

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 05/30/2025
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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and records reviews, the facility failed to ensure one of three sampled residents (Resident 1), who had a diagnoses of shortness of breath (SOB), was administered oxygen (O2) via nasal cannula (device used to deliver supplemental oxygen), as ordered by the physician when Resident 1 initially verbalized feeling unwell and having SOB with wheezing (a high-pitched, whistling sound heard during breathing, often indicating a narrowing or obstruction in the airways heard) on 5/06/25 at approximately 8 AM.</p> <p>This deficient practice resulted in Resident 1 not receiving O2 from 8 AM to 4:30 PM, a total of 8.5 hours, and Resident 1 stating she was panicking and struggling to breath, and leading to Resident 1 being transferred to the general acute care hospital (GACH) for respiratory distress.</p> <p>Findings:</p> <p>A review of Resident 1 ' s admission Record indicated the resident was originally admitted on [DATE] with diagnoses that included, hypertensive heart disease with heart failure (a condition where the heart is damaged due to prolonged high blood pressure [(hypertension)], SOB and history of Pulmonary embolism(a blood clot stuck in one of the blood vessels in the lungs).</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS- a resident assessment tool) dated 05/20/2025 indicated the resident was alert and oriented, could make decisions, understood information, and communicated clearly. The MDS indicated Resident 1 required maximal assistance, meaning helper must lift or hold limbs and trunk and provide more than half the effort for showering, dressing and toileting.</p> <p>A Review of Resident 1 ' s active Physician ' s orders, ordered on 12/29/2024, indicated to administer oxygen therapy as needed (PRN) at 2 liters (L- a unit of measurement) a minute for shortness of breath and wheezing and may titrate to 3-4 L per minute.</p> <p>A review of Resident 1 ' s Care Plan for Risk for Cardiac Distress manifested by SOB, revised 2/6/25, indicated interventions to monitor for headache and shortness of breath and to notify the medical doctor (MD) promptly.</p> <p>A review of Resident 1 ' s Vitals Summary dated 05/06/2025, indicated the following vital signs at:</p> <p>a. 1:06 AM &ndash; heart rate (HR): 77 beats per minute (bpm) , blood pressure (BP): 121/65, respiration rate (RR): 18, temperature (T): temp 98 Fahrenheit (F, a scale for temperature), and O2 sat (the normal O2 sat should be between 96% to 99%): 96% on room air (RA)</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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. 10:42 AM &ndash; HR: 104, BP 141/89, RR: 22, T: 98.1 F, and O2 sat: 91% on RA.</p> <p>c. 10:54AM &ndash; HR: 97, BP: 134/82, RR: 20, T: 98.1F, O2 sat: 95% on RA.</p> <p>d. 16:30 PM &ndash; HR: 118 BP: 132/87, RR: 24, T:102 F, O2 sat: 97% Via nasal Cannula</p> <p>A Review of Resident 1 ' s Situation, Background, Action, Response (SBAR) Communication Form dated 05/06/2025 at 10 AM, indicated Resident 1 was complaining SOB and a headache. The SBAR indicated to refer Resident 1 to psychiatric Medical Doctor (MD) for possible anxiety and to transfer via 911 for any emergent changes.</p> <p>A Review of Resident 1 ' s Situation, Background, Action, Response (SBAR) Communication Form dated 05/06/2025, indicated Resident 1 was complaining of SOB and a headache. The SBAR indicated to refer Resident 1 to psychiatric Medical Doctor (MD) for possible anxiety and to transfer via 911 for any emergent changes. The SBAR indicated that Resident 1 ' s O2 sat was 88% on room air and that 15 L of oxygen was administered via non-rebreather mask (a medical device used to deliver a high concentration of oxygen to a patient in emergency situations) and Resident 1 ' s O2 went up to 97%. The SBAR indicated the MD was notified at 4:30 PM.</p> <p>A review of Resident 1 ' s Physician ' s Order, dated 5/6/25 at 5:46 PM indicated to transfer Resident 1 to the GACH for shortness of breath via 911.</p> <p>A review of Resident 1 ' s Nursing Progress Notes dated 05/06/2025 at 11:41 AM, indicated Resident 1 complained of shortness of breath and a headache. The Note indicated when Registered Nurse (RN) 1 assessed Resident 1, Resident 1 was alert and oriented without shortness of breath and no wheezing present. The Note indicated the physician was informed.</p> <p>A review of Resident 1 ' s Nursing Progress Notes dated 5/06/25 at 3:42 PM indicated Resident 1 was alert and that after Resident 1 showered, Resident 1 of SOB and a headache. The Note indicated the MD was notified and new orders were pending.</p> <p>A review of Resident 1 ' s Nursing Progress Notes dated 05/06/2025 at 4:35 PM, indicated Resident 1 was still complaining of shortness of breath again, breathing was labored with bilateral wheezing upon lung auscultation (listening to the internal sounds of the body, usually using a stethoscope [a medical instrument for detecting sounds produced in the body that are conveyed to the ears of the listener through rubber tubing connected with a piece placed upon the area to be examined]). The Note indicated Resident 1 verbalized, I ' m short of breath, and the documented O2 sat (indicated a range from 88% - 90% and temperature of 102 F. The Note indicated that oxygen was administered, but Resident continued to experience SOB and was observed using accessory muscles (the contraction of muscles other than the diaphragm during inspiration) to breath. The Note indicated MD was notified, and 911 was called for emergency.</p> <p>A review of Resident 1 ' s Nursing progress notes dated 05/06/2025 at 4:40 PM, indicated 911 came to the facility to transport resident to the GACH.</p> <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>A Review of Resident 1 ' s GeneralAcute Care Hospital (GACH)Records dated 5/12/2025, indicated Resident 1 was admitted to the GACH on 5/6/25 with a chief complaint of SOB. Resident 1 ' s oxygen saturation (O2 sat, a measurement of the percentage of hemoglobin in the blood that is carrying oxygen) was 95 % on three (3) liters (L- a unit of measurement) via nasal cannula (NC- a device that gives you additional oxygen [supplemental oxygen or oxygen therapy] through your nose). The Records indicated Resident 1 ' s chest x ray (a medical imaging technique that uses a small amount of ionizing radiation to create images of the body's internal structures) results indicated Resident 1 had edema (swelling) and infection.</p> <p>During an interview on 5/28/2025 at 3:45PM, with Resident 1, Resident 1 stated not feeling well on 5/6/25and was experiencing shortness of breath. Resident 1 stated RN 1 did not administer oxygen even after Resident 1 verbalized having SOB. Resident 1 stated around 3 PM on 5/6/25, Resident 1 began to panic because she was struggling to breath. Resident 1 stated certified nurse assistant (CNA)1 brought in LVN 1 to Resident 1 ' s room and administered oxygen to Resident 1, and 911 was called.</p> <p>During an interview on 5/30/2025 at 7:45 AM, with family member (FM) 1, FM 1 stated that Resident 1 verbalized difficulties breathing on 5/6/25 around 10 AM to FM 1. FM 1 stated Resident 1 stated having trouble breathing and that facility staff were not administering O2 to Resident 1. FM 1 stated Resident 1 called FM 1 again around 3 PM that same day, and Resident 1 stated she was still in distress, and O2 was still not administered to Resident 1. FM 1 stated that during the call, FM 1 was placed on speakerphone and stated for someone to help Resident 1. FM 1 stated it was not long after that FM 1 received a call from the facility that Resident 1 was transferred to the GACH.</p> <p>During an interview on 05/30/2025 at 10:13 AM with CNA 1, CNA 1 stated being assigned to care for Resident 1 on 5/6/25 during the day shift (7 AM to 3 PM). CNA 1 stated on the morning of 5/6/25, Resident 1 stated not feeling well. CNA 1 stated LVN 1 was notified and assessed Resident 1. CNA 1 stated Resident 1 verbalized not feeling well and being SOB throughout CNA 1 ' s shift.</p> <p>During an interview on 5/30/25 at 12:10 PM with the Director of Nursing (DON), the DON stated on 5/6/25 around 4:40 PM, Resident 1 was transferred to the GACH due to respiratory distress. The DON stated on 5/5/25, Resident 1 ' s vital signs were monitored and appeared stable, and that Resident 1 did not require interventions, such as O2 administration or transfer to the GACH. The DON stated Resident 1 ' s O2 sat at 10:42 AM was 91% and O2 was not administered, and at 10:54 AM, when LVN 1 rechecked Resident 1 ' s O2 sat, it was 95%. The DON stated it was not until approximately 4:35 PM that Resident 1 complained of SOB and 911 was called. The DON stated Resident 1 had PRN order for O2 via NC, however, licensed nurses (LN) had not been administered the O2 to Resident 1 upon her initial complaints on 5/06/25 at 8 AM of having SOB and a headache.</p> <p>During an interview on 05/30/2025 at 12:46 PM with LVN 1, LVN 1 stated on 5/6/25 at around 8 AM or 9 AM, CNA 1 notified LVN 1 that Resident 1 was experiencing SOB. LVN 1 reported that he went to assess the resident and obtained Resident 1 ' s O2 sat. LVN 1 stated Resident 1 ' s O2 sat was low and LVN 1 reported to RN 1 immediately. LVN 1 statedRN 1 came and assessed Resident 1 and confirmed that her oxygen saturation was low, and that wheezing was heard in one of the resident ' s lungs. LVN 1 stated no O2 was administered to Resident 1. LVN 1 stated Resident 1 complained about SOB through the shift, and that LVN 1 should have administered Resident 1 ' s O2 via NC as needed.</p> <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>During an interview on 5/30/2025 at 1:44 PM with RN 1, RN 1 stated LVN 1 reported to RN 1 that Resident 1 had SOB after a shower on 5/05/2025 and that Resident 1 was anxious, and wheezing could be heard. RN 1 stated the MD was notified and orders for a psychologist consult was ordered. RN 1 stated not being informed of Resident 1 continuing to have SOB. RN 1 stated no O2 via NC was administered to Resident 1 upon RN 1 ' s initial assessment since Resident 1 was stable.</p> <p>During an interview on 5/30/2025 at 3 PM with RN 2, RN 2 stated Resident 1 experienced SOB on 5/6/25 and that the MD had been notified. RN 2 stated upon further assessment, Resident 1 continued to complain of SOB and wheezing was heard. RN2 stated that the resident also had a fever at that time. RN 2 stated O2 was administered using a non-rebreather mask and 911 was called at around 4 PM.</p> <p>A review of the facility ' s policy and procedures (P&P) titled, Oxygen Administration, dated 2010, indicated the purpose of the policy is to provide guidelines for the safe administration of oxygen. Indicating staff should assess the resident for clinical indications, including signs and symptoms of hypoxia. These may include rapid breathing, increased pulse rate, restlessness, and confusion. The policy further states that a physician ' s order must be verified prior to initiating oxygen therapy and care plan should be in place to identify and monitor the resident s needs related to oxygen administration.</p>