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	08/02/2024

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 - 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** 44372 Based on interviews and record reviews, the facility failed to ensure one of four sampled residents (Resident 1), who had severely impaired cognition (thought process), severe contractures (a permanent tightening of the muscle, tendon, skin, and nearby tissues that cause the joints to shorten and become very stiff) to the upper and lower extremities, was free from accidents and hazards by failing to: 1. Ensure Licensed Vocational Nurse [LVN] 1 and Registered Nurse (RN) 1 provided report and informed Certified Nurse Assistant (CNA) 1 on potential accident hazards concerning Resident 1's activities of daily living [ADL- fundamental skills that people need to do every day to care for themselves independently], including transfers from bed to chair and bathing, in accordance with the facility's policies and procedures [P&P] titled, Activity of Daily Living. 2. Ensure a care plan was developed to address Resident 1's specific needs for ADL assistance to monitor interventions and mitigate [make less severe] accident hazards identified is developed for Resident 1's bathing and transfer needs, in accordance with the facility's P&P Safety and Supervision of Residents, and Care Plans, Comprehensive Person-Centered. 3. Ensure CNA 1 identify and report to LVN 1 and RN 1 potential accident hazards to prevent avoidable accidents on 7/17/2024, after observing Resident 1 had severe contractures to both upper and lower extremities and stiffness [tightness or pain in the muscles, which can make it difficult to move] between the legs, prior to showering the resident on 7/17/2024. On 7/17/2024, CNA 1 placed Resident 1 from the bed to the shower chair (movable chairs designed to be used for bathing and placed inside the shower stall) alone and washed between the resident's legs by stretching the resident's lower extremities. (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 0689 Level of Harm - Actual harm Residents Affected - Few	As a result, Resident 1 complained of severe pain on 7/17/2024 after the shower. The facility transferred Resident 1 to the General Acute Care Hospital (GACH) 2 via 911 emergency services and was treated in GACH 2 Intensive Care Unit (ICU - specialized unit and treatment given to individuals who are acutely unwell and require critical medical care). Resident 1 sustained injuries to the lower extremities which included closed displaced fracture [a type of bone fracture where the bone breaks completely and moves out of alignment, creating a gap, but the skin does not break] of left acetabulum (socket of the hipbone [large bone between the waist and your legs], into which the head of the femur [thigh bone] fits), multiple pelvic fractures (break or crack open in one or more of the bones that make up the pelvis [(basin-shaped complex of the bones between the hips that connects the trunk and the leg]), marked widening of the pubic symphysis [a joint that connects the left and right pelvic bones], and hematoma [a pool of mostly clotted blood that forms in an organ, tissue, or body space caused by a broken blood vessel damaged by an injury] to the abdomen. Findings: During a review of Resident 1's Face Sheet (admission record), the Face Sheet indicated the facility admitted the resident on 1/15/2024 with diagnoses including contractures, and inactivity. During a review of Resident 1's History and Physical (H&P - a formal assessment of a patient and their medical condition performed by a healthcare provider, usually during an initial visit) dated 7/15/2024, indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's General Acute Care Hospital (GACH) 1 H&P dated 1/9/2024, indicated that prior to admission to the facility, Resident 1 was bed to wheelchair bound with pre-existing contractures to all joints. The GACH 1 H&P indicated Resident 1 had Decrease mobility due to severe bilateral [both] upper and lower extremities contractures and wound, severe disability [significantly limits your ability to perform basic work activities], bedridden [confined to bed], incontinent (having no or insufficient control over urination or defecation), and required constant nursing care and attention . During a review of Resident 1's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) dated 7/12/2024, the MDS indicated the resident's cognition (thought process) was severely impaired [a condition that significantly limits the individual's physical or mental abilities, so that he or she is unable to perform basic work activities]. The MDS indicated Resident 1 had unclear speech (slurred or mumble words). Resident 1 has rarely/never has ability to express ideas and wants and ability to understanding others. The MDS indicated Resident 1's functional limitation in range of motion (ROM-capacity for movement at a given joint) was impaired to both sides for upper and lower extremity. The MDS indicated Resident 1 was dependent (helper does all the effort. and resident does none of the effort to complete the activity, requiring assistance of two or more helper is required for the resident to complete the activity) to facility staff for shower/bathing (including washing, rinsing ,and drying self), upper body dressing, lower body dressing, personal hygiene, rolling to the left and right, sit to lying, lying to sitting on side of the bed, sit to stand, chair/bed-to-chair transfer, and toilet transfers (the ability to get on and off the toilet). The MDS further indicated for tub/shower transfers (the ability to get in and out of a tub/shower), Resident 1's assist level was Not applicable (not attempted and the resident did not perform the activity prior to the current illness). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Physical Therapy (PT) record, titled Joint Mobility assessment dated [DATE] signed by Physical Therapist (PT) 1 indicated Resident 1's joint mobility limitations. The facility's Joint Mobility Assessment indicated the appropriate percentage (%) description for each resident's joint mobility limitation indicating Moderate limitation (50% to 75%), and severe (75% to 100%) limitation. Resident 1's Joint Mobility Assessment indicated Resident 1's left, and right shoulder had moderate joint mobility limitation, left and right elbow had moderate joint mobility limitation, left and right hip had severe joint mobility limitation, left and right knee had severe joint mobility limitation. During a review of Resident 1's facility records titled, Physical Therapy Discharge Summary dated 3/26/2024 indicated Resident 1 had contracted muscle to the right and left lower leg, required maximum assistance for wheelchair mobility, bed to wheelchair transfers, sit to stand, but stand to sitting position was Not applicable. During a review of a facility document titled Nursing Service Assignment dated 7/17/2024, indicated Certified Nursing Assistant (CNA) 1 was assigned to Resident 1 on 7/17/2024 (7 AM to 3 PM). During a review of a facility document titled Nursing Care Shower Schedule indicated Resident 1's shower days were scheduled for Wednesdays and Saturdays. During a review of Resident 1's Activities of Daily Living [ADL] worksheet under the Task Shower/Bathe Self indicated a check mark for 7/3/2024, 7/5/2024, 7/6/2024, 7/10/2024, 7/12/2024, 7/13/2024, and 7/17/2024. The ADL worksheet indicated Resident 1 was totally dependent (helper does all the effort. Resident does none of the effort to complete the activity requiring assistance of two or more helper for the resident to complete activity) with staff during showering/bathing. The ADL worksheet did not indicate the type of shower or bath provided to Resident 1. During a review of Resident 1's Progress Notes dated 7/17/2024 and timed at 1:40 PM, documented by License Vocational Nurse (LVN) 1, indicated CNA [1] gave Resident 1 a shower (no time indicated). The Progress Notes indicated at 12:55 PM, Resident 1 was observed sweating and pale . The Progress Notes indicated a vital signs [V/S- clinical measurements of a person's essential body functions] 90/62 [blood pressure-BP], 97 beats/minute [heart rate -HR], 95.6 degrees Fahrenheit [temperature], and oxygen saturation [amount of oxygen in the blood] of 90 to 91 % [normal levels between 95 to 100%] on room air [the normal air we breathe in everyday environment]. The Progress Notes indicated Resident 1 stated I have chest pain when asked for pain or discomfort and was moving his head and up and down [nodding]. The Progress Notes indicated at 1 :02 PM, Registered Nurse (RN) 1 called 911 emergency services and Resident 1 was transferred to the general acute care hospital (GACH 2) on 7/17/2024. During a review of Resident 1's Situation, Background, Assessment, and Recommendation (SBAR, a technique used to facilitate prompt and appropriate communication) form dated 7/17/2024 and timed at 12:04 PM, indicated that LVN 1, who was the charge nurse for Resident 1 on 7/17/2024 wrote that at around 12: 55 PM, Resident 1 was noted sweating and pale . The SBAR form indicated LVN 1 asked Resident 1 if he has pain or chest pain in the resident's native language to move his head up and down. The SBAR form indicated Resident 1 responded by moving his head up and down . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's typewritten investigation report dated 7/22/2024, authored by the Director of Nursing (DON), the investigation report indicated Resident 1 was alert and oriented to self and able to understand simple phrases and follow simple instructions. The investigation report indicated LVN 1 was alerted by the CNA to Resident 1's room around 12:55 PM on 7/17/2024, because Resident 1 was pale and the scrotum (a part of the male reproductive system. It is a sac-like structure located behind the penis and contains the testicles) was swollen. The investigation report indicated the physician ordered the resident be transferred to GACH 2 for further evaluation via 911 emergency services. The investigation report indicated that facility staff was later notified by GACH 2 staff that Resident 1's x-ray (XR- a type of electromagnetic radiation used for imaging the inside of objects, including the human body) result indicated a fracture of the pelvis. During a review of the facility's undated handwritten investigation by the DON, indicated a telephone interview was conducted with CNA 1 on 7/18/2024. The handwritten investigation indicated that on 7/17/2024, LVN 1 informed CNA 1 that Wednesdays (7/17/2024) was Resident 1's shower day. The handwritten investigation indicated CNA 1 reported having Another CNA (CNA 2) assist him. The handwritten investigation indicated CNA 1 Attempted to wash between the Resident 1 legs with towel and there was resistance, so he did not try any harder. The handwritten investigation indicated that Resident [1] started to clench (close tightly) his legs/thighs, then put a diaper on the resident. The handwritten investigation further indicated He (CNA 1) needed assistance when putting diaper on Resident 1. The handwritten investigation indicated that at Approximately 12:55 PM, he (CNA 1) called LVN 1 because Resident [1] was pale, holding on his chest and sweating . The handwritten investigation indicated Later that evening [GACH 2 staff] notified [the] charge nurse that Resident [1] had sustained a pelvic fracture. During a review of Resident 1's GACH 2 records titled, Reason for Visit dated 7/17/2024, indicated the resident sustained a Closed displaced fracture [a type of bone fracture where the bone breaks completely and moves out of alignment, creating a gap, but the skin does not break] of left acetabulum (socket of the hipbone, into which the head of the femur [thigh bone] fits), contracture of joint of multiple sites, multiple pelvic fractures, nonverbal, severe dementia [the loss of cognitive (relating to the mental processes of perception, memory, judgment, and reasoning) functioning - thinking, remembering, and reasoning]. During a review of Resident 1's GACH 2 records titled, Physical Exam dated 7/17/2024, indicated [Resident 1] Appears in pain. In fetal position [the body lies curled up on one side with the arms and legs drawn up and the head bowed forward]. Initial concern for sepsis [a serious condition in which the body responds improperly to an infection (invasion and growth of germs in the body)], suspect likely intraabdominal [within the belly] source given abdominal pain. During a review of Resident 1's GACH 2 records and titled ED [Emergency Department] management dated 7/17/2024, indicated No history reported from [facility] of fall .Patient's (Resident 1) primary issue is open book pelvic [a type of fracture when the front of the pelvis breaks and separates into two or more pieces, often caused by trauma such as in an elderly fall] fracture. The orthopedic surgeons [doctors who specialize in surgery of bones, joints, and muscles], unable to treat these fractures here, recommend transfer to trauma center. During a review of Resident 1's GACH 2 records dated 7/17/2024 and titled, XR [x-ray] Hip Left 2 to 3 View, indicated, Reidentification of fractures of the left acetabulum and left pubis with marked widening of the pubic symphysis. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's GACH 2 records dated 7/17/2024 and titled, CT abdomen with Pelvis w Contrast indicated, there is anterior pelvic inflammatory stranding and presumed hematoma. During an interview on 8/1/2024 at 12:05 PM, CNA 1 stated he was assigned to care for Resident 1 on 7/17/2024, during the 7 AM to 3 PM shift. CNA 1 stated he was from a Nursing Registry [a business or agency that provides nursing staff to hospitals], and it was his first-time taking care of Resident 1. CNA 1 stated that on 7/17/2024, at around 7 AM, LVN 1 informed him it is Resident 1's shower day. CNA 1 stated he was not informed by facility staff if Resident 1 required one person or two people assistance. CNA 1 further stated he was not informed by LVN 1 if Resident 1 should be bathed using the shower chair or a shower gurney (a mobile, waterproof stretcher used for safely bathing patients who cannot stand or sit up. It features an adjustable frame and secure straps) or be provided with a bed bath (a technique for washing a bedridden patient using a damp washcloth or sponge and water while lying in bed) in his room. CNA 1 stated he observed Resident 1 to have contractures. CNA 1 stated around 10 AM, on 7/17/2024, he started to prepare Resident 1 for a shower. CNA 1 stated that since Resident 1 was contracted in both upper and lower body, CNA 1 called CNA 2 for help to transfer Resident 1 in the shower chair. CNA 1 stated he held Resident 1's armpits and CNA 2 held Resident 1's legs and transferred (moved) the resident to the shower chair. CNA 2 stated he wheeled Resident 1 on the shower chair to the Shower Room and showered Resident 1 while sitting up on the shower chair. CNA 1 stated, while giving Resident 1 a shower, Resident 1 was squeezing both thighs together as CNA 1 tried to clean between his legs. CNA 1 stated Resident 1 did not open his legs, so he did not try to open resident's legs any harder. CNA 1 stated Resident 1 was not able to bear weight in both upper and lower extremities. After giving Resident 1 a shower, CNA 1 wheeled Resident 1 back to the resident's room. During the same interview, on 8/1/2024 at 12:05 PM, CNA 1 stated he brought Resident 1 back to the resident's room and called CNA 2 to help him transfer Resident 1 from the shower chair back to the resident's bed. CNA 1 stated that if he received a report that Resident 1 was supposed to receive only bed baths while in bed and to not transfer or move the resident onto the shower chair to bathe in the Shower Room, he would not have transferred Resident 1 in the shower chair. CNA 1 stated he would have provided Resident 1 with bed bath only. CNA 1 stated no one had informed him about Resident 1's routine or care plan for bathing. CNA 1 stated he was not aware if Resident 1 was able to sit on a regular wheelchair or shower chair. During an interview on 8/1/2024 at 12:54 PM, LVN 1 stated she was assigned to care Resident 1 on 7/17/2024, during the 7 AM to 3 PM shift. LVN 1 stated she was familiar with Resident 1 and was aware the resident is dependent [a person who depends on or needs someone or something for aid, support] on all ADLs. LVN 1 stated the facility staff started to give Resident 1 bed baths one month ago because of the resident having severe contractures. The reason for giving the resident bed baths was to ensure resident's safety to prevent the resident from falling and sustaining an injury or fracture. LVN 1 stated she could not find documented evidence of a care plan developed for Resident 1 to be provided with bed baths only due to the severity of his contractures. LVN 1 stated she informed CNA 1 of Resident 1's shower day on 7/17/2024 but did not give a detailed instruction that Resident 1 should be given a bed bath. LVN 1 stated during the beginning of the 7 AM to 3 PM shift, Resident 1 was doing well and without distress [unusual or exaggerated emotional responses]. LVN 1 stated another CNA (CNA 3), called LVN 1 on 7/17/2024 at around 12:55 PM to report that Resident 1 was pale and in pain . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/1/2024 at 1:28 PM, CNA 3 stated she was familiar with Resident 1 and had been assigned to care for Resident 1 in the past. CNA 3 stated Resident 1 required total assistance [staff performs the entire activity of daily living without participation by the resident] with ADLs. CNA 3 stated she had not given a shower to Resident 1 in the Shower Room for more than 3 weeks, instead she provided Resident 1 bed baths in his room. CNA 3 stated Resident 1's body slides down when sitting on the shower chair, that is why the facility's CNAs do not use the shower chair and provide Resident 1 with bed baths. CNA 3 stated that Resident 1 would not be able to sit still on a shower chair. During an interview with RN 1 and record review of Resident 1's care plans from 1/15/2024 to 7/17/2024, on 8/1/2024 at 1:40 PM, RN 1 stated there was no care plan developed for Resident 1 to specifically address how the resident would be provided with shower or bathing. RN 1 stated the facility staff had been providing Resident 1 with a bed bath due to severe contractures. RN 1 stated she was the RN Supervisor on 7/17/2024, during the morning shift and recalled informing CNA 1 on 7/17/2024, to give Resident 1 a bed bath in the room and not to transfer or move Resident 1 to the shower chair. During an interview on 8/2/2024 at 10:54 AM, Physical Therapist [PT] 1 stated Resident 1 should not use a shower chair because Resident 1 required a type of wheelchair with a high back and adjustable back rest due to severe contractures. PT 1 stated that the regular shower chair [low back] with wheels was similar to a regular wheelchair that can be unstable when used for a resident with severe contractures. PT 1 stated each facility staff should be instructed about Resident 1's limitations to ensure proper care. During an interview on 8/2/2024 at 11:12 AM, the Director of staff Developer (DSD) stated when Registry Staff [staff personnel provided by a placement service on a temporary or on a day-to-day basis, in a facility] works at the facility, there should be a shift huddle [a brief meeting that takes place at the beginning or end of a shift to share information] to get report for each residents' status and limitations. The DSD stated he could not find documented evidence in the resident's records that indicated Resident 1's bathing needs to be done in bed and not in a shower chair. The DSD stated he was not aware that facility staff had been providing bed baths to Resident 1. The DSD stated there was no specific care plan developed that indicated how Resident 1 should be showered or bathe given the resident's severe contractures. During an interview on 8/6/2024 at 2:25 PM, CNA 2 stated she worked at the facility on 7/17/2024, during the 7 AM to 3 PM shift. CNA 2 stated on 7/17/2024, between 11 to 11:30 AM, CNA 1 asked for her help to transfer Resident 1 from the shower chair to the bed. CNA 2 stated when she assisted CNA 1, CNA 1 already gave Resident 1 a shower. CNA 2 stated she did not help CNA 1 transfer Resident 1 from the bed to the shower chair prior to the shower and did not assist CNA 1 during Resident 1's shower. CNA 2 stated she helped CNA 1 transfer Resident 1 from the shower chair to the bed while holding on to Resident 1's legs. CNA 2 stated that during the transfer, Resident 1 was holding on to the shower chair very hard. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/2/2024 at 12:09 PM, the DON stated Resident 1 was bed bound (are not able to move around safely or comfortably). The DON stated the facility only had a shower chair and does not have a shower bed for Resident 1 to use in the Shower Room. The DON stated the facility did not have a list of residents for facility staff to know who gets a bed bath or shower in the Shower Room. The DON stated he could not find documented evidence that a care plan was developed by the licensed nurses of Interdisciplinary Team (IDT) for Resident 1's shower/bathing activities for safety and comfort, due to contractures and being bedbound. The DON stated CNA 1 informed her that he attempted to wash Resident 1 between the legs with a towel and there was resistance (a force, such as friction, that operates opposite the direction of motion of a body), so CNA 1 did not try to wash between the legs any harder. The DON stated CNA 2 assisted CNA 1 in transferring Resident 1 back to bed on 7/17/2024. During a review of the facility's policy and procedure (P&P) titled Safety and Supervision of Residents, revised Year 2017, indicated Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The P&P stated that the facility-oriented approach to safety addresses risks for groups of residents. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes . Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents .Staff shall monitor interventions to mitigate [make less severe] accident hazards in the facility and modify as necessary . The P&P further indicated that certain resident risk factors and environmental hazards included bed safety, safe lifting and movement of residents and falls. During a review of the facility's P&P titled, Activity of Daily Living, revised Year 2018, indicated, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the appropriate services necessary with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care), mobility [transfer and ambulation (walking), including walking], elimination [toileting] . The P&P further indicated that If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing care . During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, revised Year 2022, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The interdisciplinary team, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident . Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. The interdisciplinary team reviews and updates the care plan: when there has been a significant change in the resident's condition, when the desired outcome is not met .