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	02/20/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48219 Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 2) had appropriate measures taken to ensure the privacy and confidentiality of medical records by mistakenly sending Resident 2 ' s medical records to a general acute care hospital (GACH) with Resident 1, in accordance with the facility ' s policy and procedure titled Confidentiality of information. This failure violated Resident 2 ' s rights to personal privacy and confidentiality of personal and medical records. Findings: During a review of Resident 1 ' s Admission Record (AR), the AR indicated the resident was initially admitted to the facility on [DATE] with diagnoses that included, but not limited to, influenza (contagious respiratory illness caused by influenza viruses) and dementia (a group of symptoms that affect memory, thinking, behavior, and the ability to perform everyday activities). During a review of Resident 1 ' s History and Physical (H&P) Progress Note dated 1/27/2025, the H&P indicated Resident 1 lacks capacity to make medical decisions (unable to understand, evaluate, or make informed decisions about their healthcare due to a mental or cognitive impairment) and has memory loss. During a review of Resident 2 ' s Admission Record with an initial admitted [DATE], indicated Resident 2 had diagnoses that included, but not limited to chronic obstructive pulmonary disease (a lung condition that makes it hard to breath) and pleural effusion (extra fluid that builds up between the layers of tissue surrounding the lungs making hard to breath). During a review of Resident 2 ' s Physician orders for life - Sustaining Treatment (POLST - a form that helps people with serious illnesses make decisions about medical treatment they want if they become very sick or unable to speak for themselves) dated 12/11/2024, indicated HIPAA permits disclosure of POLST to other health care providers as necessary. The POLST indicated the resident wishes are not to attempt resuscitation (helping a person to start breathing including actions to restart the heart) and to allow natural death to occur with selective treatment such as comfort - focused treatment, use of medical treatment, IV antibiotics, and iv fluids as indicated. (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

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	02/20/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s History and Physical (H&P) dated 12/12/2024, the H&P indicated the resident had mental capacity (refers to ability to make decisions for themselves) based on the POLST. During a review of medical records sent with Resident 1 on 2/16/2025, the records included Resident 2 ' s records and not Resident 1. The records included Resident 2 ' s Face Sheet (the basic document containing important identification and contact information for the resident), MD Orders (doctors instructions or medical orders regarding the care and treatment the resident should receive), POLST, and H&P. During a review of the facility ' s census for 2/16/2025 indicated Resident 1 and 2 were roommates. During an interview on 2/18/2025 at 8 PM with emergency room (ER) Case Manager (CM), ER CM stated incorrect medical records from a different resident (Resident 2) had been sent by the facility on 2/16/2025 and stated the records did not match the resident ' s (Resident 1) current condition. The ER CM stated the resident ' s records that were sent with Resident 1 at the GACH was from a person who was very sick and had a Do Not Resuscitate (DNR - it is a medical order that tells doctors and nurses not to perform life - saving measures) order, and there was concern from the GACH staff that this information may have been for the wrong resident. During an interview on 2/20/2025 at 10:15 AM with the facility ' s Director of Nursing (DON), the DON stated when transferring a resident to another facility like the GACH, the RN supervisor was responsible for ensuring the correct medical records and documentation of transfer was completed and sent with the resident. The DON stated the incident that happened on 2/16/2025, when the RN supervisor (RN 1) who was working at the facility from a Nursing Registry sent Resident ' 2s medical records to the GACH instead of Resident 1, who was the resident with change of condition. The DON stated the incident was a violation of HIPPA regulations. During an interview on 2/18/2025 at 11 AM with Registered Nurse (RN1), RN 1 stated that Resident 1 ' s change in condition on 2/16/2025 was an emergency situation, because Resident 1 was altered (meaning their condition had changed or was unstable). RN 1 stated she printed out the necessary records for the resident and sent the printed records with the paramedics. RN 1 stated the records included in the records sent out with the paramedics were the Face Sheet (basic identification and contact information), MD orders, and POLST. RN 1 stated that it was the permanent Licensed Vocational Nurse (unknown) on duty, who noticed that the wrong documents had been sent with Resident 1. RN 1 was asked how does the licensed staff know they are sending out the right resident or the correct medical records out of the facility? RN 1 stated that registry nurses would go to the nurse that are permanent staff at the facility so they can identify the resident if the resident cannot identify self. RN 1 stated she was tasked to be the RN supervisor for the shift on 2/16/2025 and stated the LVN charge nurse was the responsible person to ensure the correct medical records were sent out. However, RN 1 stated during that shift, the LVN was also from a Nursing Registry. RN 1 stated the entire staff of the facility seemed to come from Nursing Registry and unsure of the resources to go to for guidance. (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	02/20/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the Facility ' s policy and procedure titled, Confidentiality of information with a revision date of March 2014, indicated the facility shall treat all resident information confidentially and shall access protected health information only as necessary. Further indicating the facility will safeguard all resident records, whether medical, financial, or social in nature, to protect the confidentiality of the information.

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	02/20/2025

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** 48219 Based on interview and record review, the facility failed to ensure that appropriate information and documentation is communicated to the receiving health care institution for one of four sampled residents (Resident 1), who was transferred to the General Acute Care Hospital (GACH) emergency room (ER) due to a change in condition (COC) on 2/16/2025. The facility transferred Resident 1 to the GACH for a COC, with the incorrect resident ' s records meant for another resident (Resident 2), that included another resident ' s Advance Directive (a legal document that provides guidance on a person ' s preferences for medical treatment), history and physical [H&P], medication orders, and laboratory results. This deficient practice had the potential to result in a delay in treatment, inappropriate medical interventions, or the GACH not being able to follow Resident 1 ' s wishes with regard to life sustaining treatments. This failure also had the potential to impede a safe and effective transition of care. Findings: During a review of Resident 1 ' s Admission Record (AR), the AR indicated the resident was initially admitted to the facility on [DATE] with diagnoses that included, but not limited to, influenza (contagious respiratory illness caused by influenza viruses) and dementia (a group of symptoms that affect memory, thinking, behavior, and the ability to perform everyday activities). During a review of Resident 1 ' s History and Physical (H&P) Progress Note dated 1/27/2025, the H&P indicated Resident 1 lacks capacity to make medical decisions (unable to understand, evaluate, or make informed decisions about their healthcare due to a mental or cognitive impairment) and has memory loss. During a review of Resident 1 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 2/8/2025, the MDS indicated Resident 1 had severe cognitive impairment (has significant difficulty with memory, orientation, and judgment with inability to communicate effectively). The MDS also indicated Resident 1 needed substantial/maximal assistance (requiring more than half the effort) for toileting, showering, dressing and all personal hygiene. During a review of Resident 1 ' s Change of Condition (COC) Evaluation, dated 2/16/2025 timed at 4:59 PM, the COC evaluation indicated Resident 1 had a change of condition on 2/16/2025. The COC Evaluation indicated Resident 1 ' s pertinent diagnosis was checked as having dementia (a group of symptoms that affect memory, thinking, behavior, and the ability to perform everyday activities) and was transferred via 911 emergency services, with a blood pressure of 84/61 and an abnormal heart rate of 130. The COC Evaluation further indicated Resident 1 had a decreased level of consciousness (sleepy, lethargic) prior to the transfer to the GACH. (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	02/20/2025

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	During a review of Resident 1 ' s Nursing Progress Notes, dated 2/16/2025, the Progress Notes indicated Resident 1 was transferred to the GACH for a septic work up (a series of tests and procedures performed to evaluate and diagnose sepsis, determine its source, and guide treatment). The Progress Notes indicated, Resident 1 ' s attending physician was made aware, and that Resident 1 was self-responsible with no family on record. During a review of Resident 1 ' s Prescriber Phone Orders, dated 2/16/2025, the Order indicated to transfer Resident 1 to the GACH ED via 911 for evaluation and management of tachycardia (elevated heart rate). During a review of Resident 1 ' s Discharge Summary dated 2/16/2025, the Discharge Summary indicated Resident 1 ' s transfer to the GACH indicated Resident 1 ' s condition required further evaluation at the GACH. During a review of Resident 1 ' s Transfer Form dated 2/16/2025 timed at 5:34 PM, the Transfer Form indicated Resident 1 was transferred to the GACH for tachycardia (heart rate over 100 beats per minute), lethargy (extreme tiredness, fatigue or lack of energy) and hypotension (low blood pressure). During a record review of the facility ' s Staffing Assignments for the date of 2/16/2025, the Staffing Assignment indicated RN 1 was scheduled to work during the 3 PM to 11 PM shift on 2/16/2025 and was assigned to Resident 1 and Resident 2. During a review of the facility ' s census for 2/16/2025 indicated Resident 1 and 2 were roommates. During an interview on 2/18/2025 at 8 PM with the GACH ER Case Manager (CM), the ER CM stated when she arrived at the GACH in the evening of 2/16/2025, the GACH staff were attempting to obtain the correct medical records for Resident 1 from the facility. The ER CM stated It had become obvious that the resident (Resident 1) who was transferred to the GACH on 2/16/2025, did not match the records sent with Resident 1 from the facility. The ER CM stated when she called the facility to request the correct records for Resident 1, the ER CM was initially told by Registered Nurse 1 (RN1) to transfer Resident 1 back to the facility and the facility would transfer Resident 1 again with the correct records. The ER CM stated, RN 1 refused to provide the GACH her name or to fax the correct medical records to the GACH ER. The ER CM stated eventually RN 1 agreed to fax over the correct medical records for Resident 1. The ER CM stated when she asked RN 1 how the facility identifies residents in the facility, RN 1 stated the facility staff identify the residents by room numbers and bed numbers. The ER CM stated Resident 1 was not interviewable and arrived at the GACH without out an identification wrist band or any form of identification. During an interview on 2/20/2025 at 10:15 AM with the facility ' s Director of Nursing (DON), the DON stated when transferring a resident to another facility like the GACH, the RN supervisor was responsible for ensuring the correct medical records and documentation of transfer was completed and sent with the resident. The DON further stated, Resident 1 was still in the GACH as of this time. The DON stated the incident that happened on 2/16/2025, when the RN supervisor (RN 1) who was working at the facility from a Nursing Registry sent Resident ' 2s medical records to the GACH instead of Resident 1, who was the resident with change of condition. (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	02/20/2025

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	During an interview on 2/18/2025 at 11 AM with Registered Nurse (RN1), RN 1 stated that Resident 1 ' s change in condition on 2/16/2025 was an emergency situation because Resident 1 was altered (meaning their condition had changed or was unstable). RN 1 stated she printed out the necessary records for the resident and sent the printed records with the paramedics. RN 1 stated the records included in the records sent out with the paramedics were the Face Sheet (basic identification and contact information), MD orders, and POLST. RN 1 stated that it was the permanent Licensed Vocational Nurse (unknown) on duty, who noticed that the wrong resident documents had been sent with Resident 1. During a review of the facility ' s policy and procedure (P&P) tiled Record Content/Transfer Record dated 11/2017, indicated A transfer record that is complete and accurate with resident information in sufficient detail to provide for continuity of care shall be transferred with the resident at the time of the transfer to another health care facility. Further indicating transfer to another health care facility shall include the following records, resident identifying information, resident representative, physician name and telephone number, diagnosis at time of transfer, reason for transfer, admission face sheet, physician ' s orders, History and physical, laboratory results, Advance Directive, Medication and treatment records. * Note: it is critical to ensure the current Medication and treatment records are complete if these are copied and sent in the transfer packet to the acute hospital. During a review of the facility ' s P&P titled Transfer or Discharge, Facility - Initiated dated October 2022, indicated that for facility - initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy.

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	02/20/2025

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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48219 Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 1) was transferred in the General Acute Care Hospital for a change in codition, in a safe and orderly manner on 2/16/2025. The Facility failed to ensure proper transfer procedures and preparation necessary were carried out, such as providing the resident ' s correct medical history and medication to ensure the resident ' s medical status and condition was clearly communicated to the receiving facility (GACH). Furthermore, Resident 1 did not have any form of identification with him such as an identification wrist band for proper identification after being sent out to a GACH on 2/16/2025. This failure had the potential for delays in treatment and or worsening the Resident 1 ' s condition due to the possibility of the receiving facility rendering the wrong treatment or procedures due to the incorrect medical records provided. Findings: During a review of Resident 1 ' s Admission Record (AR), the AR indicated the resident was initially admitted to the facility on [DATE] with diagnoses that included, but not limited to, influenza (contagious respiratory illness caused by influenza viruses) and dementia (a group of symptoms that affect memory, thinking, behavior, and the ability to perform everyday activities). During a review of Resident 1 ' s History and Physical (H&P) Progress Note dated 1/27/2025, the H&P indicated Resident 1 lacks capacity to make medical decisions (unable to understand, evaluate, or make informed decisions about their healthcare due to a mental or cognitive impairment) and has memory loss. During a review of Resident 1 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 2/8/2025, the MDS indicated Resident 1 had severe cognitive impairment (has significant difficulty with memory, orientation, and judgment with inability to communicate effectively). The MDS also indicated Resident 1 needed substantial/maximal assistance (requiring more than half the effort) for toileting, showering, dressing and all personal hygiene. During a review of Resident 1 ' s Change of Condition (COC) Evaluation, dated 2/16/2025 timed at 4:59 PM, the COC evaluation indicated Resident 1 had a change of condition on 2/16/2025. The COC Evaluation indicated Resident 1 ' s pertinent diagnosis was checked as having dementia (a group of symptoms that affect memory, thinking, behavior, and the ability to perform everyday activities) and was transferred via 911 emergency services, with a blood pressure of 84/61 and an abnormal heart rate of 130. The COC Evaluation further indicated Resident 1 had a decreased level of consciousness (sleepy, lethargic) prior to the transfer to the GACH. (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	02/20/2025

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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Nursing Progress Notes, dated 2/16/2025, the Progress Notes indicated Resident 1 was transferred to the GACH for a septic work up (a series of tests and procedures performed to evaluate and diagnose sepsis, determine its source, and guide treatment). The Progress Notes indicated, Resident 1 ' s attending physician was made aware, and that Resident 1 was self-responsible with no family on record. During a review of Resident 1 ' s Prescriber Phone Orders, dated 2/16/2025, the Order indicated to transfer Resident 1 to the GACH ED via 911 for evaluation and management of tachycardia (elevated heart rate). During a review of Resident 1 ' s Discharge Summary dated 2/16/2025, the Discharge Summary indicated Resident 1 ' s transfer to the GACH indicated Resident 1 ' s condition required further evaluation at the GACH. During a review of Resident 1 ' s Transfer Form dated 2/16/2025 timed at 5:34 PM, the Transfer Form indicated Resident 1 was transferred to the GACH for tachycardia (heart rate over 100 beats per minute), lethargy (extreme tiredness, fatigue or lack of energy) and hypotension (low blood pressure). During a review of a Fax Transmission Verification Report dated 2/16/2025 timed at 8:50 PM, the Fax Report indicated the correct Admission Record for Resident 1 was sent to the GACH by Registered Nurse (RN) 1, after more than three hours upon Resident 1 ' s arrival at the GACH. During a review of medical records sent with Resident 1 on 2/16/2025, the records included Resident 2 ' s records and not Resident 1. The records included Resident 2 ' s Face Sheet (the basic document containing important identification and contact information for the resident), MD Orders (doctors instructions or medical orders regarding the care and treatment the resident should receive), POLST, and H&P. During a review of the facility ' s census for 2/16/2025 indicated Resident 1 and 2 were roommates. During a review of the facility ' s investigation titled Investigation of Accident/Incident indicated Resident 1 was transferred to the GACH and the nurse in charge provided the wrong paperwork to the paramedics on 2/16/2025. The investigation indicated RN 1 from a Nursing Registry would not be allowed back to the facility. During an interview on 2/18/2025 at 8 PM with the GACH ER Case Manager (CM), the ER CM stated when she arrived at the GACH in the evening of 2/16/2025, the GACH staff were attempting to obtain the correct medical records for Resident 1 from the facility. The ER CM stated It had become obvious that the resident (Resident 1) who was transferred to the GACH on 2/16/2025, did not match the records sent with Resident 1 from the facility. The ER CM stated incorrect medical records from a different resident (Resident 2) had been sent by the facility on 2/16/2025 and stated the records did not match the resident ' s (Resident 1) current condition. The ER CM stated the resident ' s records that were sent with Resident 1 at the GACH was from a person who was very sick and had a Do Not Resuscitate (DNR - it is a medical order that tells doctors and nurses not to perform life - saving measures) order, and there was concern from the GACH staff that this information may have been for the wrong resident. (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	02/20/2025

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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same interview, the ER CM stated when she called the facility to request the correct records for Resident 1, the ER CM was initially told by Registered Nurse 1 (RN1) to transfer Resident 1 back to the facility and the facility would transfer Resident 1 again with the correct records. The ER CM stated, RN 1 refused to provide the GACH her name or to fax the correct medical records to the GACH ER. The ER CM stated eventually RN 1 agreed to fax over the correct medical records for Resident 1. The ER CM stated when she asked RN 1 how the facility identifies residents in the facility, RN 1 stated the facility staff identify the residents by room numbers and bed numbers. The ER CM stated Resident 1 was not interviewable and arrived at the GACH without out an identification wrist band or any form of identification. During an interview on 2/20/2025 at 10:15 AM with the facility ' s Director of Nursing (DON), the DON stated when transferring a resident to another facility like the GACH, the RN supervisor was responsible for ensuring the correct medical records and documentation of transfer was completed and sent with the resident. The DON further stated, Resident 1 was still in the GACH as of this time. The DON stated the incident that happened on 2/16/2025, when the RN supervisor (RN 1) who was working at the facility from a Nursing Registry sent Resident ' 2s medical records to the GACH instead of Resident 1, who was the resident with change of condition. The DON stated Resident 1 was sent to the GACh on 2/16/2025 due to hypotension and tachycardia. The DON stated RN 1 called the DON on Sunday (2/16/25), the day of Resident 1 ' s transfer to the GACH and informed her that RN 1 transferred Resident 1 to the GACH but sent the roommate ' s (Resident 2) medical records with Resident 1 to the GACH. The DON stated RN 1 realized sending the wrong medical records as she was doing her documentation. The DON stated the incident that happened on 2/16/2025, when RN 1 sent Resident ' 2s medical records with Resident 1 to the GACH, had the potential to delay Resident 1 ' s immediate acute treatment. During an interview on 2/18/2025 at 11 AM with Registered Nurse (RN1), RN 1 stated that Resident 1 ' s change in condition on 2/16/2025 was an emergency situation because Resident 1 was altered (meaning their condition had changed or was unstable). RN 1 stated she printed out the necessary records for the resident and sent the printed records with the paramedics. RN 1 stated the records included in the records sent out with the paramedics were the Face Sheet (basic identification and contact information), MD orders, and POLST. RN 1 stated that it was the permanent Licensed Vocational Nurse (unknown) on duty, who noticed that the wrong resident documents had been sent with Resident 1. RN 1 was asked how does the licensed staff know they are sending out the right resident or the correct medical records out of the facility? RN 1 stated that registry nurses would go to the nurse that are permanent staff at the facility so they can identify the resident if the resident cannot identify self. RN 1 stated she was tasked to be the RN supervisor for the shift on 2/16/2025 and stated the LVN charge nurse was the responsible person to ensure the correct medical records were sent out. However, RN 1 stated during that shift, the LVN was also from a Nursing Registry. RN 1 stated the entire staff of the facility seemed to come from Nursing Registry and RN 1 stated they are unsure of the resources to go to for guidance. During the same interview on 2/18/2025 at 11 AM, RN 1 stated Resident 1 was residing in a two bedroom, but when you walk in this rooms, the first bed was Bed B, and the last bed, was Bed A. RN 1 stated It is flipped. So that is the concern. (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	02/20/2025

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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During another interview on 2/20/2025 at 11:38 AM, the DON stated all the residents must wear an identification wrist band for proper identification. The DON stated the facility only have two residents in the facility who refused to wear a wrist band and Resident 1 was not one of them. The DON stated it is important to check that all residents wear an ID band when sent out to GACH. The DON stated the RN Supervisor is the responsible staff for the shift and not the LVN on duty. The DON stated the nurses that comes from Nursing Registry works with the Director of Staff Development (DSD) and they have their own competency training complete prior to hiring to ensure the registry nurses have had all necessary trainings to provide care. During a review of the facility ' s P&P titled Transfer or Discharge, Facility - Initiated dated October 2022, indicated that for facility - initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy. The P&P indicating nursing notes will include documentation of the appropriate orientation and preparation of the resident prior to transfer or discharge.