm, unit of measurement by weight). During a telephone interview on 6/6/2025, at 5:45 p.m., with LVN 4 in the presence of the DSD, LVN 4 stated that Resident 1 watches TV and uses his iPad. LVN 4 stated that during the morning shift (7 a.m. to 3 p.m.) on June 4, 2025, Resident 1 was fine. LVN 4 stated, Resident 1 did not complain of SOB and took all of his morning medications. During a telephone interview 6/11/2025, at 3:11 p.m., with Resident 1 present and GACH 2's Case Manager/Social Worker (CM/SW) present, Resident 1 was asked about the glass pipe found in a black bag identified as his. Resident 1 said, The meth pipe has been in my bag for a long time. I got depressed and could not handle my situation. I am paralyzed and felt hopeless in my life. I try really hard to be strong. I just don't know. I meant to throw it (meth pipe) away. Resident 1 explained that he used methamphetamines in the past to help him cope with his depression. Resident 1 did not say when he last used the meth pipe or who provided him with methamphetamine or the meth pipe. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/12/2025, at 2:09 p.m., LVN 4 reported that Resident 1 used to smoked and that facility staff would assist the resident with a wheelchair to go outside to smoke. LVN 4 stated on 6/4/2025, during the day shift (7 a.m. - 3 p.m.), Resident 1 showed no signs of breathing difficulty. LVN 4 stated Resident 1 moves both arms, remained alert and oriented x4 (fully aware of person, place, time, and situation), and could use a lighter independently. LVN 4 stated Resident 1 used oxygen continuously. LVN 4 stated that the facility required visitors to bring any items for Resident 1 to the nursing station so staff could add them to Resident 1's personal belongings inventory (a record of resident possessions) list. LVN 4 stated without this process, the facility could not track when Resident 1 received new items, such as lighters, alcohol, or cigarettes. LVN 4 stated that Resident 1's room contained clutter, including food, bags, and containers, and that staff had not added the items to the resident's inventory, which left the staff unaware of what was inside of Resident 1's bags. During another interview on 6/12/2025, at 3:30 p.m., with LVN 4, LVN 4 stated he was unaware that Resident 1 had tested positive for amphetamines/methamphetamines in 2024. LVN 4 stated that the facility should have informed staff about any past positive tests so they could monitor Resident 1 for potential repeated use. LVN 4 stated that the facility has not provided any training on methamphetamine use or on recognizing its signs and symptoms. LVN 4 stated, If I knew about the positive urine test for amphetamine in 2024, I would have checked his (Resident 1) inventory, monitored the resident for amphetamine use, and educated the CNAs (Certified Nurse Assistants) on signs and symptoms to watch for and when to notify the charge nurse. LVN 4 stated that a resident using amphetamines may show symptoms such as rapid breathing, hallucinations, tachycardia (rapid heart rate), rapid pulse, and shortness of breath. During an interview and record review on 6/12/2025, at 3:39 p.m., with Medical Records Director (MRD), MRD provided Resident 1's personal belongings inventory list dated 2/7/2023. MRD stated there was no new or updated personal belongings inventory list for Resident 1. During an interview on 6/12/2025, at 4:26 p.m., with a Registered Nurse (RN) 1 stated that Resident 1 used to smoke in the patio area. RN 1 stated that on June 4, 2025, Resident 1 was transferred to the hospital (GACH 2) for breathing problems, low oxygen saturation, and tachycardia (fast, irregular heart rate). RN 1 stated that the facility did not monitor Resident 1 for illegal drug use or behavior issues related to drug use. RN 1 described signs of amphetamine/methamphetamine use as including altered mental status, confusion, trouble breathing, and tachycardia. She noted that Resident 1 had difficulty breathing on June 4, 2025, and earlier in April 2025. RN 1 stated she was not informed that Resident 1 had tested positive for methamphetamines in April 2024. RN1 said that if she had known Resident 1 had a history of methamphetamine use, she would have closely monitored the resident, reported signs of drug use to the DON and Administrator, and set up a care plan for a history of methamphetamine use. RN 1 stated a lighter was found in Resident 1 room on his table at 5:30 p.m., on June 4, 2025, during the resident's transfer to the hospital (GACH 2). RN 1 emphasized that it is illegal for Resident 1, who receives oxygen, to have a lighter in his room because the combination could cause a fire or explosion. RN 1 added that the facility should check Resident 1's belongings to prevent such risks. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/12/2025, at 5:01 p.m., the ADM stated that the facility did not file an incident report because Resident 1 had been transferred to the hospital on June 4, 2025, for tachycardia. ADM stated when the facility received a call from the hospital reporting that Resident 1 tested positive for methamphetamine, the facility called the police. ADM explained that Resident 1 left behind inside of the resident's room an opened black bag containing a meth pipe, three lighters, and an opened pack of cigarettes. During an interview on 6/12/2025, at 5:09 p.m., with the DON, DON stated, he did not know Resident 1 had three lighters inside of his room. DON stated that he and other licensed staff do rounds in the morning and look for anything visible. DON stated he did not ask Resident 1 if he could check the belongings inside of the resident's room. DON stated he did not know Resident 1 had a history of methamphetamine use. During an interview on 6/12/2025, at 5:37 p.m., with the Administrator, the ADM stated that no personal belongings inventory list had been maintained for Resident 1 since February 7, 2023. ADM admitted he did not know Resident 1 had ever tested positive for methamphetamine and found no record of monitoring the resident for meth use. ADM stated had he known of Resident 1's history of methamphetamine use, he would have placed Resident 1 on supervised visits due to the risk to others. ADM stated he discovered the resident's meth history on June 12, 2025, and noted there was no smoking safety assessment (a check to ensure it was safe for a resident receiving oxygen to smoke), so Resident 1 was removed from the resident smoking list. ADM acknowledged that he should have reviewed a May 2, 2024, IDT note, which confirmed a positive amphetamine urine test and reminded Resident 1 that recreational drug use is not tolerated in the facility. During a concurrent interview and record review on 6/12/2025, at 6:24 p.m., the Director of Nursing (DON) and Administrator (ADM) reviewed Resident 1's admission Record, Care Plans, Physician Orders, and IDT notes from April 2024 through June 2025. They found that no care plan for amphetamine use had been created when Resident 1 was readmitted on [DATE], after a positive test was reported by GACH 1. The DON noted that methamphetamine use can cause tachycardia, tachypnea, oxygen desaturation, and shortness of breath, and recalled observing these symptoms on April 16, 2025, when paramedics were called, although the resident refused hospital transport. He also observed that there was no documentation of the resident's physician being notified about his refusal to complete laboratory orders on April 30, 2025. The ADM could not find an investigation report from the May 2, 2024, IDT meeting and noted that the facility did not monitor Resident 1's methamphetamine use; the May 17, 2025, IDT meeting did not address his drug history, and no updated personal belongings inventory was completed after his readmission in June 2024. On June 5, 2025, the facility took possession of Resident 1's lighters, baggies with white residue, and glass pipe, and turned these items over to the police. During a review of the facility's undated Policy and Procedure (P&P) titled, Hazardous Areas, Devices and Equipment, indicated, All hazardous areas, devices and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible . 1. As part of the facility's overall safety and accident prevention program, hazardous areas and objects in the resident environment will be identified and addressed by the safety committee. 2. The safety committee will consist of members from the interdisciplinary team, which will include a representative from the clinical, leadership, maintenance, and environmental services teams . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A hazard is defined as anything in the environment that has the potential to cause injury or illness . Assessment and analysis of hazardous areas and equipment will include resident-specific information including identification of vulnerable residents . Resident vulnerability to hazards may change over time. Ongoing assessment helps identify when elements in the environment pose hazards to a particular resident . Improper or inappropriate use of equipment and devices will be identified as part of the hazards assessment and analysis . Interventions will address the specific hazards identified and may be facility-specific or resident-specific . Resident-specific interventions may include changes to the plan of care and/or increased supervision . Interventions will be accompanied by communication with staff and leadership, residents, family and visitors. The administrator is responsible for communicating all safety recommendations adopted by the safety committee to the appropriate departments within the facility. During a review of the facility's undated Policy and Procedure (P&P) titled, Smoking Policy - Residents, indicated, Oxygen use is prohibited in smoking areas .Residents who have independent smoking privileges are permitted to keep cigarettes, electronic-cigarettes, pipes, tobacco, and other smoking items in their possession .Residents without independent smoking privileges may not have or keep any smoking items, including cigarettes, tobacco, etc., except under direct supervision .The facility maintains the right to confiscate smoking items found in violation of our smoking policies. Confiscated resident property is itemized . The P&P further indicated that Prior to and upon admission, residents are informed of the facility's smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. During a review of the facility's undated P&P titled, Personal Property, indicated, Residents are permitted to retain and use personal possessions, including furniture and clothing, as space permits, unless doing so would infringe on the rights or health and safety of other residents . If it is determined through observation of the resident that he or she may have brought an illegal substance(s) into the facility, it is immediately reported to the charge nurse or supervisor. The supervisor and the DNS determine whether the situation warrants a referral to law enforcement .If items or illegal substances that belong to the resident are in plain view, and these pose a risk to the residents' health and safety, the items may be confiscated by facility staff. The circumstances, description of the item(s), and rationale for confiscating are documented in the resident's record .The resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary. During a review of the facility's undated P&P titled, Care Planning - Interdisciplinary Team, indicated, The interdisciplinary team is responsible for the development of resident care plans . Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT). During a review of the facility's undated P&P titled, Visitation, indicated, Some visitation may be subject to reasonable clinical and safety restrictions that protect the health, safety, security and/or rights of the facility's residents such as . denying access or providing supervised visitation to individuals who have a history of bringing illegal substances into the facility which places residents' health and safety at risk . If it is determined that an illegal substance(s) has been brought into the facility by a visitor, it is immediately reported to the charge nurse or supervisor. The supervisor and the DNS determine whether the situation warrants a referral to law enforcement. (continued on next page)

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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 - Actual harm Residents Affected - Few	a. If the supervisor notifies law enforcement, in accordance with state laws, he or she immediately implements measures to protect the health and safety of all residents, visitors and staff. This may include supervising the visitation until the situation is addressed or law enforcement arrives. b. If items or illegal substances are in plain view, and these pose a risk to the residents' health and safety, the items may be confiscated by facility staff. The circumstances, description of the item(s), and rationale for confiscating are documented in the resident's record.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately account for controlled medications (medications with a high potential for abuse) affecting six out of seven residents (Residents 2, 3, 4, 5, 6 and 7) in one of two inspected medication carts (Station 2 Cart 3) in accordance with the facility's policy and procedures for controlled medications by failing to: 1. Document in the Controlled Medication Count Sheet (CMCS, a log signed by the nurse with the date and time each time a controlled substance was administered to a resident) when the medication was removed from the medication supply of the residents and administered to Residents 2, 3, 4, 5, 6 and 7. 2. Remove and securely store the medications in the medication cart of Resident 3 who was transferred to the hospital and Resident 7 who had expired. This deficient practices increased the risk loss of controlled medication, medication errors for current residents (Residents 2, 4, 5, and 6), accidental administration of controlled medications belonging to discharged residents (Residents 3 and 7), and potential diversion (any use other than that intended by the prescriber), potentially affecting up to 54 residents on Station 2 out of a census of 110 (census dated [DATE]) possibly leading to adverse drug reaction (untoward reaction to a medication), serious health complications and hospitalization. Findings: During an observation of Station 2 Cart 3 and concurrent interview with the Licensed Vocational Nurse (LVN) 1, on [DATE], at 1:13 PM, the following discrepancies were found between the CMCS and the medication card (a bubble pack from the dispensing pharmacy labeled with the resident's information that contains the individual doses of the medication): 1. During a review of Resident 2's admission Record (AR, contains demographic and medical information), the AR indicated the facility admitted Resident 2 on [DATE] and readmitted on [DATE] with diagnoses that include, Multiple sclerosis (is a condition that affects the brain and spinal cord), and Major Depressive Disorder (a behavior condition of having severe sadness and hopelessness). During a review of Resident 2' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated [DATE], the MDS indicated Resident 2' s cognition (ability to think, remember, and reason) was intact. During a review of Resident 2' s Medication Administration Record the (MAR), included an order for Amphetamine/Dextroamphetamine (combination of two stimulant medications used to improve attention and focus,) 20 milligrams (mg - a unit of measure for mass), instructions to administer one tablet by mouth two times a day for attention deficit hyperactivity disorder (ADHD, lifelong brain disorder that makes it hard for a person to pay attention), scheduled administrations at 9 a.m., and 6 p.m. daily. Resident 2's MAR documented resident was administered one tablet at 9 a.m. on [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 2's CMCS for Amphetamine/Dextroamphetamine (combination of two stimulant medications used to improve attention and focus,) 20 milligrams (mg - a unit of measure for mass) indicated there were 33 tablets left. LVN 1 counted the tablets inside of the prescription bottle and stated the bottle contained 32 tablets (one tablet less). LVN 1 reviewed Resident 2's CMCS for Amphetamine/Dextroamphetamine and started to write on the resident's CMCS to indicate she removed a dose of Amphetamine/Dextroamphetamine from the prescription bottle. LVN 1 stated she was not sure if she had administered Resident 2's Amphetamine/Dextroamphetamine today, but she wrote down on the CMCS that she did. LVN 1 stated, I thought I gave the medication (Amphetamine/Dextroamphetamine) this morning at 9 a.m. LVN 1 acknowledged the current time was 1:29 p.m., on [DATE] (four hours and 29 minutes later) when she documented the removal and administration of Resident 2's Amphetamine/Dextroamphetamine in the resident's CMCS form. LVN 1 stated she was supposed to document in the CMCS form when she removed and administered Amphetamine/Dextroamphetamine to the resident which was scheduled for 9 a.m. on [DATE]. 2a. During a review of Resident 4's AR, the AR indicated the facility admitted Resident 4 on [DATE] and readmitted on [DATE] with diagnoses that include, Polyneuropathy (nerve damage) and personal history of healed traumatic fracture (broken bone) During a review of Resident 4' s MDS, dated [DATE], the MDS indicated Resident 4' s cognition was intact. During a review of Resident 4' s Order Summary Report (OSR), the OSR indicated active orders as of [DATE], Resident 4 OSR included the following orders: i. Pregabalin Capsule 50 mg, instructions indicated to give 1 (one) capsule by mouth two times a day for neuropathic pain, order date [DATE]. Ii. Percocet (Oxycodone/Acetaminophen, a medication used to treat pain) 5 mg/ 325 mg, instructions indicated to give one tablet by mouth every 8 (eight) hours as needed (PRN) for severe pain (7-10, pain scale with 0, zero indicating no pain and 10 indicating unbearable pain). The physician's order indicated not to exceed 3 (three) grams (gm - unit of measure) of Acetaminophen in 24 hours, with an order date of [DATE]. Resident 4's CMCS for Pregabalin (a medication used to treat pain) 50 mg indicated there were 13 tablets left, however, the medication card contained 14 tablet (one tablet extra). LVN 1 stated, I did not write the dose (one tablet of Pregabalin 50 mg) given down (on the CMCS form). LVN 1 stated she was supposed to document in the CMCS form when she removed Pregabalin for administration to the resident which was scheduled for 9 a.m. on [DATE] 2b. Resident 4's CMCS for Oxycodone/Acetaminophen (a medication used to treat pain) 5 mg/ 325 mg indicated there were 12 tablets left, however, the medication card contained 11 tablets (one tablet less). LVN 1 stated she administered one tablet of Oxycodone/Acetaminophen 5 mg/325 mg to the Resident 4 on [DATE], and did not document in the CMCS form when she removed the medication for administration to the resident. 3. During a review of Resident 6's AR, the AR indicated the facility admitted Resident 6 on [DATE] and readmitted on [DATE] with diagnoses that include low back pain, chronic pain syndrome, and age-related osteoporosis with current pathological fracture. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 6' s MDS, dated [DATE], the MDS indicated Resident 6' s cognition was intact. During a review of Resident 6' s OSR, the OSR indicated active orders as of [DATE], Resident 6 OSR included an order for OxyContin (Oxycodone, a powerful opioid painkiller used to treat severe pain) ER (Extended release) 12 Hour Abuse Deterrent 20 mg, instructions indicated to give 1 (one) tablet by mouth every 12 hours for chronic pain syndrome. Hold if drowsy or RR (respiration rate, the number of breaths a person takes per minute, normal range 12 and 20 breaths per minute) is less than 12, order date [DATE] Resident 6's CMCS for OxyContin (a powerful opioid painkiller used to treat severe pain) CR (controlled release) 20 mg indicated there were 28 tablets left; however, the medication card contained 27 tablets (one tablet less). LVN 1 stated on [DATE], I gave and did not document. 4. During a review of Resident 5's AR, the AR indicated the facility admitted Resident 5 on [DATE] with diagnoses that include acute pain due to trauma. During a review of Resident 5' s MDS, dated [DATE], the MDS indicated Resident 5' s cognition was intact. During a review of Resident 5' s OSR, the OSR indicated active orders as of [DATE], Resident 5 OSR included an order for Norco (Hydrocodone/Acetaminophen, used to relieve moderate to severe pain) 5 mg/ 325 mg, instructions indicated to give 1 (one) tablet by mouth every 6 (six) hours as needed for severe pain (7-10). Not to exceed 3 gm/day of Acetaminophen. Hold if drowsy or RR less than 12, order date [DATE] Resident 5's CMCS for Hydrocodone/Acetaminophen 5 mg/ 325 mg indicated there were 53 tablets, however, there were two medication cards labeled to contain a total of 52 tablets (one tablet less) of Hydrocodone/Acetaminophen 5 mg/ 325 mg for Resident 5. 5. During a review of Resident 3's AR, the AR indicated the facility admitted Resident 3 on [DATE] and readmitted on [DATE] with diagnoses that include Alzheimer's Disease with Early Onset (brain disorder that causes a slow decline in memory, thinking, and reasoning skills) and Hypertensive Heart Disease (heart problems that arise from long-term, uncontrolled high blood pressure). During a review of Resident 3's Transfer Form, dated [DATE], the Transfer Form indicated Resident 3 was transferred out of the facility to the hospital on [DATE] at 10:35 a.m., due to a low oxygen saturation. During a review of Resident 3' s MDS, dated [DATE], the MDS indicated Resident 3's cognition was severely impaired, rarely or never understood by others and rarely or never able to express ideas or wants. During a review of Resident 3' s OSR, the OSR indicated active orders as of [DATE], Resident 3 OSR included an order for Hydrocodone/Acetaminophen, 5 mg/ 325 mg, instructions indicated to give 1 (one) tablet by mouth every 4 (four) hours as needed for moderate to severe pain (4-10), order date [DATE] (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 3's (who was not in the facility) had Hydrocodone/Acetaminophen 5 mg/ 325 mg was observed inside of Station 2 Cart 3 mixed with controlled medications that belongs to the current residents in the facility. Resident 3's CMCS and the medication card indicated 32 doses were available. LVN 1 stated Resident 3 was out of the facility in the hospital, but his medications were still available in the medication cart. LVN 1 could not explain why Resident 3's medication was available inside of the medication cart and not removed after the resident was no longer in the facility. 6. During a review of Resident 7's AR, the AR indicated the facility admitted Resident 7 on [DATE] and readmitted on [DATE] with diagnoses that include encounter for palliative care (specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness), diseases of pancreas (a large gland behind the stomach), and adult failure to thrive. During a review of Resident 7's Record of Death dated [DATE], indicated Resident 7 date of death at the facility was [DATE] and timed at 8:30 p.m. During a review of Resident 7' s MDS, dated [DATE], the MDS indicated Resident 7's cognition was severely impaired, rarely or never understood by others and rarely or never able to express ideas or wants. During a review of Resident 7' s OSR, the OSR indicated active orders as of [DATE], Resident 7 OSR included the following orders: i. Morphine (a powerful opioid analgesic used to treat moderate to severe pain) 100 mg/ 5 ml, one 20 milliliters (ml - unit of measure), instructions indicated to give 0.25 ml by mouth every 4 (four) hours as needed for pain or shortness of breath (difficulty breathing), order date [DATE]. Ii. Lorazepam (used to treat anxiety disorders, a feeling of fear, dread, and uneasiness) 1 (one) mg, instructions indicated to give 1 (one) mg by mouth every 6 (six) hours as needed for anxiety (a feeling of unease, worry, or fear) or agitation (restlessness), with an order date of [DATE]. Resident 7's Morphine (a powerful opioid analgesic used to treat moderate to severe pain) 100 mg/ 5 ml, one 20 milliliter (ml - unit of measure) bottle and a medication card for Lorazepam (used to treat anxiety disorders, a feeling of fear, dread, and uneasiness) 1 mg tablet with a quantity of 14 tablets were observed inside of Station 2 Cart 3. LVN 1 stated Resident 7 expired at the facility a week ago. During a concurrent interview and record review on [DATE] at 2:03 p.m., with the Director of Nursing (DON), Resident 3's transfer and discharge record was reviewed. The DON stated Resident 3 was transferred to the hospital on [DATE] for low oxygen saturation (low blood oxygen) of 88 percent (%) (Normal oxygen saturation is 95% - 100%). DON stated when residents are not in the facility their medications should be removed from the medication cart to prevent medication errors. During a concurrent interview and record review on [DATE] at 2:14 p.m., with the DON, Resident 7's transfer and discharge record was reviewed. The DON stated Resident 7 passed away on [DATE]. DON stated controlled medications should have been given to him (DON) for residents that have passed away, discontinued medications, and medications left at the facility after resident transfer or discharge. DON stated he would store the discontinued controlled medications separately in a locked storage until the they can be destroyed together with the facility's consultant pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a continued interview on [DATE] at 2:18 p.m., with the DON, the DON stated the licensed nurses should document on the CMCS once the controlled medication was removed from the medication card and must sign the MAR (Medication Administration Record) after medication was administered to the resident. DON stated the importance of accurately documenting controlled medications was to ensure that residents are getting their medications as ordered, to make sure there are accurate counts, and prevent misuse of controlled medications. A review of the facility's policy and procedure (P&P), titled, Controlled Medications, dated 4/2008, indicated, When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): l) Date and time of administration. 2) Amount administered. 3) Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply. 4) Initials of the nurse administering the dose on the MAR after the medication is administered. A review of the facility's P&P, titled Controlled Medication Storage, dated, 8/2014, indicated, The director of nursing and the consultant pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications .Controlled medications remaining in the facility after the order has been discontinued are retained in the facility in a securely double locked area with restricted access until destroyed by the facility's director of nursing or a registered nurse employed by the facility and a pharmacist. The director of nursing in conjunction with consultant pharmacist or designee routinely monitors controlled medication storage, records, and expiration dates during medication storage inspection.