

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 02/13/2025
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44372</p> <p>Based on interview and record review, the facility failed to develop and implement a comprehensive care plan to address Resident 1's use of the knee immobilizer and/or abduction pillow ordered by the physician on 1/15/2025 s/p right hip reduction (a procedure that involves physically moving a dislocated hip back into place) surgery for one of three sampled residents (Resident 1).</p> <p>This deficient practice had the potential to result in post-surgical complications for Resident 1's recent right hip reduction surgery that included but not limited to increased pain, delayed recovery, and recurrent hip dislocation.</p> <p>Findings:</p> <p>During a review of Resident 1's Face Sheet (admission record), the Face Sheet indicated the facility initially admitted the resident on 12/27/2024 , and readmitted on [DATE] with diagnoses including fracture(a break in a bone that can be partial or complete) of unspecified part oof neck of right femur (the bone of the thigh), dysphagia(difficulty swallowing), and unspecified dementia(a progressive state of decline in mental abilities) with psychotic (a loss of touch with reality)features.</p> <p>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 1/10/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 12/31/2024, 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, putting on /taking off footwear, roll 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).</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s Nursing Progress Notes dated 1/14/2025 at 11:08 AM, the Notes indicated, Review summary of the Events: on 1/13/25, rehab staff reported that upon rehab assessment on 1/11/2025; resident was only able to stand up ; restless, trying to get out of bed unassisted. Resident is not following commands due to dementia and is very restless, doing what he wants like crossing his legs. The Notes indicated that Rehab staff reported this incident to the nursing staff (no indicated name) regarding resident walking and noted with pain during therapy. Xray order of the right hip and right femur done.</p> <p>During a review of Resident 1 ' s Radiology Interpretation record titled, Significant Findings, dated 1/14/2025 and timed 1: 31AM indicated, Right femur Acute posterior dislocation of femoral head prosthesis (an artificial body part) with inward rotation of femur.</p> <p>During a review of Resident 1 ' s Nursing Progress Notes Dated 1/14/2025 at 5:03 PM indicated Received orders from MD to transfer resident to GACH due to recent x-ray results of displaced femoral head. Ortho MD aware, awaiting resident at hospital. Resident left at 4:58PM in stable condition via gurney by Ambulance to GACH.</p> <p>During a review of Resident 1 ' s Nursing Progress Notes Dated 1/15/2025 and timed 9:26 AM indicated Resident was sent back to facility from hospital.</p> <p>During a review of Resident 1 ' s Nursing Progress Notes Dated 1/15/2025 and timed 11:41 AM, indicated Call Surgeon ' s office with rehab director to clarify orders and what was done when Resident was sent out last night. Per Surgeon close hip reduction was done (prosthetic hardware was put back in the socket). Surgeon also added that Resident 1 is Full Weight bearing (FWB) , continue right knee immobilizer (a medical device that limits movement of the knee) and start using abduction pillow (a device that helps keep the hips in place and prevents dislocation) when available.</p> <p>During a review of Resident 1 ' s hand written physician order dated 1/15/2025, the order indicated FWB Right lower extremities (RLE) . Per ortho order abduction pillow Right knee immobilizer on all times until abduction pillow gets available.</p> <p>During a review of Resident 1 ' s Order Recap Report, dates 12/27/2024 to 1/28/2025, the Recap Report indicated the following information:</p> <p>-Order date: On 1/18/2025, FWB RLE per ortho, Order abduction pillow, Right knee immobilizer on at all times, until abduction Pillow is available .</p> <p>-Order Date: On 1/21/2025, Per Ortho, order abduction pillow, have abduction pillow on at all times except during shower.</p> <p>During an interview on 2/12/2025 at 1:35 PM, LVN (Licensed Vocational Nurse)1 stated she was assigned to Resident 1 and was familiar with him. LVN 1 stated after hip replacement surgery, Resident 1 was confused, combative during care, and non-compliant with the post surgical treatment plan. LVN 1 stated Resident 1 liked to cross his legs all the time. LVN 1 stated Resident 1 had an order to use a knee immobilizer at all times but LVN 1 could not confirm if Resident 1 had been using the knee immobilizer all the time or not.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/13/2025 at 8:55 AM, Resident 1 responsible party stated He visited Resident 1 at facility few times a week since admission until transfer to hospital on 1/28/2025. Stated he did not see Resident 1 to have knee immobilizer or abduction pillow.</p> <p>During an interview on 2/13/2025 at 11:48 AM, the Director of Rehab (DOR) stated Resident 1 required extensive care, confused, and had hard time to follow directions. DOR stated that on 1/15/2025, she called the Orthopedic Surgeon to clarify Resident 1's post operative instructions, after Resident 1 came back from surgery. The DOR stated that the Orthopedic Surgeon ordered a hip abduction pillow for support of the right hip joint and a knee immobilizer until the hip abduction pillow becomes available. The DOR stated Resident 1 kept crossing his legs and flexing knee toward his chest (fetal position). The DOR stated flexing the knee has a potential for hip dislocation. The DOR stated the knee immobilizer was ordered to prevent Resident 1 from flexing (bending) his knees. The DOR stated Resident 1 was removing everything that was attached to him including the knee immobilizer.</p> <p>During an interview on 2/13/2025 at 12:16 PM, the Director of Nursing (DON) stated Resident 1 was confused and had hard time following instructions. The DON stated Resident 1 was readmitted after right hip dislocation on 1/13/2025 and there was an order for Resident 1 to wear the knee immobilizer all the time, except during shower. until the abduction pillow becomes available. The DON stated Resident 1 was bending his knee and turning and tossing in bed. The DON stated that in order to prevent the resident from bending his knee, the knee immobilizer was ordered, in addition to the abduction pillow. The DON stated Resident 1 was high risk for hip dislocation again. The DON sated she could not confirm if Resident 1 was wearing the knee immobilizer or not all the time. The DON stated she could not confirm if the abduction pillow was used by Resideent 1 all the time, as ordered. The DON stated she was not able to provide any documentation that the knee immobilizer was used as ordered by physician all the time. The DON stated she noticed at times when Resident 1 was wearing the knee immobilizer, Resident 1 would get agitated would try to take it off, kick, and scream.</p> <p>During an interview and record review of Resident 1's active care plans from 12/27/2024 to 1/28/2025, on 2/13/2025 at 12:36 PM, the DON stated could not find any documentation that a care plan was developed for Resident 1's use of the knee immobilizer or any care plans that Resident 1 was refusing to wear it. The DON stated a care plan is necessary and can provide specific guidelines to staff to care for each resident. The DON stated that care plan interventions should be added and implemented when Resident 1 refuses to wear the knee immobilizer.</p> <p>During an interview on 2/13/2025 at 1:22 PM, Certified Nursing Assistant (CNA) 1 stated he was assigned only to Resident 1 for a few shifts including 1/18/2025 and 1/20/2025, for the 7 pm to 7 am shifts. CNA 1 stated Resident 1 was combative, agitated, and would try to get out of bed. CNA 1 stated Resident 1 did not have and was not wearing the knee immobilizer during the days that he was assigned with Resident 1. CNA 1 stated he did not see a abduction pillow was used by Resident 1 as well. CNA 1 stated anything that would be placed next to Resident 1 including pillow or sheets, Resident 1 would throw on the floor.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled Care Planning - Interdisciplinary Team, revised on March 2022, indicated The interdisciplinary team is responsible for the development of resident care plans. Resident care plans are developed according to the timeframes and criteria established by S483 . 21.Comprehensive, person-centered earn plans are based on resident assessments and developed by an interdisciplinary team (IDT).</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>During a review of the facility ' s P&P titled Surgery-Related (Pre-and Postoperative) Management-Clinical Protocol, revised October 2010, indicated After readmission to the facility postoperatively, the physician and staff will maintain appropriate communication with the referring surgeon to ensure that the resident receives adequate postoperative care and that the staff and Attending Physician receive relevant medical information. The staff and physician will review the continuing relevance of the preoperative medications and treatments, along with those added postoperatively, and adjust them accordingly. The staff and physician will monitor for, and address, postoperative risks and complications such as infection, deep vein thrombosis, cardiac arrhythmia, bleeding, failure of surgical wounds to heal, urosepsis from indwelling catheters inserted in the hospital, delirium, depression, etc.</p> <p>During a review of the facility ' s P&P titled Dementia - Clinical Protocol, revised March 2015, indicated The IDT will review the past and current physical, functional, and psychosocial status of each individual with dementia to formulate an accurate overall picture of the individual's condition, related complications, and functional impairments. For the individual with confirmed dementia, the IDT will identify a resident-centered care plan to maximize remaining function and quality of life. The IDT will adjust interventions and the overall plan depending on the individual's responses to those interventions, progression of dementia, development of new acute medical conditions or complications, changes in resident or family wishes, etc.</p>		