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 10/14/2024
NAME OF PROVIDER OR SUPPLIER Glendale Post Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 103) was treated in a dignified and respectful manner when a certified nursing assistant (CNA 2) did not provide body coverage when transporting Resident 103 through the hallway in a shower chair, in accordance with the facility ' s policy and procedure titled Dignity. This deficient practice had the potential to cause psychosocial (mental and emotional well-being) decline, resident ' s individuality, self-esteem, and self-worth. Findings: A review of Resident 103 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 103 was admitted to the facility on [DATE], with diagnoses that included Parkinson ' s disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and hypothyroidism (condition in which the thyroid gland [makes hormones that control the way the body uses energy] doesn ' t produce enough thyroid hormone). A review of Resident 103 ' s History and Physical dated 7/5/2024, indicated Resident 103 had the capacity to understand and make decisions. During an observation of the facility hallway near Shower room [ROOM NUMBER] on 10/14/2024 at 10:50 AM, Resident 103 was observed being transported via shower chair to the shower room by CNA 2. Resident 103 ' s buttocks were not covered and exposed. During an interview with CNA 2 on 10/14/2024 at 12:18 PM, CNA 2 stated she was unaware that Resident 103 ' s buttocks were exposed and will make sure next time to cover resident entirely. CNA 2 stated it was important for the resident ' s body to be fully covered to protect their privacy. During an interview with the Director of Staff Development (DSD) on 10/14/2024 at 12:37 PM, the DSD stated she will have a 1:1 with CNA 2. The DSD stated the importance for residents to be fully covered during transportation to the shower room is for resident dignity. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 10/14/2024 at 12:56 PM, the DON stated the importance of making sure resident ' s body are fully covered was to provide dignity because there are still people in the hallway. A review of the facility ' s policy and procedure titled Dignity, dated 02/2021 indicated staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854 Based on observation, interview, and record review, the facility IDT (Interdisciplinary Team- team of facility staff that plans the care for the residents) did not accurately assess on of one resident (Resident 90) to ensure safely self-administer 17 bottles of medications that were stored the bedside which were not prescribed or ordered by the physician to self administer by failing to: Conduct an Interdisciplinary Team (IDT) meeting to assess if Resident 90 had the cognitive and physical abilities to self-administer medications. Review if any of the medications were expired, discontinued, or recalled. Document time when Resident 90 self-administered her medications. Ensure the medications were stored in a secure place, and not easily accessible to other residents besides Resident 90. This deficient practice put Resident 90 and other residents in the facility that could access the medications to be at risk for potentially harmful side effects (undesirable effect of medication) and adverse reaction (an untoward reaction to a medication) of the drug to the current drug regimen of the resident that could result in hospitalization and death. Findings: During a review of Resident 90 ' s Admission Record indicated the resident was admitted on [DATE] with diagnoses that included leg fracture (break in the bone), malignant neoplasm (cancerous tumor that develops when cells grow and divide abnormally) of the kidney and the bone. During a review of Resident 90 ' s History and Physical (H&P), dated [DATE], indicated the resident has fluctuating capacity to understand and make decisions. During a review of Resident 90 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated [DATE], indicated the resident has intact cognition (ability to reason and thought process). During a review of Resident 90 ' s entire medical records did not indicate any evidence that Resident 90 was assessed by the facility if the resident was safe to self-administer medications at the bedside or if the medications were safe to be taken by Resident 90. The records also did not indicate any evidence that Resident 90 was being monitored by the facility for self-administering medications at the bedside. During a review of Resident 90 ' s Medication Administration Record (MAR) for September and [DATE] did not have documented evidence that Resident 90 was being monitored for the administration of her bedside medications or of any side effects associated with taking them. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on [DATE] at 12:16 PM inside Resident 90 ' s room, Resident 90 ' s bedside table and bedside nightstands were observed with multiple bottles of medications. Resident 90 stated the bottles are herbal medications and oils that she consumes for her illness. Resident 90 stated she has not talked to facility staff regarding the medications that she was taking. Resident 90 stated she takes the medications at least once a day and at any time she feels necessary. During a concurrent interview and observation on [DATE] at 2:16 PM with Registered Nurse (RN) 1, inside Resident 90 ' s room, Resident 90 ' s bedside medications were inspected. RN 1 stated the medications are easily accessible for Resident 90 and anyone who would walk into the room because they are just on top of the tables. RN 1 stated the resident has multiple bottles of medications that include: Lion's Mane Mushroom (medication derived from a mushroom that might improve nerve development and function) [NAME] Oil (made from the beans (seeds) of the [NAME] plant and is used for constipation, dry eye, childbirth, and to empty the colon) [NAME] Digest (blend of herbs) Cordyceps Eleuthero Root loose leaves (used to stimulate the body's resistance to physical, environmental, and emotional stressors) Mushroom powder (made of dried mushroom) [NAME] Root (made from a root and is often used for some skin conditions) Passionflower loose leaves (a type of herb that can be used for difficulty sleeping and anxiety [feelings of intense, excessive, and persistent worry and fear]) Guduchi powder (herbal powder that may be used to boost the immune system) Turmeric powder (herbal powder from turmeric that may be used to relieve pain and inflammation) Broc Elite Plus (herbal powder from broccoli that may be used to relieve inflammation) Oxy powder capsule (used to relieve constipation and bloating) Ultimate Enzyme capsule (used to support the digestive system) B17 capsule (a vitamin) Oregano oil (used to relieve inflammation) [NAME] ' s oil (used to relieve inflammation) Chaga oil (used to boost the immune system) (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Brain and body 7% solution (a supplement) During a concurrent interview and record review on [DATE] at 2:20 PM with RN 1, Resident 90 ' s entire medical records, including the nurses ' progress notes and IDT notes, were reviewed. RN 1 stated there was no evidence that Resident 90 was assessed if she was safe to take medications by herself. RN 1 stated before a resident can take medications, the resident must be assessed if they have the capacity to self-administer medications. RN 1 also stated there was no documented evidence that Resident 90 was being monitored by staff whenever she takes her bedside medications or if Resident 90 had any side effects from taking any of the bedside medications. RN 1 also stated there is no order from Resident 90 ' s doctor that Resident 90 may self-administer her bedside medications. During an interview on [DATE] at 3:53 PM with Pharmacist (PH), PH stated if there are no orders in the resident ' s chart, she would not be able to review Resident 90 ' s bedside medications. PH stated if the medications were not reviewed by the pharmacist prior to allowing the resident to taking them, the resident could be at risk for side effects. PH stated reviewing each medication is the only way of knowing if the bedside medications are safe for the resident to take. During an interview on [DATE] at 11:12 AM with Director of Nursing (DON), DON stated when a resident wishes to self-administer their own medications, they should be assessed first and the assessment documented on the form, Self-Administration of Medications. DON stated the resident ' s safety could be compromised when they self-administer bedside medications because there could be side effects for each medication. DON stated the facility should have verified with the pharmacist before allowing Resident 90 to take her bedside medications. DON stated all medications could have potential side effects and could pose a risk to Resident 90 ' s safety. DON stated he was not aware that Resident 90 was self-administering medications at her bedside. DON stated if he had known, the medications would have been brought to the attention of the pharmacist. During a concurrent interview and record review on [DATE] at 2:26 PM with DON, the facility ' s MRR for July, August, and September were reviewed. DON stated Resident 90 ' s bedside medications were not addressed in the MRR. DON stated the pharmacist was not aware of the medications the resident was taking because the resident did not have an order that she could self-administer medications. During a review of the facility ' s policy and procedure (P&P) titled, Administering Medications, revised , d+[DATE], indicated only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so. The P&P also indicated residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. During a review of the facility ' s P&P titled, Self-administration of Medications, revised ,d+[DATE], indicated the following: The interdisciplinary team (IDT) assesses each resident ' s cognitive and physical abilities to determine whether self-administration of medications is safe and appropriate for the resident. Nursing staff must determine who is responsible (the resident or nursing staff) for documenting that medications are taken. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. Nursing staff routinely checks self-administered medications and removes expired, discontinued, or recalled medications. Nursing staff reviews the self-administered medication record for each nursing shift, and transfers pertinent information to the Medication Administration Record (MAR) kept at the nursing station, appropriately noting that the doses were self-administered.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854 Based on observation, interview, and record review, the facility failed to accommodate the needs of three sampled residents (Residents 26, 83, and 314) by ensuring the residents call light (a device used to alert staff to the resident ' s room) within their reach (within arm ' s reach). This deficient practice had the potential for the residents not to receive or receive delayed care and services that could result in accidents and falls. Findings: 1. During a review of Resident 83 ' s Admission Record indicated the resident was admitted on [DATE] with diagnoses that included muscle wasting, cerebral infarction (stroke, loss of blood flow to a part of the brain), and contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion). During a review of Resident 83 ' s History and Physical (H&P), dated 2/21/2023, indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 83 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 7/16/2024, indicated the resident has severely impaired. cognition (ability to reason and thought process). The MDS also indicated the resident is dependent (helper does all of the effort) for activities such as dressing, toileting, and personal hygiene. The MDS also indicated the resident requires supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for eating. During a review of r83 ' s care plan for falls, initiated on 7/19/2024, indicated r83 is at risk for falls. The care plan included interventions for staff to ensure the resident ' s call light is within reach and encourage (the resident to use if for assistance as needed. The resident needs prompt response to all requests for assistance. During a review of Resident 83 ' s care plan for Visual Function, initiated on 8/2/2023, indicated Resident 83 was at risk for injuries related to impaired visual function. Interventions included to ensure Resident 83 ' s call light [is] within reach. During a concurrent observation and interview on 10/11/2024 at 1:53 PM with Registered Nurse (RN) 2, r83 ' s call light was observed on the floor and not within Resident 83 ' s reach. RN 2 stated Resident 83 ' s call light is not within the resident ' s reach because it is on the floor. RN 2 stated accidents, such as falls, could happen if call lights are not within reach of the resident. 2. During a review of Resident 314 ' s Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and pancreatitis (a condition that causes inflammation of the pancreas, a large organ that produces digestive enzymes and hormones). (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 314 ' s H&P, dated 7/1/2022, did not indicate if the resident has or does not have the capacity to understand and make decisions. During a review of Resident 314 ' s MDS, dated [DATE], indicated the resident has intact cognition. The MDS indicated the resident requires supervision on activities such as oral hygiene, dressing, and personal hygiene. The MDS also indicated the resident requires moderate assistance (Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) on activities such as toileting, bathing, and managing footwear. During a review of r314 ' s care plan for falls, initiated on 9/10/2024, indicated Resident 83 is at risk for falls related to limited mobility. The care plan included interventions for staff to ensure the resident ' s call light is within reach and encourage (the resident to use if for assistance as needed. The resident needs prompt response to all requests for assistance. During a concurrent observation and interview on 10/11/2024 at 11:42 AM with Licensed Vocational Nurse (LVN) 2 inside Resident 314 s room, Resident 314 ' s call light was observed on the floor and not within Resident 314 ' s reach. LVN 2 stated the resident ' s call light should be within the resident ' s reach. LVN 2 stated the resident could try to reach for the call light and potentially fall and get injured. During an interview on 10/14/2024 at 11:12 AM with Director of Nursing (DON), DON stated the resident ' s call light must be kept within arm ' s reach or within the resident ' s reach. DON stated if the resident does not have immediate access to the call light, there could be a delay in response by staff to the resident ' s needs. DON also stated accidents could happen when residents try to reach for the call light or if they cannot the help they need and get up by themselves. During a review of the facility ' s policy and procedure (P&P) titled, Call System, Residents, revised 9/2022, indicated each resident is provided with a means to call staff directly for assistance from his/her bed. The P&P also indicated calls for assistance are answered as soon as possible, but no later than 5 minutes. During a review of the facility ' s P&P titled, Answering the Call Light, revised on 9/2022, indicated for staff to ensure that the call light is accessible to the resident when in bed.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on interview and record review the facility failed to ensure that a current copy of a resident ' s advance directive was in the resident ' s medical record for two of three sampled residents (Resident 21 and 53). This deficient practice had the potential to result in misinformation of medical care and treatment and not honoring resident ' s wishes in cases where the resident and/or responsible party was unable to participate in making healthcare decisions. Findings: 1. During a review of Resident 53 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated an admission to the facility on [DATE] with diagnoses that included of metabolic encephalopathy (brain disease that alters brain function or structure), end stage renal disease (ESRD-irreversible kidney failure), and lobar pneumonia (an infection/inflammation in the lungs). A review of Resident 53 ' s History and Physical [H&P] dated 09/02/2024, the H&P did not indicate if Resident 53 had the capacity to understand and make decisions. The H&P Assessment indicated Resident 53 ' s decision maker was his family member (Family 1). A review of Resident 53 ' s Multidisciplinary Care Conference Note dated 06/12/2024, the note indicated the resident had an Advance Healthcare Directive (AHCD) and the facility requested a copy for file. A review of Resident 53 ' s Advance Healthcare Directive (AHCD) Acknowledgement form dated 09/01/2024 indicated Resident 53 did not have an Advance Directive. During a concurrent interview and record review of Resident 53 ' s Multidisciplinary Care Conference Note and AHCD Acknowledgment form with the Social Services Director (SSD) on 10/14/2024 at 10:31 AM, the SSD stated a copy of Resident 53 ' s Advance Directive was requested by the facility on 06/10/2024 and there was no follow up from facility staff since then. The SSD stated it was important to have Advance Directive readily available in the resident ' s medical chart, in case of emergency if any decisions need to be made. 2. During a review of Resident 21 ' s Face Sheet indicated an admission to the facility on [DATE], with diagnoses that included ESRD, pneumonia, and Vitamin B12 deficiency (a condition where the body does not have enough health red blood cells). During a review of Resident 21 ' s H&P dated 07/02/2023, the H&P indicated Resident 21 had the capacity to understand and make decisions. A review of Resident 21's AHCD Acknowledgment form dated 03/15/2023 indicated Resident 21 did not have an Advance Directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 21 ' s Acknowledgment of Decisions dated 07/21/2023, indicated Resident 21 had completed an Advance Directive. During a review of Resident 21 ' s medical records on 10/13/2024 at 6:45 PM, Resident 21 did not have a copy of an Advance Directive readily available in the medical records. During a concurrent interview and record review of Resident 21 ' s AHCD Acknowledgment form and Acknowledgment of Decisions with the SSD on 10/14/2024 at 10:35 AM, the SSD stated she did not know if Resident 21 had an Advance Directive, she did not follow up with family. During an interview with the Director of Nursing (DON) on 10/14/2024 at 12:55 PM, the DON stated it was important to obtain a copy of resident ' s Advance Directive to know how to take care of residents when that time comes, to know what resident wishes are and the interventions to provide case of emergency. A review of the facility ' s policy and procedure titled Advance Directives, dated 7/2018 indicated upon admission, the admission staff or designee will obtain a copy of resident ' s advance directive. The policy indicated a copy of the resident ' s advance directive will be included in the resident ' s medical record.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48661 Based on interview and record review the facility failed to notify the resident ' s physician and resident representative(s) for one of two sampled residents (Resident 21) with significant weight loss (when you lose more than 5% of your body weight over a period of six to 12 months) of 23 pounds (lbs.) in a period of 15 days. These deficient practices had the potential for the resident not to receive the necessary interventions to prevent further weight loss and negatively affect the provision of necessary care and services. Findings: A review of Resident 21 ' s Admission Record indicated the facility admitted the resident on 7/1/2021, with diagnoses including Parkinson ' s disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), cognitive communication deficit (difficulty with communication that was caused by a disruption in cognition), and heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). A review of Resident 21 ' s History & Physical (H&P) dated 5/11/2024, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 21 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/11/2024, indicated the resident had moderate cognitive impairment (could not navigate to new places, and they have significant difficulty completing complex tasks such as managing finances). The MDS indicated the Resident 21 weighed 126 pounds and had no weight loss or weight gain of 5% or more in the last month or 10% or more in the last six (6) months. The MDS indicated the resident was receiving mechanically altered diet (a diet that alters the texture of food to make the food easier to chew and swallow) and a therapeutic diet (a meal plan that was prescribed by a doctor and designed by a dietician to treat a medical condition). A review of Resident 21 ' s Nutrition assessment dated [DATE], indicated the resident ' s most recent weight was 148 lbs. The Nutrition Assessment indicated the resident was noted with significant weight gain and after re-weighing the resident, the new weight was showing a weight loss. The Nutrition Assessment indicated the residents Body Mass Index (BMI - a calculation that estimates body fat based on a person ' s weight and height) was overweight. The Nutrition Assessment indicated nutritional risks included variable oral intake, disease process, and psychotropic medications (a class of drugs that affect the brain, emotions, and behaviors) which may alter the resident ' s appetite. The Nutrition Assessment indicated nutritional interventions for weekly weights times four (4) to monitor for weight changes. A review of Resident 21 ' s Weights and Vitals Summary indicated the following: -On 6/10/2024 the resident weighed 148 lbs. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 6/25/2024 the resident weighed 125 lbs. A total of 23 pounds and 15.54% weight loss in 15 days. A review of Resident 21 ' s Medical Records, indicated the resident did not have a COC completed on 6/25/2024 for the resident ' s 23 lb. weight loss. A review of Resident 21 ' s Comprehensive Care Plan, indicated the resident did not have a care plan created on 6/25/2024 for the resident ' s 23 lb. weight loss. A review of Resident 21 ' s Nutrition Progress Note dated 7/1/2024 six (6) days after the weight loss, indicated the resident had a significant weight loss of 23 lbs. in two (2) weeks. The Progress Note indicated the resident was eating good. The Progress Note indicated prior to the resident ' s weight loss, resident did not have edema (swelling caused by a buildup of fluid in the spaces around the body ' s tissues and organs) or was receiving diuretics (a medication that increases the amount of urine produced by the kidneys, helping the body get rid of excess fluid and salt). The Progress Note indicated for the resident to be weighed times one (1), monitor weight changes, and adjust the residents plan as needed. A review of Resident 21 ' s Nutrition Progress Note dated 7/8/2024, indicated the resident ' s oral intake varies was between 51% to 100 %. The Progress Note indicated recommendations to provide snacks three (3) times a day between meals for weight management. During a dining observation in Resident 21 ' s room on 10/13/2024 at 12:35 PM, the resident was being assisted with feeding by a facility staff and was able to inform the staff what she wanted to eat first from the food tray. During an interview on 10/14/2024 at 9:24 AM, The DON stated there was not a COC or Care Plan completed for the resident ' s weight loss on 6/25/2024 but there should have been. The DON stated if a COC or Care Plan was not completed for the resident, the weight loss could lead to harm and physical or emotional distress. During a review of the facility ' s policy & procedure (P&P) titled Charting and Documentation revised 7/2017, indicated The following information was to be documented in the resident medical record: changes in the resident ' s condition. During a review of the facility ' s P&P titled Change in a Resident ' s Condition or Status revised 2/2021, indicated Prior to notifying the physician or healthcare provider, the nurse would make detailed observations and gather relevant and pertinent information for the provider. The nurse would notify the resident ' s attending physician or physician on call when there had been a significant change in the resident ' s physical/emotional/mental condition. The P&P indicated The nurse would record in the resident ' s medical record information relative to changes in the resident ' s medical/mental condition or status. During a review of the facility ' s P&P titled Weight Assessment and Intervention revised 4/2017, indicated Individualized care plans shall address to the extent possible the identified causes of weight change, goals and benchmarks for improvements, and time frames and parameters for monitoring and reassessment.

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 10/14/2024
NAME OF PROVIDER OR SUPPLIER Glendale Post Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0622

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48854

Based on interview and record review, the facility initiated facility initiated discharges on two of four sampled residents (Resident 320 and 111) when:

1. Resident 320 was informed by the Social Services Director [SSD] that she did not meet the criteria to stay admitted at the facility on 7/25/2024, after being admitted to the facility on [DATE]. Resident 320 was provided an option to pay out of pocket for Rehabilitation Services or sign the Against Medical Advice [AMA] on 7/25/2024. The facility did not provide adequate discharge planning for Resident 320, resulting in an unsafe discharge against medical advice [AMA] on 7/25/2024. Resident 320 was not provided with the information of the resident's rights to appeal and stay at the facility while an appeal is pending.

2. Resident 111, who had moderately impaired cognition (ability to reason and thought process), was not allowed to remain in the facility after the resident went out-on-pass on 7/27/2024 (OOP, a temporary permission of a resident to leave the facility in a specified time). On 7/28/2024, Licensed Vocational Nurse (LVN) 4 informed Resident 111 that she could no longer come back to the facility despite Resident 111 verbally informing LVN 4 of her desire to return to the facility. The facility did not provide adequate discharge planning for Resident 111, resulting in an unsafe discharge against medical advice [AMA] on 7/28/2024.

As a result of these deficient practices, Resident 320 signed the AMA form as instructed by the SSD and pre-emptively left the faciity on [DATE] and Resident 111 did not return to the facility. Both Resident 320 and Resident 111 did not receive further discharge planning and resources such as medications and treatments from the facility. Both residents had the potential to suffer the negative health effects of not receiving their medications or home health services.

Findings:

1. During a review of Resident 320 ' s Admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] with diagnoses that included gender identity disorder and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing).

During a review of Resident 320 ' s History and Physical (H&P, a comprehensive physician ' s note regarding the assessment of the resident ' s health status), dated 7/25/2024, indicated the resident have the capacity to understand and make decisions. In the H&P is a hand-written note that indicated the resident after arriving to the facility, she decided to leave AMA to [Family Member (FM) 2] ' s house in Orange County.

During a review of Resident 320 ' s medical records inquiry from the General Acute Care Hospital [GACH], signed on 6/20/2024, that was sent by the GACH to the facility on [DATE] at 4:49 PM, indicated the Resident 320 will need to be in a nursing home post-operatively.

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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

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 320 ' s Patient Medical Information from the GACH, dated 7/23/2024, timed at 3:39 PM, that was sent to the facility, indicated the resident will need Morphine (a pain medication) for pain as needed as well as Zofran (a medication that helps to relieve nausea and vomiting) 4 mg (milligrams, a unit of measure) every 6 hrs. Please start [resident] on IV (Intravenous, given into a person ' s veins) when she arrives to the facility. During a review of Resident 320 ' s Order Summary Report (a set of physician ' s order) for 7/2024, included an order entered on 7/24/2024 that indicated admit to Skilled Nursing [Facility name] from [General Acute Care Hospital (GACH)]. Another order entered on 7/24/2024 indicated admitted to custodial 7/24/2024. During a review of the Resident 320 ' s form titled, California Standard Admission Agreement for Skilled Nursing Facilities and Intermediate Care Facilities and Intermediate Care Facilities, included the sections titled Consent to Treatment, Your Rights as a Resident, and Financial Agreement. The form indicated Financial Arrangements were discussed with Resident 320. The form was electronically signed by Admissions Coordinator (AC) on dated 7/25/2024 at 11:32 AM, and Resident 320 on 7/25/2024 at 11:17 AM. During a review of the Resident 320 ' s Progress Notes, from date ranges 7/13/2024 to 8/13/2024, included a Social Service Entry Note authored by the Social Services Director (SSD) on 7/25/2024 at timed 11:38 AM that indicated Resident 320 does not meet the criteria for rehab therapy and had not been stably housed for some time. [Resident] requests to be discharged to family. The Progress Notes did not indicate Resident 320 was provided an option to apply for insurance coverage or appeal the insurance ' s decision. The Progress Notes did not indicate the resident received any post discharge assistance or resources such as home health services (medical care delivered in the patient's home), medications, or medication prescription (a written order for the preparation and use of a medicine). During a review of the Resident 320 ' s Notice of Proposed Discharge/Transfer, dated 7/25/2024, indicated the resident ' s reason for discharge as against medical advice. The document indicated the resident has a right to appeal the discharge and the facility may permit the resident to remain until the decision is rendered if the facility chooses to. The Notice indicated Resident 320 is self-responsible. The Notice did not include a signature of the resident or a representative in the section for Signature & Date- Resident or Resident ' s Representative. During a phone interview on 10/13/2024 at 4:16 PM with Resident 320, Resident 320 stated she did not leave the facility against medical advice (AMA- when a resident chooses to leave the facility before the doctor recommends discharge). Resident 320 stated the facility informed her that she did not have insurance coverage because she did not qualify for physical therapy (therapy that is used to preserve, enhance, or restore movement and physical function) and would have to pay for her stay at the facility. Resident 320 stated she did not have the financial capabilities to pay for the stay in the facility. (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same phone interview with Resident 320, Resident 320 stated the facility did not inform her that she could appeal the insurance ' s decision nor that she could apply for emergency insurance coverage. Resident 320 stated the facility did not inform her that she could stay in the facility when an appeal is being processed and a decision from the insurance company is pending. Resident 320 stated she did not want to leave the facility because she wanted to recover from her surgery in the facility. Resident 320 stated she was not provided a form titled, Notice of Proposed Transfer/Discharge that indicated her appeal rights. Resident 320 also stated she signed a form titled, Leave Hospital Against Advice, but did not understand what the form was about because he did not have any other options. Resident 320 stated she would have appealed the discharge if she was made aware, instead of leaving the facility. During the concurrent phone interview and record review on 10/13/2024 at 4:24 PM with Resident 320, the document titled, Leave Hospital Against Advice, was reviewed. Resident 320 stated she did not understand the AMA form that he signed. Resident 320 stated the AMA form was not explained by any of the facility ' s staff, he was just informed to sign it if he cannot pay for his stay to do physical therapy at the facility. During an interview on 10/13/2024 at 5:36 PM with Director of Nursing (DON), the DON stated Resident 320 was admitted to the facility after the resident underwent facial surgery. The DON stated the resident was admitted to the facility to recover from the surgery. During an interview on 10/13/2024 at 5:43 PM with Business Office Manager (BM), the BM stated before admitting residents into the facility, it is the facility ' s process to review the resident ' s financial documents, including the insurance, prior to accepting residents. The BM stated it is the facility ' s process to request for authorization (approval from a health plan that may be required before a person receives services in order for the service be covered) before admitting residents. During a concurrent interview and record review on 10/13/2024 at 6:12 PM with the BM, Resident 320 ' s financial documents were reviewed. The BM stated the GACH that transferred Resident 320 into the facility did not provide an insurance authorization to the facility. The BM stated the facility had to submit the request to Resident 320 ' s insurance for an authorization. During a review of Resident 320 ' s Notice of Authorization Services, dated 8/12/2024 [18 days after resident was discharged to the facility], indicated Resident 320 ' s stay at the facility was approved by the insurance. The BM stated because it was approved, the resident ' s stay at the facility was pre-authorized, or paid by the insurance. During another interview on 10/13/2024 at 6:32 PM with the DON, the DON stated that on 7/25/2024, the morning after Resident 320 was admitted to the facility, the facility conducted a meeting which discusses newly admitted residents to the facility. The DON stated that during the meeting, the facility identified that Resident 320 did not have insurance coverage for the resident ' s facility stay due to not qualify for physical therapy services. The DON stated that after the meeting, the SSD informed Resident 320 that the resident ' s stay will not be covered by the insurance. The DON stated before admitting a resident, the facility must ensure that all financial documents have been reviewed. The DON stated the BM is responsible for verifying all financial documents prior to a resident ' s admission. (continued on next page)

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Glendale Post Acute Center	250 N. Verdugo Road Glendale, CA 91206

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 10/14/2024 at 9:56 AM with the SSD, the SSD stated if a resident does not have a health insurance, the facility could apply for an emergency insurance for the resident ' s behalf. The SSD stated he was not sure if he assisted the resident in applying for emergency insurance. During a record review of the resident ' s Progress Notes, from date ranges 7/13/2024 to 8/13/2024, did not indicate documented evidence that Resident 320 was assisted in applying for emergency insurance. During a concurrent interview and record review on 10/14/2024 at 2:53 PM with the DON, Resident 320 ' s Notice of Proposed Discharge/Transfer document was reviewed. The DON stated the document did not have Resident 320 ' s signature, which could mean the resident and/or representative did not receive the document during the stay/discharge from the facility. The DON stated the Notice indicated that the resident had an option to appeal the decision of the insurance to not approve the resident ' s stay at the facility. The DON stated Resident 320 would have remained in the facility if the insurance was going to pay for the resident ' s stay at the facility. During a concurrent interview and record review on 10/14/2024 at 2:53 PM with the DON, Resident 320 ' s entire medical records was reviewed. The DON stated the records did not indicate documented evidence that the resident received other services, such as home health services, when the resident left the facility. The DON stated the records did not indicate documented evidence that the resident received any medication or medication prescription when the resident left the facility. During a review of the facility ' s policy and procedure (P&P) titled, Transfer or Discharge, Facility-Initiated, revised 10/2022, indicated the following: The resident and his or her representative are given a thirty (30)-day advance written notice of an impending transfer or discharge from the facility. The resident is notified in writing of an explanation of the resident ' s rights to appeal the transfer or discharge. Notices are provided in a form and manner that the resident can understand, taking into account the resident ' s educational level, language, communication barriers, and physical or mental impairment. Upon notice of transfer or discharge, the resident will be provided with a statement of his or her right to appeal the transfer or discharge, including: The name, address, email and telephone number of the entity which receives such requests; Information about how to obtain, complete and submit an appeal form; How to get assistance completing the appeal process; and The facility bed-hold policy. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s P&P titled, Admission Criteria, revised 3/2019, indicated the facility is to ensure the facility receives appropriate medical and financial records prior to or upon the resident ' s admission. The P&P indicated prior to the admission, the resident or representative is informed of any service limitations or special characteristics of the facility. During a review of the facility ' s P&P titled, Resident Rights, revised 2/2021, indicated residents ' rights include the right to equal access to quality care, regardless of source of payment. 2. During a review of Resident 111 ' s Admission Record [AR], the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included difficulty walking, muscle wasting, hypertension (HTN-high blood pressure) and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 111 ' s History and Physical (H&P, a comprehensive physician ' s note regarding the assessment of the resident ' s health status), dated 5/25/2024, the H&P indicated the resident have the capacity to understand and make decisions. During a review of Resident 111 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 5/24/2024, indicated the resident had moderately impaired cognition. The MDS also indicated the resident required touching assistance (helper provide verbal cues and/or touching/steadying as resident completes the activity) to walk 10 feet. The MDS also indicated the resident was not assessed to walk more than 50 feet due to the resident ' s medical condition or safety concerns. During a review of Resident 111 ' s Order Summary Report, dated 10/13/2024, the Order Summary Report included a physician order, entered on 7/27/2024, that indicated the resident may go out on pass [OOP] with responsible party only for 4 hours max. Another physician order was entered the next day, on 7/28/2024 that indicated Resident 111 may discharge against medical advice (AMA, when a resident chooses to leave the facility before a doctor recommends discharge). During a review of Resident 111 ' s care plans from 5/20/2024 to 7/27/2024, did not indicate a care plan was developed for Resident 111 ' s out on pass order and/or issues/concerns the resident ' s OOP. The care plans further indicated the following information: A care plan initiated on 5/24/2024 indicated the resident uses antidepressant medication [related to] depression: Cymbalta. Interventions for the care plan included for staff to give antidepressant medications ordered by the physician. A care plan initiated on 5/21/2024 indicated the resident is at risk for cardiac distress [due to] HTN. Interventions for the care plan included for staff to monitor the blood pressure and administer medications as ordered. Interventions also included for staff to provide a calm and non stressful environment. During a review of Resident 111 ' s Order Summary Report, dated 7/1/2024, indicated Resident 111 was receiving the following medications while in the facility: Amlodipine besylate [medication to control the blood pressure] oral tablet 10 MG Give 1 tablet by mouth one time a day for hypertension, ordered on 5/20/2024. (continued on next page)

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F 0622

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Cymbalta [medication used to treat depression] oral capsule delayed release particles 60 MG Give 1 capsule by mouth at bedtime for depression [manifested by] excessive verbalization of sadness, ordered on 6/26/2024.

During a review of a facility document titled Temporary Leave of Absence, the document indicated one entry with a date out date of 7/27 (no year), a Time out time of 4:40 [PM] and Time exp. [expected] to return indicated 8:40 [PM]. The document indicated the destination of Resident 111 as home. The document also indicated two handwritten signatures- one under Signature of person taking [the] resident and one under nurse. The document indicated under the sections date return, time return, and signed in by remained blank.

During a review of Resident 111 ' s Progress Notes dated 7/27/2024, timed at 4:40 PM, the Progress Notes indicated Resident 111 went out on pass with [Family Member, FM] at 4:40 PM.

During a review of Resident 111 ' s Progress Notes dated 7/28/2024, timed at 1:44 PM, indicated the facility called resident to ask where she was and when will she come back, resident stated that she will come back tomorrow.

During a review of Resident 111 ' s Progress Notes dated 7/28/2024, timed at 1:52 PM, indicated the facility called Resident 111 and LVN 4 explained to the resident that Resident 111 exceeded the 4 hours OOP. The Progress Notes further indicated that LVN 4 explained that starting that day [7/28/2024], Resident 111 was AMA. The Progress Notes indicated Resident [111] verbalized that she did not understand why she is AMA. The Progress Notes did not indicate the reason why Resident 111 could not come back timely to the facility and an attempt to reach out to the resident ' s physician to notify/ask if Resident 111 could come back to the facility after missing the 4 hours OOP. The Progress Notes indicated the resident ' s physician agreed to Resident 111 ' s AMA.

During a review of Resident 111 ' s Progress Notes from May 2024 to July 2024 did not indicate the resident had previous history or issues with not following the facility ' s policy and procedure for temporarily going out on pass prior to 7/27/2024.

During a concurrent interview and record review on 10/13/2024 at 7:53 PM with the Director of Nursing (DON), Resident 111 ' s Progress Notes were reviewed. The DON stated the Progress Notes indicated Resident 111 went OOP on 7/27/2024. The DON stated according to the notes entered on 7/28/2024, Resident 111 did not want to be discharged from the facility because the notes indicated the resident planned to come back the next day. The DON stated he could not find documented evidence of other reasons why Resident 111 was discharged to the facility. The DON stated the only reason for Resident 111 ' s discharge was failing to return back to the facility after 4 hours of OOP.

During a concurrent interview and record review on 10/13/2024 at 8:17 PM with the DON, the facility ' s policy and procedure (P&P) titled, Signing Residents Out, revised on 8/2006, was reviewed. The DON stated the facility ' s P&P did not indicate there was a 4 hour a time limit for OOP. The DON stated the P&P did not indicate a resident who exceeds the time limit of an OOP could be considered as leaving the facility AMA. The DON stated Resident 111 should have been permitted to come back to the facility on [DATE].

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/14/2024 at 2:26 PM with the DON, Resident 111 ' s entire medical records were reviewed, including the care plans, progress notes, and Temporary Leave of Absence log was reviewed. The DON stated Resident 111 ' s Progress Notes indicated the resident did not have prior incidents of leaving the facility AMA. The DON added the resident ' s care plans do not have an entry that addresses non-compliance to the OOP policy or attempts to leave the facility. The DON stated Resident 111 ' s Temporary Leave of Absence log indicated the resident only exercised her OOP for one time, on 7/27/2024. During a review of Resident 111 ' s Progress Notes did not show documented evidence that Resident 111 received any discharge paperwork or prescriptions for her medications. During a review of the facility ' s P&P titled, Transfer or Discharge, Facility-Initiated, revised 10/2022, indicated the following: 1.Each resident will be permitted to remain in the facility, and not be transferred or discharged unless: a. The transfer or discharge is necessary for the resident ' s welfare and resident ' s needs cannot be met in the facility; b. The transfer or discharge is appropriate because the resident ' s health had improved sufficiently so the resident no longer needs the services provided by the facility; c. The safety of the individuals in the facility is endangered due to the clinical or behavioral status of the resident; d. The health of individuals in the facility would otherwise be endangered; e. The resident has failed, after reasonable and appropriate notice, to pay for (or to have pain under Medicare or Medicaid) a stay in the facility. f. The facility ceases to operate. During a review of the facility ' s P&P titled, Transfer or Discharge, Resident-Initiated, revised 10/2022, indicated the following: 1. ' Resident-initiated transfer or discharge ' means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility. 2.A resident ' s lack of objection to a facility-initiated transfer or discharge is not considered resident-initiated. 3.A resident ' s declination of treatment is no considered a resident-initiated discharge. 4.A resident ' s verbal or written notice of intent to leave against medical advice is considered a resident-initiated discharge.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48661 Based on interview and record review the facility failed to develop and revise the resident ' s care plan for one (1) of 3 residents, (Resident 38) by failing to revise Resident 38 ' s care plan for pain management when the resident continued to complain of pain everyday to indicate alternative interventions to relieve the resident ' s pain experience. This deficient practice resulted in Resident 38 to continue experiencing pain everyday that affected her quality of life. Findings: A review of Resident 38 ' s Admission Record indicated the facility initially admitted the resident on 3/6/2018 and readmitted the resident on 10/31/2023, with diagnoses including chronic congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), hypothyroidism (when the thyroid [a small, butterfly-shaped gland in the neck that produces hormones that regulate the body ' s metabolism, growth, and development] gland did not produce enough thyroid hormones), and anemia (a condition where the body did not have enough healthy red blood cells). A review of Resident 38 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/21/2024, indicated the resident ' s cognition was intact (sufficient judgement and self-control to manage the normal demands of the environment). The MDS indicated the resident received scheduled and as needed (PRN) pain medication and had experienced pain occasionally in the last five days. The MDS indicated the residents numeric pain rating scale was a nine from a zero to 10 scale (zero being no pain and 10 as the worst pain you could imagine). A review of Resident 38 ' s Pain Care Plan updated on 3/13/2024, indicated the resident ' s pain was related to advanced rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), deformed fingers, and osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D). The Care plan indicated a goal for the resident to sleep through the night and have no decline in functional activity or mobility related to pain. The Care Plan interventions included to evaluate the resident for breakthrough pain and establish pain relief interventions, and implement nonpharmacological interventions of repositioning, quiet environment, and reassuring words or gestures. A review of Resident 38 ' s Physician ' s Order dated 9/27/2024, indicated to administer Norco (opioid pain reliever [hydrocodone] and a non-opioid pain reliever [acetaminophen]) oral tablet 7.5-325 milligram (mg - unit of measurement), one (1) tablet by mouth every six (6) hours to the resident as needed for severe pain (7-10). A review of Resident 38 ' s Medication Administration Record (MAR) dated 10/1/2024 to 10/31/2024, indicated the resident received Norco oral tablet 7.5-325 mg ten times with a pain level ranging from seven (7) to 10 on the pain scale from 10/3/2024 to 10/13/2024. (continued on next page)

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	055523	A. Building B. Wing	10/14/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/12/2024 at 10:48 AM, Resident 38 stated she had pain every day and pain medication was provided to her when requested. Resident 38 stated Norco was the pain medication that helped to relieve the pain. During an interview on 10/14/2024 at 9:57 AM, the Director of Nursing (DON) stated Resident 38 ' s Pain Care Plan interventions were not revised. The DON stated the care plan should have been revised to reflect the resident continued to have pain and alternative interventions should had been identified because Resident 38 was still having pain. The DON stated although the medication was helping the resident ' s pain after given pain medication everyday, the facility should have been finding different ways to help alleviate Resident 38 ' s pain which should reflect in the care plan. During an interview on 10/14/2024 at 11:20 AM, the MDS Coordinator (MDSC) stated Resident 38 ' s Pain Care Plan was not revised since 3/13/2024. The MDSC stated if the care plan was not revised, the care plan would not reflect the resident ' s actual pain status, and the resident might experience worsening pain. The MDSC stated the care plan should have been revised because the resident ' s pain could affect her overall functional level. During a review of the facility ' s policy & procedure (P&P) titled Care Plans, Comprehensive Person-Centered dated 3/2022, indicated A comprehensive, person-centered care plan included measurable objectives and timetables to meet the resident ' s physical, psychosocial, and functional needs was developed and implemented for each resident. The comprehensive, person-centered care plan included measurable objectives and timeframes and describe the services that were to be furnished to attain or maintain the resident ' s practicable physical, mental, and psychosocial well-being. Assessments of resident were ongoing, and care plans were revised as information about the residents and the resident ' s conditions changed.

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F 0685

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Assist a resident in gaining access to vision and hearing services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 42878

Based on observations, interviews, and record reviews the facility failed to assist Resident 72 in receiving proper treatment and assistive devices to maintain vision when Resident 72 reported his prescription glasses (glasses prescribed by a doctor based on the resident ' s ability to see or vision) were broken by facility Certified Nursing Assistant (CNA).

This deficient practice could lead to Resident 72 experiencing a decline in his everyday quality of life while at the facility.

Findings:

A review of Resident 72 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated the resident was admitted to the facility on [DATE] with diagnoses that included cellulitis (a bacterial infection that affects the skin and underlying tissue) of upper limb, major depressive disorder (a mental health condition that causes a low mood and loss of interest in activities).

A review of Resident 72 ' s History and Physical assessment dated [DATE], indicated Resident has the capacity to understand and make decisions.

A review of Resident 72 ' s Minimum Data Set (a federally mandated resident assessment tool) dated 7/22/2024, indicated under the Hearing, Speech and Vision section Resident 72 uses corrective lenses.

A review of Resident 72 ' s Care Plan for Visual Function dated 1/3/2023 indicated Resident 72 was at risk for injuries related to impaired visual function, further deterioration in visual activity. The CP interventions for Resident 72 included: call light within reach, clean eyeglasses, instruct resident to use eyeglasses/ visual appliance routinely, Ophthalmology consult/Optometry consult (a physician specializes in eye diseases and vision)

During an interview and observation on 10/11/2024 at 2:49 PM of Resident 72 ' s room, Resident 72 ' s glasses wear observed on top of his bedside table. Resident 72 ' s glasses were observed broken and missing a glass lens. Resident 72 stated his prescription glasses had broken over a month ago when a CNA grabbed them from the side and the glasses dropped on the floor and broke, and the glass lens fell out. Resident 72 stated he had informed multiple facility staff that his eyeglasses broke. Resident 72 stated one of the social services staffs had told him they would help schedule an appointment with the doctor (Optometrist) but he had not heard anything or seen any doctors. Resident 72 stated his prescription glasses are very important to him as he needs them to see, read every day. Resident 72 stated he was making do by wearing his broken glasses and at times wearing non-prescription reading glasses one of his friends had bought for him while he waits for an update from the facility staff.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review on 10/13/2024 at 12:08 PM of Resident 72 ' s medical record with Social Service Assistant (SSA), SSA stated Resident 72 had notified her his glasses were broken over 3 weeks ago. SSA stated she had not reached out to facility ' s Optometrist when Resident 72 informed her about his broken glasses as she was waiting for the facility Optometrist to do their routine visit so she could inform him. SSA stated she had seen Resident 72 holding his glasses to his face and thought he was managing without prescription glasses, that was why she did not reach out to optometrist. SSA stated she had not documented on Resident 72 ' s records any communication to facility optometrist regarding Resident 72 ' s broken eyeglasses. During an interview on 10/13/2024 at 8:31 PM with Director of Nursing (DON), DON stated he became aware of Resident 72 ' s broken glasses a week ago when he saw Resident 72 ' s broken glasses. DON stated he informed Social Services to help make an appointment and assist Resident 72 in obtaining a new pair of glasses. DON stated he was not aware Resident 72 ' s glasses had been broken for over a month. DON stated Social Services should have contacted facility optometrist as soon as they were aware of Resident 72 ' s broken glasses and helped schedule an appointment or obtain a prescription for new glasses and not wait until the facility Optometrist conducted their routine facility visits as Resident 72 needs his glasses to see every day. During an interview on 10/14/2024 at 5:00 PM with DON, DON stated the facility did not have a policy for Ancillary eyeglasses services but it was facility practice to assist all Residents in by arranging appointments and obtaining necessary personal assistive devices such as prescription glasses as soon as possible when the Resident notifies the facility of an issue.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878 Based on observation, interview, and record review, the facility failed to administer oxygen therapy (treatment that provides supplemental, or extra, oxygen) with a physician order of the amount of oxygen and with the parameter to when or when not to administer oxygen in accordance to acceptable standards of clinical practice and accordance with the facility ' s policy and procedure for one of two sampled residents (Resident 47). This deficient practice could result in Resident 47 to receive too much or not sufficient oxygen to meet the body ' s demand and place the resident at risk for shortness of breath and/or hypoxia (low levels of oxygen in the body tissues) which can lead into serious injury or death. Findings: A review of Resident 47 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated the resident was admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes mellitus (a condition when the body doesn ' t produce enough insulin or use it properly) with diabetic chronic kidney (progressive failure of the kidney to remove toxins and excess body fluid) disease and heart failure (a condition where the heart has difficulty pumping blood thought out the body). A review of Resident 47 ' s History and Physical assessment dated [DATE], indicated Resident 47 did not have the capacity to understand and make decisions. A review of Resident 47 ' s Order Summary Report indicated on 8/25/2024, a physician order was made to administer Oxygen at 2 Liters (L- unit of measurement) per minute. A review of Resident 47 ' s Care plan for Risk of Respiratory Distress (difficulty breathing) indicated to administer Oxygen 2-3 liters per minute via nasal canula (a small plastic tube, which fits into the person ' s nostrils for providing supplemental oxygen) to keep Oxygen saturation above 92%. During an observation in Resident 47 ' s room on 10/14/2024 at 1:30 PM, Resident 47 ' s responsible party was observed asking Licensed Vocational Nurse 3 (LVN 3) to put on Resident ' s 47 ' s oxygen nasal cannula because the resident ' s oxygen saturation was at 89% (normal range 90%-100%). LVN 3 was observed entering Resident 47 ' s room and turning on oxygen tank dial to 3L and placing nasal cannula on Resident 47. LVN 3 then was observed putting on facility oxygen saturation monitor on Resident 47 ' s finger to measure Resident 47 ' s Oxygen level with a reading of 98%) (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 47 ' s active Physician orders on 10/14/2024 at 1:35 PM with LVN 3, LVN 3 stated Resident 47 had a current oxygen order indicating to administer to administer Oxygen at 2 Liters (L- unit of measurement) per minute. LVN 3 stated Resident 47 ' s order did not have any parameters to when to and when not to administer oxygen, and she would normally administer oxygen when Resident 47 ' s oxygen saturation level dropped below 90% or as needed when Resident 47 was observed having shortness of breath. LVN 3 stated she had not noticed Resident 47 ' s oxygen administration order did not have any parameter indicating when to administer the oxygen and would call Resident 47 ' s Primary Physician to clarify when Resident 47 ' s should receive Oxygen. During an interview with the Director of Nursing (DON) on 10/14/2024 at 3:42 PM, the DON stated all oxygen orders should have parameters so that the staff knows when they should administer the oxygen to residents. DON stated the licensed nurses should have called the doctor to clarify the order before administering to Resident 47 to make sure the oxygen was being used for the proper indication of use. A review of the facility ' s policy and procedure titled Oxygen Administration, with revision date of October 2010, indicated The purpose of this procedure is to provide guidelines for safe oxygen administration. 1. Verify that there is a physician ' s order for this procedure. Review the physician ' s order or facility protocol for proper oxygen administration.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 42854 Based on interview and record review, the facility failed to ensure two out of two licensed nurses (Registered Nurse [RN] 3 and Licensed Vocational Nurse [LVN] 3) in the facility completed their annual competency assessment and evaluation (a process that assess and evaluates an employees skills, knowledge and performance) for the appropriate job category, in accordance with the facility ' s policy and procedure. This deficient practice placed the residents at risk for receiving care and services that was not within the standard of practice appropriate and safe which could result in abuse and decline in the resident's quality of life and care. Findings: A review of RN 3 ' s employee file records indicated the facility hired RN 3 on 1/16/2023. RN 3 ' s employee records included a Skills Check List dated 1/16/2023 signed by employee and the Director of Nursing (DON). A review of LVN 3 ' s employee file records indicated the facility hired LVN 3 on 3/27/2023. LVN 3 ' s employee records included a Skills Check List dated 03/27/2024 signed by employee and the DON. During an interview and concurrent record review of employee file records with the DON on 10/14/2024 at 12:47 PM, the DON confirmed RN 3 and LVN 3 did not have documented evidence that a skills competency evaluation was completed since they were hired. The DON stated the facility holds a Skills Competency and Evalution fair yearly so everyone would have skills check at the same time. The DON stated there has not yet been a skills fair for this year. The DON stated the purpose of updating licensed nurses' skills competency was to make sure the nurses meet the standards and the qualifications of taking care of resident and whatever is in the skills competency to make sure nurses are up to date to keep residents safe. A review of the facility ' s policy and procedure titled Staffing, Sufficient and Competent Nursing, dated 08/2022 indicated competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. The policy indicated licensed nurses and nursing assistants are trained and must demonstrate competency in identifying, documenting, and reporting resident changes of condition consistent with their scope of practice and responsibilities. The policy indicated competency requirements and training for nursing staff are established and monitored by nursing leadership.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854 Based on observation, interview, and record review, the facility failed to conduct a Medication Regimen Review (MRR- a thorough evaluation of a patient's medications to identify and resolve issues, and to promote positive outcomes) to one of three sample residents (Resident 90) who consumed 17 bottles of medications kept at bedside that were not prescribed by the physician. This deficient practice put Resident 90 and other residents in the facility that could access the medications to be at risk for potentially harmful side effects (undesirable effect of medication) and adverse reaction (an untoward reaction to a medication) of the drug to the current drug regimen of the resident that could result in hospitalization and death. Findings: During a review of Resident 90 ' s Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included leg fracture (break in the bone), malignant neoplasm (cancerous tumor that develops when cells grow and divide abnormally) of the kidney and the bone. During a review of Resident 90 ' s History and Physical (H&P), dated 1/10/2024, indicated the resident has fluctuating capacity to understand and make decisions. During a review of Resident 90 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/27/2024, indicated the resident had no cognitive impairment (ability to reason and thought process). During a review of Resident 90 ' s Medication Administration Record (MAR) for September and October 2024, indicated no documented evidence that Resident 90 was being monitored keeping and taking medications kept at bedside and was not monitored for the side effects, adverse effect due to the interactions of the medications that the resident was consuming. During an observation and interview on 10/11/2024 at 12:16 PM inside Resident 90 ' s room, Resident 90 ' s bedside table and bedside nightstands were observed with multiple bottles of with medications. Resident 90 stated the bottles contained herbal medications and oils that she consumes for her illness. Resident 90 stated none of the facility staff has spoken to her about taking the medications that was stored in her bedside. Resident 90 stated she takes the medications that was not prescribed by the physician at least once a day and at any time she feels necessary. During an interview on 10/11/2024 at 12:42 PM with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she was not aware that Resident 90 was self-administering medications. LVN 2 stated she only administers medications that were prescribed by the resident ' s physicians. During a concurrent interview and observation on 10/11/2024 at 2:16 PM with Registered Nurse (RN) 1, inside Resident 90 ' s room, Resident 90 ' s bedside medications were inspected. RN 1 stated the resident had the medications for a few months. RN 1 stated the resident has multiple bottles of medications that include: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Lion's Mane Mushroom (medication derived from a mushroom that might improve nerve development and function) [NAME] Oil (made from the beans (seeds) of the [NAME] plant and is used for constipation, dry eye, childbirth, and to empty the colon) [NAME] Digest (blend of herbs) Cordyceps Eleuthero Root loose leaves (used to stimulate the body's resistance to physical, environmental, and emotional stressors) Mushroom powder (made of dried mushroom) [NAME] Root (made from a root and is often used for some skin conditions) Passionflower loose leaves (a type of herb that can be used for difficulty sleeping and anxiety [feelings of intense, excessive, and persistent worry and fear]) Guduchi powder (herbal powder that may be used to boost the immune system) Turmeric powder (herbal powder from turmeric that may be used to relieve pain and inflammation) Broc Elite Plus (herbal powder from broccoli that may be used to relieve inflammation) Oxy powder capsule (used to relieve constipation and bloating) Ultimate Enzyme capsule (used to support the digestive system) B17 capsule (a vitamin) Oregano oil (used to relieve inflammation) [NAME] ' s oil (used to relieve inflammation) Chaga oil (used to boost the immune system) Brain and body 7% solution (a supplement) During a concurrent interview and record review on 10/11/2024 at 2:20 PM with RN 1, Resident 90 ' s entire medical records, including the nurses ' progress notes, were reviewed. RN 1 stated there was no order from Resident 90 ' s physician that Resident 90 was allowed to self-administer medications that were kept at bedside. RN 1 also stated there was no documented evidence that Resident 90 was being monitored by staff whenever she takes her bedside medications or if Resident 90 had any side effects or adverse reaction from taking any of the bedside medications. During another interview on 10/11/2024 at 3:40 PM with Resident 90, Resident 90 stated none of the nurses or the pharmacist has spoken to her about the possible side effects of her medications. Resident 90 stated none of the facility staff have examined the medications kept at her bedside. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/11/2024 at 3:53 PM with Pharmacist Consultant (PH), PH Consultant stated if there are no physician ' s orders of medications in the resident ' s chart, she would not be able to review Resident 90 ' s bedside medications. PH Consultant stated if the medications were not reviewed by the pharmacist prior to allowing the resident to taking them, the resident could be at risk for side effects. PH Consultant stated reviewing each medication is the only way of knowing if the bedside medications are safe for the resident to take. During an interview on 10/14/2024 at 11:12 AM with Director of Nursing (DON), DON stated the facility should have verified with the pharmacist before allowing Resident 90 to take her bedside medications. DON stated all medications could have potential side effects and could pose a risk to Resident 90 ' s safety. DON stated he was not aware that Resident 90 was self-administering medications at her bedside. DON stated if he had known, the medications would have been brought to the attention of the pharmacist. During a concurrent interview and record review on 10/14/2024 at 2:26 PM with DON, the facility ' s MRR for July, August, and September were reviewed. DON stated Resident 90 ' s bedside medications were not addressed in the MRR. DON stated the pharmacist was not aware of the medications the resident was taking because the resident did not have an order that she could self-administer medications. During a review of the facility ' s policy and procedure (P&P) titled, Reconciliation of Medications on Admission, revised 7/2017, indicated information from the medication history should include herbal or dietary supplements, including vitamins and minerals. During a review of the facility ' s policy and procedure (P&P) titled, Consultant Pharmacist Reports, indicated the Medication Regimen Review (MRR) includes evaluation the resident ' s response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854 Based on observation, interview and record review, the facility failed to follow their policy and procedure guidelines to prevent food contamination and the spread of foodborne illness for one of one kitchen when: 1.Multiple opened dry food items in the kitchen ' s dry goods storage area were not sealed and labeled. 2.Two boxes containing 229 unpasteurized eggs were found in the kitchen and were being used as ingredients to foods served to residents. These deficient practices had the potential to result in pathogen (germ) exposure to residents and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever and can lead hospitalization . Findings: 1. During an observation on [DATE] at 8:55 AM in the facility ' s kitchen, the following opened food items were observed wrapped inside a transparent plastic wrap that were unlabeled: 4 Pasta bags 1 Gelatin Powder bag 4 [NAME] gravy bags During a concurrent observation and interview on [DATE] at 9:10 AM in the facility ' s kitchen with Dietary Supervisor (DS), DS stated opened food items must be stored in plastic bags. DS also stated the bags must be labeled with the date the items were opened and the expiration date of the items. During an interview on [DATE] at 1:57 PM with Registered Nurse (RN) 2, RN 2 stated food items must be labeled with open date and expiration date then stored in proper containers to prevent food contamination and use of expired food items. RN 2 stated using expired food items can cause foodborne illnesses. During a follow up interview on [DATE] at 12:45 PM with DS, DS stated opened food items must be stored in plastic bags that are sealable. DS stated opened items must have a label that indicates the product name, opened date, and the expiration date. DS stated not following the facility ' s policy could cause food contamination and food-borne illnesses if staff use expired food items. A review of the facility ' s policy and procedure (P&P) titled, Food Storage, revised 2017, indicated all opened and partially used foods shall be dated, labeled, and sealed before being returned to the storage area. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an observation on [DATE] at 8:52 AM inside the facility ' s kitchen ' s walk-in refrigerator, two (2) boxes of eggs were observed. The two boxes were examined and did not indicate whether the eggs were pasteurized. One box was unopened and contained 180 eggs. Another box was opened and contained 49 eggs. During a concurrent observation and interview on [DATE] at 9:35 AM with Kitchen Staff (KS), the two boxes of eggs were examined. KS stated the boxes do not have any labels that indicate the eggs were pasteurized. KS also stated each individual eggs do not have a stamp of P (indication of eggs were pasteurized). During a concurrent interview and record review on [DATE] at 9:44 AM with DS, the facility ' s delivery invoice, with delivery date of [DATE], was reviewed. DS stated the invoice indicated pasteurized eggs were out of stock. DS further stated the invoice indicated the facility received a substitute that did not indicate whether the eggs were pasteurized. DS stated she did not notice that the facility received unpasteurized eggs because the facility only orders pasteurized eggs. DS stated she did not know that the pasteurized eggs that were originally ordered were out of stock and the facility received unpasteurized eggs. During an interview on [DATE] at 1:57 PM with RN 2, RN 2 stated pasteurized eggs are used to prevent foodborne illnesses. RN 2 stated residents could potentially get sick if they consume unpasteurized eggs. A review of the facility ' s delivery invoice, with delivery date of [DATE], indicated the following: Egg Shell Lg Past CF Out/Stock Egg Shell Lg Wht AA CA CGFR EGG Prop 12 Compliant Substitute A review of the facility ' s P&P titled, Egg Preparation, revised 2017, indicated the following: Pasteurized eggs must be used for residents requesting soft cooked, over-easy, and soft poached eggs. Fried Eggs- Pasteurized in-shell eggs must be used. Boiled Egg- Pasteurized in-shell eggs must be used.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 48661 Based on interview and record review the facility failed to maintain complete and accurate documentation of medical records for one (1) of 11 sampled residents (Resident 80) by failing to update the contact phone number of the representative of Resident 80 in the Admission Record. The contact number listed in Resident 80 ' s chart was out of service. This deficient practice had the potential to interrupt provision of care and services for Resident 80 that could lead to delayed interventions to the resident especially during an emergency. Findings: A review of Resident 80 ' s Admission Record indicated the facility admitted the resident on 8/3/2023, with diagnoses including palliative care (a specialized medical care that helps people with serious illnesses feel better and improve their quality of life), anemia (a condition where the body did not have enough healthy red blood cells), and end stage renal disease (ESRD - irreversible kidney failure). The Admission Record indicated the resident ' s representative Family 1 (FAM) 1 was the responsible party for Resident 80 but the contact phone number listed was not updated and no other means indicated on how to contact and/or communicate with the resident ' s representative. A review of Resident 80 ' s History & Physical (H&P) dated 8/8/2023, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 80 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 7/25/2024, indicated the resident had moderate cognitive impairment (could not navigate to new places, and they have significant difficulty completing complex tasks such as managing finances). The MDS indicated the resident was receiving Hospice care (compassionate care for people who are near the end of life provided at the person ' s home or within a health care facility). The MDS indicated the resident and family participate in assessment and goal setting. During an attempt to contact the resident ' s responsible party on 10/12/2024 at 9:59 AM, the contact phone number listed on the Admission Record was out of service. During an interview on 10/13/2024 at 8 PM, the Infection Preventionist (IP) stated the receptionist obtained the resident representatives new contact number on 10/4/2024 but did not update the Admission Record on that day. The IP stated the receptionist should have updated the contact information otherwise the facility would not have the right number and would not know who to contact in case of an emergency. During an interview on 10/13/2024 at 8:45 PM, the Director of Nursing (DON) stated he was unaware that Resident 80 ' s representatives contact information was incorrect and out of order. The DON stated the resident representative ' s contact information should have been updated. The DON stated if the contact information was not updated the facility would not know who to contact and that would delay the care because the facility was unable to make decisions for the resident. (continued on next page)

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 10/14/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy & procedure (P&P) titled Resident Identification System revised 12/2007, indicated A resident identification system was used to help facility personnel provide medical and nursing care. Nursing staff will review and update resident identification information as necessary, in conjunction with the business office.

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NAME OF PROVIDER OR SUPPLIER Glendale Post Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48854

Based on observation, interview, and record review, the facility failed to implement the facility ' s policy and procedure for infection control related to Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs, Bacteria that resist treatment with more than one antibiotic]) due to presence of multiple wounds and use of a foley catheter (an indwelling medical device that consists of a hollow tube inserted into the bladder to drain or collect urine) for one of eight sampled residents (Resident 13). Certified Nursing Assistant (CNA) 1 was observed providing care to Resident 13 without wearing the proper personal protective equipment (PPE).

This failure placed Resident 13 and other residents to contract and or transmit the infectious organisms to other vulnerable residents and result in the spread of infection in the facility.

Findings:

A review of Resident 13 ' s Admission Record indicated the resident was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included urinary tract infection (UTI- an infection in the bladder/urinary tract) and pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence).

A review of Resident 13 ' s History and Physical (H&P, a comprehensive physician ' s note regarding the assessment of the resident ' s health status), dated 9/16/2024, indicated the resident does not have the capacity to understand and make decisions.

A review of Resident 13 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/20/2024, indicated the resident has severely impaired cognition (thought process and/or ability to think and reason).

A review of Resident 13 ' s Order Summary Report (a set of physician ' s order) dated 10/2024, included the following orders:

Enhanced Barrier Precautions (due to presence of wound), ordered on 9/14/2024.

Sacrum Pressure Injury cleanse with ns (Normal Saline, a saltwater solution), pat dry, apply Santyl (a medication to help in wound healing), then cover with island border dressing, ordered on 10/7/2024.

Left Heel Pressure Injury, cleanse with ns, pat dry, apply betadine (a cleaning solution) cover with roll gauze, ordered on 10/6/2024.

Right Heel Pressure Injury, cleanse with ns, pat dry, apply betadine cover with roll gauze, ordered on 10/6/2024.

F/C [Foley catheter] FR# (Fr, French gauge, a unit of measure) 16/10cc (cc, milliliter, a unit of measure), ordered on 9/14/2024.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 13 ' s care plan (a document that outlines the facility ' s plan to provide personalized care to a resident based on the resident ' s needs) initiated on 9/3/2024, indicated the resident requires Enhanced Barrier Precautions (EBP) due to presence of multiple wounds. The care plan included interventions that included for the facility to provide gowns and gloves at door entry and for staff to use gown and gloves during high contact resident care activities (dressing, bathing, transfers, hygiene, toileting, brief changes, changing linens, device care, wound care). During an observation on 10/11/2024 at 11:15 AM inside Resident 13 ' s room, Certified Nursing Assistant (CNA) 1 was observed providing care to Resident 13 without wearing an isolation gown (a type of PPE, a disposable gown made of paper-like material or plastic that helps in protecting the user ' s clothes). CNA 1 was within arm ' s length of Resident 13 and CNA 1 was handling a basin filled with soapy water. During a concurrent observation and interview on 10/11/2024 at 11:22 AM with CNA 1, CNA 1 provided a bed bath to Resident 13. When interviewed, CNA 1 stated she forgot to put on a gown while providing care to Resident 13 who required EBP. CNA 1 stated she should have worn a gown to protect her clothes and to prevent the spread of infections. During an interview on 10/11/2024 at 11:42 AM with Licensed Vocational Nurse (LVN) 2, LVN 2 stated residents who have wounds or catheters such as Resident 13 are placed on EBP. LVN 2 stated the purpose of EBP is to prevent the spread of infections from resident to resident. LVN 2 stated staff should wear a gown and gloves when providing care such as providing bed baths. During an interview on 10/14/2024 at 11:12 AM with Director of Nursing (DON), DON stated not following EBP instructions could cause a spread of infection from resident to resident. DON stated staff should use the appropriate pro equipment when providing high contact resident care such as bathing and showering. A review of the facility ' s policy and procedure (P&P) titled, Enhanced Barrier Precautions, revised 4/2024, indicated the following: Enhanced barrier precautions (EBP) is utilized to prevent the spread of multidrug-resistant organism (MDRO). EBP employs targeted gown and glove use during high contact resident care activities. High-contact resident care activities include bathing/showering, providing hygiene, and changing linens. EBP is indicated for residents with wounds and/or indwelling medical devices. PPE (Personal protective equipment) will be made available near or outside the resident rooms.

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on observation, interview and record review, the facility failed to provide a minimum of 80 square feet (sq. ft., unit of measurement) per resident for 33 out of 44 resident ' s rooms (Rooms 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 18, 19, 23, 24, 25, 26, 28, 29, 30, 31, 32, 33, 34, 41, 42, 43, 44, 45, 46). The 33 resident rooms consisted of 31- three (3) bed capacity rooms and two (2)- 2 bed capacity rooms. This deficient practice had the potential to impact the ability to provide safe nursing care and privacy to the residents. Findings: During an interview with the Administrator (ADM) on 10/11/2024 at 8:53 AM, the ADM stated the facility would like to request for a room waiver this year. During a review of the Client Accommodations Analysis form dated 10/11/2024, indicated the facility had 33 rooms (room [ROOM NUMBER], 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 18, 19, 23, 24, 25, 26, 28, 29, 30, 31, 32, 33, 34, 41, 42, 43, 44, 45, 46) that did not meet the federal requirements with more than 4 residents and measured less than the required 80 square(sq) feet (ft) per bed. During a review of the facility ' s request for additional room waiver dated 10/11/2024 indicated the granting of the variance will not compromise the health, welfare, and safety of the residents. The request indicated the following resident bedrooms were: room [ROOM NUMBER] (3 beds) 2 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 3 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 3 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 3 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 3 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 1 resident 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 3 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 2 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 3 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 3 residents 220 sq. ft. 73.3 sq. ft. (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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	room [ROOM NUMBER] (3 beds) 3 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 3 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 3 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 2 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 2 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 3 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 3 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 3 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 3 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 3 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 2 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 3 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 3 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 2 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 3 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 3 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 3 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 3 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (3 beds) 3 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (2 beds) 1 resident 143 sq. ft. 71.5 sq. ft. room [ROOM NUMBER] (3 beds) 3 residents 220 sq. ft. 73.3 sq. ft. room [ROOM NUMBER] (2 beds) 2 residents 143 sq. ft. 71.5 sq. ft. room [ROOM NUMBER] (3 beds) 3 residents 220 sq. ft. 73.3 sq. ft. During an interview with the ADM on 10/14/2024 at 11:49 AM, the ADM stated there have been no complaints from residents, resident families, and staff about the room size. (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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During an observation from 10/11/2024 to 10/14/2024, Rooms 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 18, 19, 23, 24, 25, 26, 28, 29, 30, 31, 32, 33, 34, 41, 42, 43, 44, 45, and 46 had adequate space, nursing care, comfort, and privacy to the residents. The residents residing in the affected rooms with an application for variance were observed to have enough space for the residents to move freely inside the rooms. Each resident inside the affected rooms had beds and bedside tables with drawers. There was adequate room for the operation and use of the wheelchairs (a chair fitted with wheels for use as a means of transport by a person who is unable to walk as a result of illness, injury, or disability), walkers (is a device that gives additional support to maintain balance or stability while walking,), or canes. The room variance did not affect the care and services provided to the residents when nursing staff were observed providing care to the residents. During a review of the facility ' s policy and procedure titled Bedrooms, dated 5/2017 indicated bedrooms accommodate no more than two residents at a time. The policy indicated the bedrooms measure at least 80 square feet of space per resident in double rooms and at least 100 square feet of space in single rooms.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48661 Based on observation, interview and record review the facility failed to maintain to keep the electric wheelchair of one of one sampled resident (Resident 40) in safe and functional condition. Resident 40 stated her electric wheelchair (a battery-powered device that helps people with mobility challenges move around) had been broken for two years and was waiting for the facility to fix the electric wheelchair. Resident 40 stated she was very frustrated that the electric wheelchair was broken and needs the electric wheelchair to go outside and be able to do things. This deficient practice resulted in the resident ' s feeling frustration that limits her ability to mobilize in and out of the room to socialize and do outside activities which negatively affected her quality of life that could affect her mental/emotional/psychological state. Findings: During a review of Resident 40 ' s Admission Record indicated the facility initially admitted the resident on 6/12/2018 and readmitted the resident on 8/26/2023, with diagnoses including morbid (severe) obesity (a severe and dangerous level of obesity that significantly increases the risk of health problems and shortens lifespan), anemia (a condition where the body did not have enough healthy red blood cells), and paraplegia (loss of movement and/or sensation, to some degree of the legs). During a review of Resident 40 ' s History & Physical (H&P) dated 5/8/2024, indicated the resident had the capacity to understand and make decisions. During a review of Resident 40 ' s MDS dated [DATE], indicated the resident ' s cognition was intact. The MDS indicated the resident ' s functional limitation in range of motion (ROM) were impaired on both sides of the resident ' s lower extremities (hip, knee, ankle, and foot). A review of Resident 40 ' s Care Plan dated 9/25/2024, indicated the resident used an electric wheelchair. The care plan ' s goal was for the resident to avoid hazards during immobility and to prevent dependent disabilities. The Care Plan interventions included the facility to check electric wheelchair for function before used, evaluate resident ' s ability to perform activities of daily living efficiently and safely on a daily basis, and will observe and monitor the resident maneuvering the electric wheelchair. The Care Plan did not mention the electric wheelchair was broken or any goals or interventions on the repair of the electric wheelchair. A review of Resident 40 ' s undated Medicare Drop Repair Assessment, indicated the chair (electric wheelchair) did not turn on and the right-side joystick was broken. The Repair Assessment indicated no repairs were done on the day of the assessment and parts to be ordered included two (2) batteries and a joystick mounting hardware. The Repair Assessment had a space for a signature and a date for the assessment, but the form was blank. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/11/2024 at 2:17 PM, Resident 40 stated her electric wheelchair had been broken for two years and was awaiting on the facility to fix the electric wheelchair. Resident 40 stated she was very frustrated that the electric wheelchair was broken and needs the electric wheelchair to go outside and be able to do things. During an interview on 10/13/2024 at 2:30 PM, the Social Services Assistant (SSA) stated she spoke with the resident on Monday 10/7/2024 to discuss the type of battery needed for the electric wheelchair to be fixed. The SSA stated Resident 40 ' s family was to purchase the battery, and the facility would change the battery out because the company for the electric wheelchair stated they would not be able to fix the electric wheelchair. During a concurrent interview and record review of Resident 40 ' s Electric Wheelchair Care Plan dated 9/25/2024 was reviewed on 10/14/2024 at 10:35 AM with the DON, the DON stated the resident ' s wheelchair should after two (2) years of trying to find a solution to fix the electric wheelchair, the facility attempted to have the Maintenance Supervisor try but that was beyond his scope and the electric wheelchair was still broken. The DON stated not having the electric wheelchair affects Resident 40 ' s quality of life negatively because the resident was unable to get out of her room and socialize, and that could have an effect on her mental/emotional/psychological state. During a review of the facility ' s policy & procedure (P&P) titled Care Plans, Comprehensive Person-Centered dated 3/2022, indicated A comprehensive, person-centered care plan included measurable objectives and timetables to meet the resident ' s physical, psychosocial, and functional needs was developed and implemented for each resident. The comprehensive, person-centered care plan included measurable objectives and timeframes and describe the services that were to be furnished to attain or maintain the resident ' s practicable physical, mental, and psychosocial well-being. Assessments of resident were ongoing, and care plans were revised as information about the residents and the resident ' s conditions changed. During a review of the facility ' s P&P titled Activities of Daily Living (ADL), Supporting dated 3/2018, 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 mobility (transfer and ambulation).