STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555839	A. Building B. Wing	01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dreier's Nursing Care Center	1400 West Glenoaks Blvd Glendale, CA 91201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48152 Based on interview and record review, the facility failed to decrease the risk of preventable falls for two of three sampled by failing to: 1. Complete the post fall monitoring for Residents 1 and 2, every shift for 72 hours per the facility protocol. 2. Ensure facility staff are aware of Resident 1's fall history, fall status, fall prevention interventions and injury from a previous fall during assigned shift. These failures placed Residents 1 and 2 at an increased risk for preventable falls with possible injury. Findings: 1. During a review of Resident 1's Admission Record, the record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of generalized muscle weakness (decreased muscle strength of the muscles), muscle spasm (involuntary contractions of a muscle), fibromyalgia (a disorder characterized by widespread musculoskeletal pain accompanied by fatigue, sleep, memory and mood issues), epilepsy (a disorder of the nervous system in which abnormal electrical activity in the brain causing seizures) and morbid obesity (a disorder involving excessive body fat that increases the risk of health problems). During a review of Resident 1's Minimum Data Set (MDS - a standardized resident assessment care screening tool) dated 10/31/2023, indicates the resident was assessed as being moderately impaired with cognitive skills for daily decision making. The MDS indicated Resident 1 was unable to walk. During a review of Resident 1's Morse Fall Scale (a tool of assessing a patient's likelihood of falling), dated 1/3/2023 indicated Resident 1 with a score of 95 making her high risk for falls (a score of 45 or more) for falls. The fall scale also indicated Resident 1 had an impaired gait (walking) and either overestimates or forgets ability to walk safely. During a review of Resident 1's Falls Care Plan, initiated on 11/29/2023, indicated Resident 1 as a high risk for falls and injury due to poor trunk control (upper body) and weakness, unsteady gait and need for assistance with transfers and ambulation (the act of walking). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Monthly Fall Logs, dated December 2023 and January 2024, the fall logs indicated Resident 1 had falls on 12/21/2023, 1/3/2024 and 1/22/2024. During a review of Resident 1's Witnessed Fall Care Plan, initiated 12/21/2023, the care plan indicated an added intervention on 1/3/2024 for staff to monitor and document for 72 hours any changes in mental status, pain, bruising and new onset of confusion, agitation, sleepiness, or inability to maintain posture. During an interview on 1/22/2024 at 1:55PM with Certified Nurse Assistant (CNA), CNA 1 stated he was assigned to Resident 1 to care for the resident on the morning shift and received report prior to starting his assignment. CNA 1 stated he did not receive any report regarding Resident 1's fall risks, current fracture (a break in the bone) and had no knowledge related to Resident 1's past falls, current fall risks or specific fall prevention interventions. During a concurrent interview and record review on 1/22/2024 at 3:43PM with Licensed Vocational Nurse (LVN) 1, Resident 1's Progress Notes (via electronic chart) for the month of 01/2023 were reviewed. The notes indicated no fall monitoring documented by licensed staff on 1/3/24 and 1/6/2024 during the 3-11pm (evening) shift. LVN 1 stated there should be documentation for the evening shifts on 1/3/24 and 1/6/2024 because monitoring is done for three days and every shift. LVN 1 also stated the importance of completing the 72-hour monitoring after a fall is to ensure there are no additional clinical changes with the resident, to prevent further falls and evaluate if further teaching is necessary. 2. During a review of Resident 2's Admission Record, the record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses of Parkinson's disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves) with dyskinesia (uncontrolled, involuntary muscle movements ranging from shakes, tics and tremors to full-body movements), history of falling, muscle spasms (involuntary contractions of a muscle) and unsteadiness on feet. During a review of Resident 2's Minimum Data Set (MDS - a standardized resident assessment care screening tool) dated 10/28/2023, indicates the resident's cognitive skills for daily decision making is intact. The MDS indicated Resident 1 required set up assistance with toilet transfer, but independent with walking 10 to 150 feet. During a review of Resident 2's Morse Fall Scale, dated 11/3/2023 indicated Resident 2 with a score of 90 resulting at a high risk for falls. The scale also indicated Resident 2 had an impaired gait and either overestimates or forgets ability to walk safely. During a review of Resident 2 's Falls Care Plan, initiated on 07/31/2023, the care plan indicated Resident 2 as a high risk for falls and injury due to Parkinson's disease, poor trunk control and weakness, unsteady gait, need of assistance for transfers and ambulation, unsteadiness on feet and history of falls. During a review of the facility's Monthly Fall Logs, dated January 2024, the fall logs indicated Resident 2 fell [DATE]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Actual Fall Care Plan, initiated 1/13/2024, the care plan indicated staff to monitor and document for 72 hours any changes in mental status, pain, bruising and new onset of confusion, agitation, sleepiness, or inability to maintain posture. During a concurrent interview and record review on 1/23/24 at 10:34AM with Registered Nurse Supervisor (RNS), the facility's Fall Documentation Guidelines, (undated), was reviewed. The guideline indicated licensed staff to document nurse's notes for 72 hours. RNS stated the documentation indicated is for licensed staff of each shift for 72 hours. During a concurrent interview and record review on 1/23/2024 at 10:46AM with LVN 2, Resident 2's Progress Notes (via electronic chart) for the month of 01/2023 were reviewed. The notes indicated no fall monitoring documented by licensed staff on 1/15/24 during the 3-11pm (evening) shift. LVN 2 stated there is no documentation, and the facility policy is to document for 72 hours, every nurse, every shift and once per shift. LVN 2 stated the importance of monitoring the residents for the 72 hours is because they can develop symptoms like dizziness, confusion and for resident's safety to ensure they are getting assistance. LVN 2 stated residents are at risk for falling again and possible injury (if not already injured) when 72-hour monitoring is not done per protocol. During a concurrent interview and review on 1/23/2024 at 11:19AM with RNS, the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, revised date of 12/2007 was reviewed. The P&P indicated staff will monitor and document each resident's response to interventions intended to reduce the risk or actual falling of residents. RNS stated that documentation indicated on policy refers to staff documenting for 72 hours, each shift after a resident as a fall. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, revised date of 7/2017, indicated all services provided to resident and any changes in the resident's medical, physical, or functional condition shall be documented in the medical record. The P&P also indicated the documentation will be complete and accurate. During an interview on 1/23/24 at 12:49PM with LVN 3, LVN 3 stated the facility does not have a system to identify residents at risk for falls or with a history of falls and that verbal report is the only way registry staff would know which residents are at risk. During an interview on 1/23/24 at 2:52PM with Director of Nursing, DON stated facility has no policy for endorsing resident information between shifts, staff or to registry staff. DON stated resident information is passed verbally during huddle reports. During a review of the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, revised date of 12/2007, indicated staff will identify interventions related to the resident's specific risks and causes to try and prevent residents from falling and minimize complications from falling. During a review of the facility's CNA Job Duties, dated 2003, the duties indicated CNAs are to provide each of their assigned residents with nursing care and services in with the Resident's assessment and care plan.