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	01/29/2025

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 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** 47467 Based on observation, interview and record review, the facility (Skilled Nursing Facility [SNF] 1) failed to allow one of two sampled residents (Resident 1) to remain in the facility and does not initiate a facility-initiated discharge (a discharge which the resident objects to or did not originate through a resident ' s verbal or written request, and/or is not in alignment with the resident ' s stated goals for care and preferences) to another facility (SNF 2) based on SNF 1 ' s inability to meet the resident ' s need for supervision due to wandering (residents who aimlessly move about within the building or grounds unaware of their personal safety) and risk for elopement (a resident who is incapable of adequately protecting himself, and who departs a health care facility unsupervised and undetected). Furthermore, SNF 1 failed to ensure SNF 1 and Resident 1 ' s physician (Physician 1) documented the information about the basis for Resident 1 ' s discharge to SNF 2, that included the specific resident needs the facility could not meet, the facility ' s efforts to meet those needs, and the specific services SNF 2 would provide to meet the needs of Resident 1 which could not be met at the current facility (SNF 1), in accordance with the facility ' s policy and procedures (P&P) on Transfer or Discharge, Facility-Initiated. Consequently, SNF 1 discharged Resident 1 to SNF 2 on 1/29/2025 timed at 12 PM, without Resident 1 and Resident 1 ' s responsible party ' s (RP 1 and RP 2) knowledge and approval. As a result of these deficient practices, on 1/29/2025, upon Resident 1 ' s arrival to SNF 2, Resident 1 refused to go inside SNF 2. Resident 1 verbalized feeling scared being discharged at a new facility (SNF 2) without RP 1 ' s knowledge. Resident 1 was screaming and under distress, refused any type of care, including medications and food at SNF 2. Resident 1 verbalized wanting to go back to his home at SNF 1. On 1/29/2025, at 6:30 PM, after 6.5 hours of being out of SNF 1, SNF 2 returned Resident 1 back to SNF 1 due to Resident 1 refusing to stay and receive care and services at SNF 2. Findings: (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Admission Record (AR), the AR indicated Resident 1 was admitted to the facility with diagnoses that included dementia [the loss of cognitive functioning (thinking, remembering, and reasoning) to such an extent that it interferes with a person's daily life and activities], altered mental status (a change in how well the brain is working, which can cause a variety of behavioral changes), difficulty walking, and abnormalities of gait and mobility. During a review of Resident 1 ' s Wandering Assessment, dated 11/11/2024, the Assessment indicated Resident 1 was at risk for wandering. The Assessment indicated Resident 1 could communicate and follow instructions, could move without assistance while in wheelchair, had no history of wandering, diagnosed with dementia/cognitive impairment and diagnosis impacting gait/mobility or strength. The Assessment indicated Resident 1 had wandering episodes in the previous month. During a review of Resident 1 ' s Minimal Data Set (MDS-a federally mandated resident assessment), dated 11/21/2024, the MDS indicated Resident 1 ' s cognition (ability to think, remember, and reason with no difficulty) was severely impaired and walking was not attempted due to medical condition or safety concern. During a review of Resident 1 ' s Nurses Progress Notes, dated 1/13/2025, the Progress Notes indicated after Resident 1 was found walking down the ramp in front of the facility by SNF 1 lobby on 1/11/2025, SNF 1 recommended Resident 1 to be transferred to a Memory Care Facility (a type of facility that provides specialized residential care for people living with other forms of dementia and need for around the clock supervision). The Progress Notes indicated the recommendation was made because Resident 1 was at high risk for wandering/elopement. During a review of Resident 1 ' s Admission Summary Progress Notes, dated 1/27/2025, the Notes indicated Admissions Coordinator (ADC) 1 sent a referral (the act of directing someone to a different place or person) to SNF 2 and was approved with a bed available. During a review of Resident 1 ' s Order Summary Report, the Summary Report indicated a physician order dated 1/28/2025, for a Lateral transfer to SNF 2. During a review of Resident 1 ' s Notice of Transfer/Discharge, dated 1/28/2025, the Notice indicated a notification date of 1/28/2025 with an effective date of 1/31/2025, for Resident 1 to discharge to SNF 2. The Notice indicated that The transfer/discharge was necessary for the resident ' s welfare and that the resident ' s needs could not be met in the facility. The Notice indicated the resident had the right to appeal the transfer/discharge and could file an appeal within ten calendar days of being notified. The Notice indicated The facility may not transfer or discharge the resident while the appeal is pending, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. During a review of Resident 1 ' s Admission Summary Progress Notes, dated 1/28/2025, one day prior to Resident 1 ' s discharge to SNF 2, the Progress Notes indicated at 2:47 PM, ADC 1 spoke to RP 1 over the phone to notify her of Resident 1's discharge plan that would take place on 1/31/2025. The Notes indicated Lateral SNF placement was recommended to attend to patient's (Resident 1) medical necessity - Memory Care/Secure Unit Transfer order made necessary for the patient's (Resident 1) welfare and safety, and these cannot be met at the current SNF (SNF 1). (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 a review of Resident 1 ' s Nurses Progress Notes, documented by RN 1, dated 1/28/2025 timed at 6:30 PM, the Progress Notes indicated that on 1/28/2025, a transportation arrived at SNF 1 to pick up Resident 1 to be discharged to SNF 2. The Notes indicated RP 1 was at bedside and verbalized how RP 1 was not notified and unaware of Resident 1 ' s discharge plan to SNF 2 on 1/28/2025. The Progress Notes indicated the DON spoke to RP 1 on the phone on 1/28/2025 and the discharge was cancelled on that same day (1/28/2025). The Progress Notes indicated RP 1 requested to further discuss the situation with the DON and Administrator but was informed to call back SNF 1, the next day (1/29/2025) after 9 AM. During a review of Resident 1 ' s Nurses Progress Notes, dated 1/28/2025, indicated on 1/28/2025 documented by RN 1 at 10:14 PM, the Progress NOtes indicated that during the evening shift (time not mentioned) RP 2 and the Ombudsman Representative (OMB 1- a patient advocate who assists individuals and groups in the resolution of conflicts or concern) arrived at SNF 1 asking for an explanation why Resident 1 was getting discharged to SNF 2 and requested to speak to the Administrator and the DON. The Notes indicated RN 1 informed RP 2 and OMB 1 that they would be able to speak to the Administrator and DON during normal office hours. During a review of Resident 1 ' s Discharge (DC) Summary/Comprehensive Assessment, dated 1/29/2025, documented by Registered Nurse (RN) 1, the DC Summary indicated the section to confirm if the DC assessment was given to Resident 1 or Resident 1 ' s RP was left blank. During a review of Resident 1 ' s Nurses Progress Notes, dated 1/29/2025, the Notes indicated Resident 1 left SNF 1 at 12 PM for a lateral transfer to SNF 2. During a review of Resident 1 ' s Case Management Notes, dated 1/29/2025, the Case Management Notes indicated Case Coordinator (CC) 1 called RP 1 to inform her of Resident 1 ' s discharge because it was Medically necessary (memory care/secure unit) for resident's welfare and safety. During an interview on 1/29/2025 at 10:40 AM with OMB 1, OMB 1 stated that on 1/28/2025, OMB 1 received a call that Resident 1 was being discharged against his will and his family ' s approval, so she went to SNF 1 to intervene on 1/28/2025 at around 7:30 PM. OMB 1 stated, she requested to speak with the DON but the DON refused to speak to her. OMB 1 stated, she reviewed Resident 1 ' s medical records and confirmed there was no written Notice of Resident 1 ' s transfer/discharge to SNF 2 for 1/28/2025. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/2025 at 10:50 AM with RP 1, RP 1 stated, on 1/27/2025, RP 1 received a call from SNF 2 ' s Business Development (BD) 1, BD 1 informed RP 1 that SNF 1 ' s ADC 1 asked SNF 2 ' s BD 1 to ask RP 1 for her authorization to transfer Resident 1 to SNF 2. RP 1 stated, she had not heard from SNF 1 and was unaware of this transfer, so she told SNF 2 ' s BD 1 that she needed to speak with SNF 1 ' s Social Worker (SSW) 1 first before giving discharge authorization for Resident 1. RP 1 stated, she called ADC 1 on 1/27/2025 and left a message for ADC 1 to call her back. RP 1 stated, on 1/28/2025, ADC 1 called her back stating that Resident 1 would be discharged on [DATE]. RP 1 stated, she had been working with SNF 1 ' s SSW 1 regarding Resident 1 ' s discharge plans and was not informed about the discharge plan to SNF 2. RP 1 stated, ADC 1 informed her that SSW 1 was no longer employed for SNF 1, and ADC 1 took over SSW 1 ' s SNF 1 responsibility. RP 1 stated, she informed ADC 1 that she did not agree to Resident 1 ' s planned discharge to SNF 2 and came to visit Resident 1 in the afternoon of 1/28/2025. RP 1 stated, while she was at SNF 1 on 1/28/2025, a person came and asked Resident 1 to get ready for the discharge to go to another facility (SNF 2). RP 1 stated, being in disbelief that SNF 1 still pursed the plan to discharge Resident 1 to SNF 2 despite RP 1 not authorizing ADC 1 to discharge Resident 1 to SNF 2 on 1/28/2025. RP 1 stated, she told RN 1 that she was not aware and did not approve Resident 1 to be discharges to SNF 2 on 1/28/2025. RP 1 stated, due to the incident, Resident 1 verbalized on 1/28/2025 to RP 1 that he was surprised, scared, and anxious and asked RP 1 why somebody would want to take him (Resident 1) out of his home. RP 1 also stated, she did not receive any written notification of transfer/discharge and was not given any list or resources or options of any SNFs to choose from prior to Resident 1 being picked up by a transportation to another SNF on 1/28/2025. During an interview on 1/29/2025 at 12:07 PM with RP 1, RP 1 stated that CC 1 just called RP 1 saying (Resident 1) is being discharged now, then hung up the phone. RP 1 stated, she did not receive any explanation or family meeting since the night before (1/28/2025) when the facility tried to discharge Resident 1 to SNF 2 for the first time without her approval. RP 1 stated, she was terrified how the facility treated Resident 1 given that SNF 1 already tried to discharge Resident 1 the first time on 1/28/2025 and again today (1/29/2025) without her authorization/approval as Resident 1 ' s RP. RP 1 stated, she was worried that Resident 1 would be under emotional distress because he was already scared and anxious from the first attempt to discharge out of SNF 1, the night before (1/28/2025). During an interview on 1/29/2025 at 12:20 PM with CC 1, CC 1 stated, ADC 1 had been in contact with RP 1. CC 1 stated, she just got involved in the case this morning (1/29/2025) to discharge Resident 1 to SNF 2. CC 1 stated, she called RP 1 after the driver took Resident 1 to SNF 2. CC 1 stated, RP 1 was upset, stating that she did not sign any paperwork or agreeing to the transfer and wanted to hold off the discharge. CC 1 stated, CC 1 told RP 1 that the facility had to transfer Resident 1 for his safety. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/2025 at 12:30 PM with ADC 1, ADC 1 stated, SSW 1 had been in contact with RP 1 but no longer working in the facility. ADC 1 stated, she took over Resident 1 ' s discharge planning on 1/27/2025. ADC 1 stated, SNF 2 approved SNF 1 ' s referral on 1/28/2025 so ADC 1 attempted to discharge Resident 1 on the same day (1/28/2025) because SNF 2 had a bed available. ADC 1 stated, ADC 1 did not receive any endorsements from SSW 1 when ADC 1 took over. ADC 1 stated, she based her decisions to discharge Resident 1 on SSW1 ' s progress notes and did not confirm if SSW 1 already provided RP 1 a list of SNF options for Resident 1 to transfer to. ADC 1 stated, she did not give RP 1 the resources for the plan to transfer/discharge to another facility. ADC 1 stated, she did not have any documented evidence that she gave SNF 2 ' s information to RP 1 prior to the attempt to discharge Resident 1 to SNF 2 on 1/28/2025 and again the actual discharge on 1/29/2025 (at 12 PM). ADC 1 stated, the discharge plan had been going on and planned since he was found outside SNF 1 unsupervised for the second time on 1/11/2025 as indicated in Resident 1 ' s progress notes. During a concurrent record review and interview on 1/29/2025 at 12:45 PM with ADC 1, Resident 1 ' s Notice of Transfer/Discharge, dated 1/28/2025, was reviewed. The Notice indicated ADC 1 informed RP 1 about the transfer on 1/28/2025 over the phone with the effective date of transfer was 1/31/2025. ADC 1 stated, she transferred Resident 1 on the same day because a bed was available at SNF 2. ADC 1 stated, she did not provide RP 1 a copy of the written Notice because she only notified RP 1 over the phone. During an interview on 1/29/2025 at 1 PM with the DON, the DON stated, the facility did not have a wander guard system (bracelets that residents wear, sensors that monitor doors and a technology platform that sends safety alerts in real time), so facility staff only supervise the residents. The DON stated, if a resident attempted to leave the facility, the facility staff would redirect the resident, contact the physician to check for any infection and monitor the resident ' s behavior. The DON stated, they could not meet Resident 1 ' s needs for safety measures due to Resident 1 ' s dementia and two occasions that Resident 1 was found just outside the facility unattended some time in November 2024 and on 1/11/2025. The DON stated, they conducted an IDT meeting on 1/13/2025 regarding the incident and explained to RP 1 that transferring Resident 1 to a Memory Care Facility would be better for Resident 1 ' s safety. During an interview on 1/29/2025 at 1:30 PM with RP 1, RP 1 stated, there was no IDT and Family meeting for Resident 1 ' s discharge planning. RP 1 stated, the facility did not discuss with her for any care plan or interventions that they would do regarding his dementia and confusion. RP 1 stated, the facility did not inform her the interventions the facility attempted to address for Resident 1 ' s behavior of wandering. RP 1 stated, she was just informed that the discharge to another facility was for Resident 1 ' s safety. RP 1 stated, ADC 1 did not provide her with any resources or offer her any facility choices that would meet Resident 1 ' s needs. During a telephone interview on 1/29/2025 at 3:15 PM with Resident 1, Resident 1 stated, he was sitting in a front office of a building (SNF 2) that he does not know. Resident 1 stated, he was so scared and felt so lost. Resident 1 stated, he did not eat or drink anything. Resident 1 stated to help bring him home (SNF 1). (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/2025 at 3:55 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, Resident 1 was able to walk with his wheelchair around the facility. LVN 1 stated, she did not witness Resident 1 trying to elope or leave the facility. LVN 1 stated, she saw Resident 1 getting close to the door maybe once a month. LVN 1 stated, Resident 1 had dementia and could get confused. LVN 1 stated, she did not think the Resident 1 intentionally tried to elope the facility. LVN 1 stated, she had not seen Resident 1 attempted to endanger to himself or other residents in the facility. LVN 1 stated, she was not aware of the discharge process going on for Resident 1. LVN 1 stated, she would not know about the discharge until the day a resident is supposed to be discharged . During a concurrent record review and interview on 1/29/2025 at 4 PM with RN 3, Resident 1 ' s care plan and assessment were reviewed. RN 3 stated, there was no care plan for discharge planning in Resident 1 ' s records. RN 3 stated, the SSW and CC team were responsible for the resident ' s transfer/discharge. RN 3 stated, he was familiar with Resident 1 and had seen Resident 1 walking around and got close to the door sometimes, like once or twice a month. RN 3 stated, he had not seen Resident 1 endanger himself or other residents in the facility. During an interview on 1/29/2025 at 4:10 PM with Certified Nurse Assistant (CNA) 1, CNA 1 stated, Resident 1 could walk with his wheelchair around the facility. CNA 1 stated, Resident 1 was usually confused. CNA 1 stated, he did not think Resident 1 intentionally seeking to elope the facility or tried to endanger himself or others. During an interview on 1/29/2025 at 4:20 PM with SNF 2 ' s BD 1, BD 1 stated, she spoke to RP 1 on 1/27/2025 and RP 1 stated RP 1 was not aware of the transfer/discharge of Resident 1 scheduled on 1/28/2025. BD 1 stated RP 1 refused Resident 1 ' s discharge to SNF 2 on 1/28/2025. BD 1 stated, she informed ADC 1 about the family ' s refusal and ADC 1 told her that she would conduct a meeting with RP 1. BD 1 stated, the day after, on 1/28/2025, she received a text message from ADC 1 that Resident 1 was good to go. BD 1 stated, she sent a driver to SNF 1 to pick up Resident 1 on 1/28/2025 and was informed by the driver that Resident 1 and his family was refusing the transfer/discharge to SNF 2. During the same interview, BD 1 stated, the next morning of 1/29/2025, ADC 1 let BD 1 know that SNF 1 was sending Resident 1 over to SNF 2. BD 1 stated, when Resident 1 arrived to SNF 2 around 12:30 to 1 PM, he was throwing a fist. BD 1 stated, Resident 1 was screaming and refused to go inside SNF 2. BD 1 stated, the SNF 2 staff had to calm Resident 1 down to walk him inside the facility (SNF 2). BD 1 stated, Resident 1 refused all care and food offered a SNF 2. BD 1 stated, Resident 1 repeatedly stated he wanted to go back to his home. BD 1 stated, due to Resident 1 ' s distress and refusal, they could not admit Resident 1 to the facility. During the same interview with BD 1, BD 1 stated, SNF 1 did not inform or discuss with her (BD 1) what interventions SNF 1 tried that did not work and did not meet Resident 1 ' s needs. BD 1 stated, SNF 2 was not a locked facility and not a Memory Care Facility. BD 1 stated, she approved Resident 1 because ADC 1 informed her that Resident 1 needed a more secured facility, and SNF 2 just have a Wander guard system. BD 1 stated that SNF 2 is also a Skilled Nursing facility, the same as SNF 1. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/2025 at 5:50 PM with RN 1, RN 1 stated, she worked the afternoon shift (3-11PM) on 1/28/2025. RN 1 stated, she was informed at the beginning of her shift on 1/28/2025, that Resident 1 was ready to be discharged to SNF 2. RN 1 stated, when she prepared Resident 1 for discharge, Resident 1 was calm and did not say anything. RN 1 stated, when the transporter came in, Resident 1 became anxious and agitated. RN 1 stated, she believed Resident 1 was agitated because he was confused with the discharge situation. During the same interview with RN 1, RN 1 stated, she completed Resident 1 ' s discharge package including Notice of Transfer/Discharge, Post Discharge Plan of Care, and Discharge Summary/Comprehensive Assessment on 1/28/2025 when she was preparing Resident 1 for discharge to SNF 2. RN 1 stated, she did not provide Resident 1 or Resident 1 ' s RP 1 a copy of the Notice of Transfer/Discharge, Post Discharge Plan of Care, and Discharge Summary/Comprehensive Assessment and did not ask Resident 1 or Resident 1 ' s RP 1 to sign the abovementioned forms because RP 1 refused the discharge on 1/28/2025. During an interview on 1/29/2025 at 6:10 PM with the DON, the DON stated, Resident 1 ' s transfer was planned to be a lateral transfer, which meant another nursing facility, not a higher level of care facility. The DON stated, there was no Resident 1 ' s physician or psychiatrist progress notes that recommended and documented Resident 1 ' s urgent transfer to SNF 2 on 1/29/2025. During a concurrent observation and interview on 1/29/2025 at 6:25 PM with Resident 1, Resident 1 was observed readmitted back to SNF 1 from SNF 2. Resident 1 was sitting on his bed and appeared in distraught with facial grimaces. When asked what happened and where he had been to, Resident 1 stated, he could not recall the facility he was at prior to his transfer back to SNF 1. Resident 1 stated, he only remembered that he was so scared with unfamiliar faces because he did not know what (SNF 2) wanted to do to him. Resident 1 stated, he thought he was arrested. Resident 1 stated, he was shivering and kept praying for somebody to come and rescue him. Resident 1 stated, as soon as he arrived back to SNF 1 and see familiar faces, he started to feel safe. During an interview on 1/29/2025 at 6:40 PM with the DON, the DON stated, CC 1 was supposed to let RP 1 or RP 2 aware of the discharge prior to discharging Resident 1 to SNF 2. The DON stated, there was no IDT meeting for Resident 1 ' s discharge planning to SNF 2. The DON stated, they only had IDT meeting for the two incidents that Resident 1 was found outside of the facility. The DON stated, Resident 1 ' s discharge to SNF 2 was not considered an emergency situation because Resident 1 had not endangered himself yet. The DON stated, there was no reason why he had to transferred or discharged urgently on the same day of his Notice of transfer/discharge. The DON stated, due to the transfer/discharge, Resident 1 already missed his afternoon Gabapentin medication. During a review of the facility ' s Policy and Procedure (P&P) titled, Discharge Summary and Plan, revised October 2022, indicated the following: -Every resident is evaluated for his or her discharge needs and has an individualized post-discharge plan. -The post-discharge plan is developed by the care planning/interdisciplinary team with the assistance of the resident and his or her family and includes: where the individual plans to reside, and how the IDT will support the resident or RP in the transition to post-discharge care, (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident/RP is involved in the post-discharge planning process and informed of the final post-discharge plan. -Residents transferring to another skilled nursing facility .are assisted in selecting a post-acute care provider that is relevant and applicable to the resident ' s goals of care and treatment preferences. Data used in helping the resident select an appropriate facility include the receiving facility ' s: standardized patient assessment data; quality measure data; and data on resource use. -A member of the IDT reviews the final post-discharge plan with the resident and family at least twenty-four (24) hours before the discharge is to take place. During a review of the facility ' s P&P titled, Transfer or Discharge, Facility-Initiated, dated October 2022, indicated the following: -Notice of Transfer or Discharge (Planned): a.The resident and his or her RP are given a thirty (30)-day advance written notice of an impending transfer or discharge from the facility. b.The resident and RP are notified in writing of the following information: the specific reason for the transfer or discharge, the effective date of the transfer or discharge, the specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is being transferred or discharged . c.A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and RP.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on interview and record review the facility (SNF 1) failed to follow its Policies and Procedures (P&P) titled, Transfer or Discharge, Facility-Initiated, dated October 2022, to provide the resident (Resident 1), who has a diagnosis of dementia and wandering behavior and Resident 1 ' s responsible party (RP 1) a written notice and send a copy of the notice to the Ombudsman prior to discharging Resident 1 to another Skilled Nursing Facility (SNF 2). This deficient practice had the potential to result in an unsafe discharge and or denying the resident of the right to appeal the discharge. Findings: During a review of Resident 1 ' s Admission Record, (AR) the AR indicated Resident 1 was admitted to the facility with diagnosis that included dementia [the loss of cognitive functioning (thinking, remembering, and reasoning) to such an extent that it interferes with a person's daily life and activities], altered mental status (a change in how well the brain is working, which can cause a variety of behavioral changes), difficulty walking, and abnormalities of gait and mobility. During a review of Resident 1 ' s Minimal Data Set (MDS-a federally mandated resident assessment), dated 11/21/2024, the MDS indicated Resident 1 ' s cognition (ability to think, remember, and reason with no difficulty) was severely impaired and walking 50 feet was not attempted due to medical condition or safety concern. During a review of Resident 1 ' s Order Summary Report, indicated on 1/28/2025, Resident 1 received a physician order for a lateral transfer to SNF 2. During a review of Resident 1 ' s Notice of Transfer/Discharge, dated 1/28/2025, indicated the notification date was 1/28/2025 with the effective date of 1/31/2025 for Resident 1 to transfer to SNF 2. The notice indicated the resident had the right to appeal the transfer/discharge and could file an appeal within ten calendar days of being notified. The notice indicated the facility may not transfer or discharge the resident while the appeal is pending, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. During a review of Resident 1 ' s Nurses Progress Notes, dated 1/29/2025, indicated Resident 1 left SNF 1 at 12 PM for a Lateral transfer to (SNF 2). During a review of Resident 1 ' s Case Management Notes, dated 1/29/2025, indicated CC 1 called Resident 1 ' s RP 1 to inform her of Resident 1 ' s discharging since it was Medically necessary (memory care/secure unit) for resident' welfare and safety. (continued on next page)

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	01/29/2025

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/2025 at 10:40 AM with OMB 1, OMB 1 stated that on 1/28/2025, OMB 1 received a call that Resident 1 was being discharged against his will and his family ' s approval, so she went to SNF 1 to intervene on 1/28/2025 at around 7:30 PM. OMB 1 stated, she requested to speak with the DON but the DON refused to speak to her. OMB 1 stated, she reviewed Resident 1 ' s medical records and confirmed there was no written Notice of Resident 1 ' s transfer/discharge to SNF 2 for 1/28/2025. During an interview on 1/29/2025 at 10:50 AM with RP 1, RP 1 stated, on 1/28/2025, ADC 1 informed RP 1 that Resident 1 would be discharged on [DATE]. RP 1 stated, she had been working with SSW 1 and nobody informed her about the transfer to SNF 2. RP 1 stated, she did not receive any written notice of transfer/discharge from SNF 1. During a concurrent record review and interview on 1/29/2025 at 12:45 PM with ADC 1, Resident 1 ' s Notice of Transfer/Discharge, dated 1/28/2025, was reviewed. The notice indicated ADC 1 informed RP 1 about the transfer on 1/28/2025 over the phone with the effective date of transfer was 1/31/2025. ADC 1 stated, she transferred Resident 1 on the same day because a bed was available at SNF 2. ADC 1 stated, she did not provide RP 1 a written notice because she notified RP 1 over the phone. During an interview on 1/29/2025 at 6:10 PM with the DON, the DON stated, Resident 1 ' s transfer was planned to be a lateral transfer, which meant another nursing facility, not a higher level of care facility. The DON stated, there was no Resident 1 ' s physician or psychiatrist progress notes that recommended Resident 1 ' s urgent transfer to SNF 2. During an interview on 1/29/2025 at 6:40 PM with the DON, the DON stated, CC 1 was supposed to let RP 1 or RP 2 aware of the discharge prior to discharging Resident 1 to SNF 2. The DON stated, there was no IDT meeting for Resident 1 ' s discharge planning to SNF 2. The DON stated, they only had IDT meeting for the two incidents that Resident 1 was found outside of the facility. The DON stated, Resident 1 ' s discharge to SNF 2 was not considered an emergency situation because Resident 1 had not endangered himself yet. The DON stated, there was no reason why he had to transferred or discharged urgently on the same day of his Notice of transfer/discharge. The DON stated, due to the transfer/discharge, Resident 1 already missed his afternoon Gabapentin medication. During a review of the facility ' s P&P titled, Transfer or Discharge, Facility-Initiated, dated October 2022, indicated the following: -Notice of Transfer or Discharge (Planned): a.The resident and his or her RP are given a thirty (30)-day advance written notice of an impending transfer or discharge from the facility. b.The resident and RP are notified in writing of the following information: the specific reason for the transfer or discharge, the effective date of the transfer or discharge, the specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is being transferred or discharged . c.A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and RP. (continued on next page)

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	555839	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Notice of Transfer or Discharge (Emergent or Therapeutic Leave): a.When resident who are sent emergently to an acute care setting, these scenarios are considered facility-initiated transfers, because the resident ' s return is generally expected. b.The notice is given as soon as it is practicable but before the transfer or discharge, the health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident. -Appealing transfer: If a resident exercise his or her right to appeal a transfer or discharge notice, he or she will not be transferred or discharged while the appeal is pending.