

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555839	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Dreier's Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>36925</p> <p>Based on interview and record review, the facility failed to notify the physician of one of three sampled residents (Resident 1) with the significant change in condition when the resident ' s blood sugar level (the amount of glucose in the blood) was consistently elevated from 12/12/2023 - 12/14/2023.</p> <p>This deficient practice can cause the resident to be in a state of hyperglycemia (a condition where there is too much glucose in the blood) that could result to a serious health problem requiring emergency care, including a diabetic coma (a life-threatening medical emergency that occurs when a person with diabetes has dangerously high or low blood sugar levels) that could lead to death.</p> <p>Findings:</p> <p>A review of Resident 1 ' s Admission Record indicated that the facility admitted the resident on 11/29/2023 with diagnoses that included type 2 diabetes mellitus.</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and screening tool), dated 12/05/2023, indicated that the resident ' s cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and senses) was severely impaired and the resident had an active diagnosis of diabetes mellitus.</p> <p>A review of Resident 1 ' s Weights and Vitals signs (measurement of the blood pressure, heart rate, respiratory rate and body temperature) Summary Report indicated that the resident ' s blood sugar level from 12/12/2023 - 12/14/23 were as follows:</p> <p>On 12/12/2023</p> <p>6:29 AM - 372 milligrams per deciliter (mg/dL, unit of measure to determine the concentration of glucose in the blood), normal nmage 80 to 120 mg/dL.</p> <p>12:03 PM - 300 mg/dL</p> <p>8:19 PM - 321 mg/dL</p> <p>10:04 PM - 243 mg/dL</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>12/13/2023</p> <p>12:57 AM - 284 mg/dL</p> <p>6:20 AM - 344 mg/dL</p> <p>11:45 AM - 212 mg/dL</p> <p>5:00 PM - 343 mg/dL</p> <p>9:54 PM - 390 mg/dL</p> <p>12/14/2023</p> <p>1:00 AM - 399 mg/dL</p> <p>6:29 AM - 226 mg/dL</p> <p>6:30 AM - 495 mg/dL</p> <p>6:34 AM - 226 mg/dL</p> <p>A review of Resident 1 ' s Progress Notes did not indicate that the facility notified the resident ' s physician about the resident ' s elevated blood sugar level on 12/12/2023 and 12/13/2023.</p> <p>A review of Resident 1 ' s Change of Condition Evaluation, dated 12/13/2023 indicated the licensed nurse notified the physician on 12/13/2023 at 6:36 PM about observing the resident with labored breathing and shortness of breath, but did not report the resident ' s elevated blood sugar levels since 12/12/2023.</p> <p>A review of Resident 1 ' s physician ' s orders indicated that the facility only obtained a one-time telephone order to inject six (6) units of Insulin Lispro (a fast-acting insulin that starts to work about 15 minutes after injection to treat hyperglycemia) and a sliding scale (an insulin prescription that adjusts the amount of insulin a person receives based on their blood sugar level) for Insulin Lispro on 12/13/2023 at 11:40 PM and on 12/14/2023 at 12:12 AM respectively, a day after the resident ' s blood sugar was consistently elevated.</p> <p>During an interview with the Director of Nursing (DON) on 11/15/2024 at 9:02 AM, she stated that a change of condition is the presence of symptoms that the resident has outside of his baseline that could indicate a potential disease or infection. She stated that the licensed nurse should notify the physician as soon as possible after confirming the change of condition.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Licensed Vocational Nurse (LVN) 1 on 11/15/2024 at 10 AM, she stated that she worked on 12/13/2023 during the 3-11 PM shift. During a concurrent review of Resident 1 ' s Weights and Vitals Summary with LVN 1, that showed the blood sugar levels over 200 mg/dL on 12/12, 12/13, and 12/14/2023, she stated that she notified the nurse practitioner on 12/13/2023 at 6:36 PM about Resident 1 ' s labored breathing but did not report the resident ' s blood sugar level of 343 mg/dL at 05:00 PM, since she already had given the resident ' s prescribed routine medications for diabetes and the physician did not specify a parameter when to report an elevated blood sugar level. She stated she also did not report the resident ' s blood sugar levels that were over 200 mg/dL on 12/12/2023 and 12/13/2023 because of the same reason that there was no parameter when to call the doctor and the resident had been receiving his routine blood sugar medications. She stated that she would notify the physician, as a standard of practice, if the blood sugar level reached 400 mg/dL. LVN 1 stated that she created Resident 1 ' s Change of Condition Evaluation on 12/13/2023 during a concurrent review of the record.</p> <p>During an interview with the DON on 11/15/2024 at 10:56 AM, she stated that if the blood sugar level is not within normal values (80-130 mg/dL), the licensed nurse should immediately notify the physician because the resident could lead to hyperglycemia or hypoglycemia (when the blood sugar level drops too low) that could result to an altered level of consciousness, affect the kidneys, or diabetic ketoacidosis (a life-threatening complication of diabetes that occurs when the body doesn't have enough insulin to use blood sugar for energy).</p> <p>During a telephone interview with the physician (Physician 1) of Resident 1 on 11/15/2024 at 2:33 PM, he stated that the facility should notify him if the blood sugar level of the resident is over 200 mg/dL, since the resident could lead to a state of diabetic coma because of diabetic ketoacidosis due to hyperglycemia.</p> <p>A review of the facility ' s policy titled, Change in a Resident ' s Condition or Status, version 2.1, revised in 11/2015, indicated that the facility shall promptly notify the attending physician of changes in the resident ' s medical condition or status.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>36925</p> <p>Based on interview and record review, the facility failed to implement its policy and procedure for the care of a resident with urinary catheter (a thin, flexible tube that drains urine from the bladder into a collection bag outside the body) for one of three sampled residents (Resident 1) by failing to maintain an accurate record of the resident ' s daily urine output to prevent a urinary catheter-associated urinary tract infection (UTI-infection of the urinary tract, the bladder, ureters, urethra and the kidney).</p> <p>This deficient practice resulted Resident 1 to be hospitalized in an acute care hospital (GACH), transferred via 911 (an emergency service) due to a UTI, sepsis (severe infection in the blood) and a sudden decline in health condition.</p> <p>Findings:</p> <p>A review of Resident 1 ' s Admission Record indicated that the facility admitted the resident on 11/29/2023 with diagnoses that included severe sepsis (a life-threatening condition that occurs when the body's immune system has an extreme response to an infection or injury) and pneumonia (an infection/inflammation in the lungs).</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool), dated 12/05/2023, indicated that the resident ' s cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and senses) was severely impaired and that the resident used an indwelling urinary catheter (a hollow tube inserted into the bladder to drain or collect urine).</p> <p>A review of Resident 1 ' s Progress Notes, dated 11/29/2023, indicated that the facility admitted the resident with a indwelling (inserted in the bladder) urinary catheter.</p> <p>A review of Resident 1 ' s Order and Summary Report indicated that the physician made an order on 11/29/2023, to administer Furosemide oral tablet (also known as water pills, given to help treat fluid retention) 20 milligrams (mg, a unit of measure for mass) by mouth in the morning for heart failure.</p> <p>A review of Resident 1 ' s Care Plan, dated 11/30/2023, indicated that the resident used a urinary catheter in a closed system drainage for neurogenic bladder (a condition that occurs when the nerves and muscles of the bladder don't communicate properly with the brain, resulting in a loss of bladder control). The care plan indicated to monitor and document the fluid intake and output of the resident per facility policy in order to prevent the resident from having a urinary tract infection.</p> <p>A review of Resident 1 ' s Paramedic Report, dated 07/14/2023 indicated that the paramedics the resident had sepsis and an altered level of consciousness upon their arrival at the facility at 8:57 AM.</p> <p>During an interview with the Director of Nursing (DON) on 11/14/2024 at 3:20 PM, she stated that it is the policy of the facility to monitor the I&O (fluid intake and urine output monitoring) of the resident if the resident has an indwelling urinary catheter.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent review of Resident 1 ' s medical record with the DON, she stated that she could not find any record that would show that the facility monitored the I&O of the resident while she had an indwelling urinary catheter during her stay in the facility.</p> <p>During an interview with the DON on 11/15/2024 at 10:56 AM, she stated that the I&O monitors the fluid intake and the urine output of the resident who uses a urinary catheter to determine if the resident is retaining urine in the bladder. She stated that it can also detect potential complications like dehydration (fluid deficit in the body) and urinary tract infections (UTIs).</p> <p>During a concurrent review of Resident 1 ' s medical record with the DON, she confirmed that the resident had a care plan for the use of a urinary catheter and one of the interventions in the care plan was to monitor and document the I&O according to the policy of the facility.</p> <p>During a telephone interview with the primary physician (PHY 1) of Resident 1 on 11/15/2024 at 2:33 PM, he stated that the facility should monitor the fluid intake and output of a resident who uses an indwelling urinary catheter because if the output is significantly lower than the input, there could be an obstruction in the urinary system or the catheter that should be addressed promptly in order to prevent pain and infection.</p> <p>A review of the facility ' s undated policy titled, Catheter Care, Urinary version 1.1, revised in 9/2014 indicated that the purpose of the policy is to prevent catheter-associated urinary tract infections by maintaining an accurate record of the resident ' s daily output per facility policy and procedure.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>36925</p> <p>Based on interview and record review, the facility failed to implement its own policy and procedure by failing to provide necessary respiratory care to one of three sampled residents (Resident 1) by failing to:</p> <ol style="list-style-type: none"> 1. Assess the respiratory status and report to the physician immediately when Resident 1 ' s oxygen saturation decreased to 92% (a measurement of how much oxygen the blood is carrying as a percentage, normal range 90-100%). 2. Obtain a physician ' s order to safely administer oxygen. 3. Reassess the effectiveness of the oxygen intervention. <p>This deficient practice had the potential to expose Resident 1 to oxygen toxicity (a condition when the lungs and the central nervous system are damaged due to an excessive amount of oxygen breathed in) or respiratory depression (a condition when a buildup of carbon dioxide is in the blood due to slow or shallow breathing) due to an inappropriate amount of oxygen delivered and oxygen monitoring.</p> <p>Findings:</p> <p>A review of Resident 1 ' s Admission Record indicated that the facility admitted the resident on 11/29/2023 with diagnoses that included pneumonia (an infection/inflammation in the lungs) and respiratory failure (a serious condition that occurs when the lungs can't get enough oxygen into the blood that causes shortness of breath).</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool), dated 12/05/2023, indicated that the resident ' s cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and senses) was severely impaired and that the resident had an active diagnosis of pneumonia.</p> <p>A review of Resident 1 ' s Change in Condition Evaluation, dated 12/13/2023 indicated that the licensed vocational nurse notified the physician on 12/13/2023 at 6:36 PM about observing Resident 1 with labored breathing, shortness of breath, with an oxygen saturation of 92% on room air and the facility administered oxygen therapy running at two (2) liters per minute via nasal cannula (a small plastic tube, which fits into the person ' s nostrils for providing supplemental oxygen) per physician ' s order.</p> <p>A review of Resident 1 ' s clinical record indicated no physician order to administer oxygen therapy on 12/12/2023 at 6:36 PM. Resident 1 ' s clinical record did not indicate the resident was assessed for the possible cause of decreased oxygenation from 12/13 to 12/14/2023.</p> <p>A review of Resident 1 ' s Weights and Vitals Summary indicated that the resident ' s O2 saturation on the following dates and time were as follows:</p> <ol style="list-style-type: none"> 1. On 12/13/2023 at 8:26 PM, oxygen saturation was 97% in room air. <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. On 12/14/2023 at 1:15 AM, oxygen saturation was 95 % with oxygen via nasal cannula.</p> <p>3. On 12/14/2023 at 8:45 AM oxygen saturation was 91% with oxygen via nasal cannula.</p> <p>A review of Resident 1 ' s clinical record did not indicate if the resident ' s respiratory status and oxygen saturation was reassessed to determine if the oxygen delivered was effective to increase the resident ' s oxygen saturation after 8:45 AM on 12/14/2023.</p> <p>A review of Resident 1 ' s Progress Notes with the DON on 11/15/2024 at 10:56 AM, dated 12/14/2023 at 9:09 AM, indicated that the Registered Nurse (RN) assessed the resident and noted the resident to have sternal retractions (a sign of respiratory distress that occurs when a person is having difficulty breathing) with breathing, variable respiratory rates with apnea (when breathing temporarily stops or becomes very shallow) episodes, and obtained an order from the physician to send the resident via 911 (an emergency call number) to the hospital.</p> <p>The RN placed the resident on oxygen at 15 liters per minute with a non-rebreather mask (NRB, an oxygen mask that delivers high concentrations of oxygen for emergency situations when a person needs oxygen quickly) and stood beside the resident until the paramedics (an emergency personnel) arrived. There was no documented evidence in the progress notes that the RN rechecked the O2 sat of the resident after she administered 15 liters of oxygen via NRB to see if the intervention was effective or not.</p> <p>During an interview and a record review of Resident 1 ' s medical records with the Director of Nursing (DON) on 11/15/24 at 10:56 AM, she stated that the licensed nurse notified the physician on 12/13/2023 at 6:36 PM that the resident had shortness of breath and obtained an order to deliver oxygen at 2 liters per minute via nasal cannula. The DON stated that the registered nurse administered 15 liters of oxygen via NRB to the resident on 12/14/2023 when the resident ' s O2 sat dropped to 91% with oxygen at 2 L/min while waiting for the paramedics to arrive, but did not recheck the resident ' s O2 sat to see if the intervention was effective or not.</p> <p>During an interview and a record review of Resident 1 ' s medical records with the DON on 11/15/2024 at 1:39 PM, indicated no documented evidence that the physician ordered to administer 2 liters of oxygen via nasal cannula on 12/13/2023 at approximately 6:36 PM and 15 liters of oxygen via NRB to the resident on 12/14/2023 at approximately 08:45 AM respectively.</p> <p>During a telephone interview with the physician (Physician 1) of Resident 1 on 11/15/2023 at 2:33 PM, he stated that the facility did right by administering 15 liters of oxygen via NRB mask to the resident who had an O2 sat of 91% but the facility should reassess the O2 sat promptly to see if the intervention was effective or not.</p> <p>A review of the facility ' s policy titled, Oxygen Administration, version 1.1, revised in 10/2020, indicated that the facility should verify that the physician made an order to deliver oxygen to a resident, review the physician ' s order or facility protocol for oxygen administration, and assess the oxygen saturation of the resident before and while providing the oxygen therapy.</p>		