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	09/10/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 44372 Based on interview and record review, the facility failed to implement its abuse prevention policy for one of five sample residents (Resident 1) by failing to report allegation of abuse to law enforcement according to the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigating. This deficient practice had the potential to result in unidentified abuse in the facility and failure to protect residents from abuse. Findings: During a review of Resident 1's Face Sheet (admission record), the Face Sheet indicated the facility admitted the resident on 7/31/2024 with diagnoses including Diabetes Type II (high blood pressure), dysphagia (difficulty swallowing), and cirrhosis of liver (a condition where scar tissue replaces healthy liver tissue , preventing the liver from functioning properly). 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 7/31/2024, indicated Resident 1 has the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) dated 8/06/2024, 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 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) lower body dressing, 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). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Dreier's Nursing Care Center	1400 West Glenoaks Blvd Glendale, CA 91201

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s facility records titled, Report for alleged inappropriate contact involving 1 and Unknown Male, indicated ,on 8/31/2024 at around 7 AM, CNA (Certified Nursing Assistant) 1 saw that Resident 1 was crying. CNA 1 approached Resident 1 and asked Resident1 what was wrong. Resident 1 reported to CNA 1 that she was hit last night. CNA 1 alerted RN (Registered Nurse) 1 about the event and the RN Supervisor went to Resident 1's room to speak to Resident 1 regarding the event, Resident 1 stated that He threatened to hit me last night. When asked to describe the person and identify him, the resident could not provide any information. The resident did not know if she was hit and denied that anyone had hit her. The RN Supervisor completed a thorough body assessment and noted no injuries. The RN Supervisor notified the DON, and the DON notified the Administrator. The record indicated the DON initiated an investigation into the allegation. During a review of Resident 1 ' s Progress Notes dated 8/31/2024 and timed at 2:24 PM, documented by RN, indicated CNA 1 requested supervisory assistance regarding Resident 1 reported to her at 7 AM she was hit, and Resident 1 was crying. RN 1 went into Resident 1 room to assess patient, awake no crying noted. Asked Resident did someone hit her, Resident 1 answered, I don ' t know. RN 1 asked if someone hurt her, resident stated, No. Resident asked what happen, resident stated, He threatened to hit me. RN 1 asked who? Resident unable to answer question, RN 1 asked specific questions ethnicity? Height? Hair Color? and Body Statue of male? Unable to answer question. RN asked when this occurred, resident stated last night. Complete body assessment done, no visible markings or trauma noted. During an interview on 9/10/2024 at 10:38 AM, LVN (Licensed Vocational Nurse) 1 stated he did not know if he should report allegation of abuse to Law enforcement or not. LVN 1 stated he had to verify with the (DON) Director of Nursing the reporting process to law enforcement. During an interview on 9/10/2024 at 10:47 AM, RN 2 stated she does not know which agencies she should report the allegation of abuse. RN 2 stated she would report to the DON. During an interview on 9/10/2024 at 11:14 AM, the Director of Staff Development (DSD) stated the allegation of abuse should be reported to California department of Public Health, Law Enforcement, and Ombudsman. During an interview on 9/10/2024 at 12:13 PM, RN 1 stated on 8/31/2024 at around 7 AM, CNA 1 reported to her that Resident 1 was crying and told her someone hit her. RN 1 stated went into Resident 1 room. Resident 1 in her room, in bed not crying, calm and stated no one hit her, then ask more questions and later she said he threaten to hit me ask the name and she said did not know, ask if he was tall short, etc RN 1 stated Resident 1 was unable to answer. RN 1 stated she assessed the resident head to toe, no injury noted. RN 1 stated she informed Resident 1's Physician, responsible party, and the DON. RN 1 stated she did not report the allegation of abuse to law enforcement, nor the Ombudsman. During an interview on 9/10/2024 at 12:34 PM, the DON stated administrator is the abuse coordinator but she was assigned to investigate the allegation of abuse and she was fully responsible for the investigation and reporting. The DON stated she reported the allegation of abuse for Resident 1 to CDPH and the ombudsman. The DON stated she was not aware that she had to report the allegation of abuse to law enforcement. The DON stated she has no evidence that allegation of abuse was reported to law enforcement. (continued on next page)

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Dreier's Nursing Care Center	1400 West Glenoaks Blvd Glendale, CA 91201

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P&P) titled Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigating, revised September 2022, indicated If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; c. The resident's representative: d. Adult protective services (where state law provides jurisdiction in long-term care); e. Law enforcement officials. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Verbal/written notices to agencies are submitted via special carrier, fax, e-mail, or by telephone.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 44372 Based on interview and record review, the facility failed to develop a resident-centered care plan and monitor Resident 1 after the allegation of abuse for one of five sampled Residents (Resident 1). Resident 1 did not have a care plan developed for allegation of abuse. This deficient practice had the potential to negatively affect Resident 1 psychosocial wellbeing. Findings: During a review of Resident 1's Face Sheet (admission record), the Face Sheet indicated the facility admitted the resident on 7/31/2024 with diagnoses including Diabetes Type II (high blood pressure), dysphagia(difficulty swallowing), and Cirrhosis of liver (a condition where scar tissue replaces healthy liver tissue , preventing the liver from functioning properly) 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 7/31/2024, indicated Resident 1 has the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) dated 8/06/2024, 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 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) lower body dressing, 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). During a review of Resident 1 ' s facility records titled, Report for alleged inappropriate contact involving 1 and Unknown Male, indicated, on 8/31/2024 at around 7 AM, CNA (Certified Nursing Assistant) 1 saw that Resident 1 was crying. CNA 1 approached Resident 1 and asked the resident what was wrong. Resident 1 reported to CNA 1 that she was hit last night. CNA 1 alerted RN (Registered Nurse)1 about the event and the RN Supervisor went to the room to speak to Resident 1 regarding the event , Resident 1 stated that He threatened to hit me last night. When asked to describe the man or identify him, the resident could not provide any information. The resident did not know if she was hit and denied that anyone had hit her. The RN Supervisor completed a thorough body assessment and noted no injuries. The RN Supervisor notified the DON, and the DON notified the Administrator. The DON initiated an investigation into the allegation. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Progress Notes dated 8/31/2024 and timed at 2:24 PM, documented by RN, indicated, CNA 1 requested supervisory assistance regarding Resident 1 reported to her at 7 AM she was hit, and patient was crying. RN 1 went into Resident 1 room to assess patient, awake no crying noted. Asked Resident did someone hit her, Resident 1 answered, I don ' t know. RN 1 asked if someone hurt her, resident stated, No. Resident asked what happen, resident stated, He threatened to hit me. RN 1 asked who? Resident unable to answer question, RN 1 asked specific questions ethnicity? Height? Hair Color? and Body Statue of male? Unable to answer question. RN asked when this occurred, resident stated last night. Complete body assessment done, no visible markings or trauma noted. During an interview on 9/10/2024 at 10:38 AM, LVN (Licensed Vocational Nurse)1 stated any allegation of abuse care plan should be initiated so staff know what intervention to take such as monitoring Resident for emotional distress. During an interview and record review of Resident 1 active care plan 8/31/2024 to 9/2/2024 on 9/10/2024 at 11:16 AM, Director of Staff Development (DSD) stated there is no care plan initiated for Resident 1 after allegation of abuse. DSD stated care plan is necessary so staff aware about what intervention to take after allegation of abuse such as monitoring Resident 1 for any emotional distress. During an interview and record review of Resident 1 nurses note from 8/31/2024 to 9/2/2024 on 9/10/2024 at 11:18 AM, Director of Staff Development (DSD) stated the document about monitoring Resident for emotional distress be documented in nurses progress note, DSD stated there is no record that staff monitor Resident 1 for emotional distress. During an interview on 9/10/2024 at 12:15 PM, RN 1 stated on 8/31/2024 around 7 AM CNA 1 reported to her that Resident 1 was crying and told her someone hit her. RN 1 stated went into Resident 1 room. Resident 1 in her room, in bed not crying, calm and stated no one hit her, then ask more questions and later she said he threaten to hit me ask the name and she said did not know, ask if he was tall short , etc RN 1 stated Resident 1 was unable to answer. RN 1 stated she assessed head to toe, no injury noted. Informed Resident 1 Physician, responsible party, and DON. RN 1 stated she did not develop a care plan for Resident 1's allegation of abuse. During an interview on 9/10/2024 at 12:15 PM, Social Worker 1 stated after any allegation of abuse she visit the resident and provide emotional support. Social Worker 1 stated she was informed on 9/2/2024 about Resident 1's allegation of abuse and Resident 1 was already transferred to the hospital. Social Worker 1 stated she was not working on 8/31/2024 and 9/1/2024. Social Worker 1 stated if she is not available nurses should monitor Resident 1 for any emotional distress. During an interview and record review of Resident 1 active care plans and nurses notes from 8/31/2024 to 9/2/2024, on 9/10/2024 at 12:46 PM, the DON stated any allegation of abuse, the licensed nurses should develop a care plan and monitor the resident for emotional distress. The DON stated she was not able to provide any documentation that the licensed nurses developed a care plan and monitor Resident 1 for emotional distress every shift. During an interview on 9/11/2024 at 11:34 AM, CNA 1 stated on 8/31/2024 around 7 AM, notice Resident 1 crying and in distress. CNA 1 stated Resident 1 told her He hit me and right away had ask RN 1 to come to the room. When RN 1 interviewed Resident 1, Resident 1 stated he threatens to hit me. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, revised March 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 intradisciplinary team in conjunction with Resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being, including: services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. When possible, interventions address the underlying source(s) of the problem area(s) not just symptoms or triggers. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.