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	06/18/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the resident and/or responsible party (RP) were informed in advance, of the risks and benefits of hypnotic medications (a type of drug specifically designed to help you fall asleep and stay asleep) and an informed consent was reviewed and completed for psychotropic medications (medication that affects mood and behavior) for one of six sampled residents (Resident 44). This deficient practice violated the resident's right to make an informed decision and consent to receive hypnotic medications. Findings: During a review of Resident 44's admission Record (AR), indicated the resident was admitted to the facility on [DATE] and readmitted to the facility on [DATE], with diagnoses that included acute respiratory failure with hypoxia (a sudden and life-threatening condition where the respiratory system cannot adequately exchange gases, resulting in insufficient oxygen or excessive carbon dioxide in the blood), end stage renal disease (ESRD, the final, irreversible stage of chronic kidney disease [CKD, kidneys were so damaged and could not filter blood as well as they should have]), and heart failure (a condition where the heart was unable to pump enough blood to meet the body ' s needs). During a review of Resident 44's History and Physical (H&P) dated 1/17/2025, the H&P indicated the resident had capacity to understand and make decisions. During a review of Resident 44's Facility Verification of Informed Consent to Physical Restraint, Psychotherapeutic Drugs, or Prolonged Use of a Device form dated 3/31/2025, the consent form did not include Resident 44 ' s signature. During a review of Resident 44's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 4/7/2025, indicated the resident ' s cognition was intact (sufficient judgment and self-control to manage the normal demands of the environment). The MDS indicated the resident was receiving a hypnotic medication. During a review of Resident 44's Physician ' s Order (PO) dated 4/15/2025, the PO indicated Zolpidem Tartrate (also known as Ambien, a sedative-hypnotic medication used to treat insomnia, or trouble sleeping) tablet, 10 milligrams (mg, unit of measurement), give one tablet by mouth at bedtime for insomnia (a sleep disorder characterized by difficulty falling asleep, staying asleep, or waking up too early, despite having adequate opportunity to sleep) manifested by inability to sleep. (continued on next page)

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
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 44's Ambien Care Plan revised 6/15/2025, the Care Plan indicated a goal for the resident to be free of any discomfort or adverse side effects of hypnotic use and limited episodes of inability to sleep at bedtime. The Care Plan interventions included administering the medication as ordered and to monitor, document, and report for the following adverse effects: daytime drowsiness, confusion, loss of appetite in the morning, increased risk of falls and fractures, and dizziness. During a concurrent interview and record review with Licensed Vocational Nurse (LVN) 4 of Resident 44 ' s Informed Consent for Ambien on 6/17/2025 at 4:33 PM, LVN 4 stated the Informed Consent was not signed but should have been. LVN 4 stated if the Informed Consent was not signed, there would be a gray area if the resident was okay with receiving a medication that could cause respiratory suppression. LVN 4 stated the resident would need to be informed of all the potential risks of this medication before the resident could receive the medication otherwise if Resident 44 experienced any adverse effects, the resident would not know why. During a concurrent interview and record review with the Director of Nursing (DON) of Resident 44 ' s Informed Consent for Ambien on 6/18/2025 at 10:20 AM, the DON stated the Informed Consent was not signed but should have been. The DON stated the resident had been on the medication for a long time and I think it was missed. The DON stated if the Informed Consent was not signed the resident might not be aware of the risks/benefits/adverse effects of the medication. During a concurrent interview and record review with the DON on 6/18/2025 at 1:27 PM of the facility ' s policy and procedure (P&P) titled, Informed Consents dated July 2021, the P&P indicated The facility shall ensure the resident ' s rights are maintained and a copy of these rights and pertinent policies are made available to the resident and/or resident representative. Among these rights under this section are the right to: receive in advance all information that is material to a decision to accept or refuse treatment, consent to or to refuse any treatment or procedure or participation in experimental research and participate in care planning. The P&P indicated The facility staff shall verify the resident or resident representative has given informed consent to the proposed treatment or procedure prior to the initiation of psychotherapeutic drugs, antipsychotic drugs, physical restraints, bedrail(s) use, or the prolonged use of device that may lead to the inability to regain use of normal bodily function, or prior to the installation of bedrails.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide one of six sampled residents (Resident 12) with information regarding the right to formulate an Advance Directive (AD, a written instruction, such as a living will or durable power of attorney for health care, recognized under State law relating to the provision of health care when the individual was incapacitated). This deficient practice had the potential for the facility to not honor Resident 12 ' s wishes and for the resident to receive inaccurate or unnecessary care and/or treatment services regarding life-sustaining treatment. Findings: During a review of Resident 12's AD Acknowledgement Form (confirmed that you understand your right to make decisions about your future medical care and have either documented those wishes or appointed someone to make those decisions for you if you were unable to do so) dated 2/16/2024, the AD Acknowledgement Form indicated the resident had executed an AD. During a review of Resident 12's admission Record (AR), indicated the resident was admitted to the facility on [DATE], with diagnoses that included congestive heart failure (CHF, a heart disorder which caused the heart to not pump the blood efficiently, sometimes resulting in leg swelling), Type 2 Diabetes (a condition where the body did not use insulin [a hormone produced by the pancreas that helped regulate blood sugar levels] properly, meaning the body could not get enough sugar from the blood into cells for energy) and vascular dementia (a type of dementia caused by reduced blood flow to the brain, resulting in damage to brain tissue and impaired cognitive function). During a review of Resident 12 s History and Physical (H&P) dated 7/25/2024, indicated the resident had capacity to understand and make decisions. During a review of Resident 12's Interdisciplinary Team Conference Record (IDT Conference Record) dated 7/26/2024, the IDT Conference Record indicated the resident ' s POLST indicated the Resident 12 had an Advance Healthcare Directive, but the facility did not have a copy on file. The IDT Conference Record indicated when the facility asked the resident about the Advance Healthcare Directive, Resident 12 stated she was not aware. During a review of Resident 12' s Physician Orders for Life-Sustaining Treatment (POLST, a document that translated a seriously ill or frail person ' s wishes for medical care during a medical emergency into actionable medical orders) dated 10/23/2024, the POLST indicated the resident did not have an AD. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 12 ' s Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 5/16/2025, indicated the resident ' s cognition was intact (sufficient judgement and self-control to manage the normal demands of the environment). The MDS indicated Resident 12 required substantial/maximal assistance (helper did more than half the effort) from facility staff for toileting/personal hygiene, upper/lower body dressing, and transfers. The MDS indicated Resident 12 required supervision or touching assistance (helper provided verbal cues and/or contact guard assistance) from facility staff for eating and oral hygiene. During a review of Resident 12 ' s IDT Conference Record dated 5/19/2025, the IDT Conference Record indicated the resident and the resident ' s responsible agent attended the conference. The IDT Conference Record indicated the POLST was reviewed with no changes made. During a concurrent interview and record review of Resident 12 ' s POLST and AD Acknowledgement Form on 6/17/2025 at 10:36 AM, the Director of Nursing (DON) stated the two documents should have had matching information. The DON stated the information should have been clarified amongst the IDT because the facility worked together as a team. The DON stated if the two documents were not clarified, there was potential for the resident ' s wishes not being met and could affect Resident 12 emotionally. During a concurrent interview and record review of Resident 12 ' s POLST and AD Acknowledgement Form on 6/17/2025 at 3:44 PM, the Social Worker (SW) stated the two documents had conflicting information and should not have been that way. The SW stated if the two documents were not clarified there could be confusion as to whether the resident had an AD and create conflict if the information from the AD and POLST information were not matching. The SW stated there was no documentation found indicating the resident was provided information regarding Advance Directives. During an interview on 6/18/2025 at 12:22 PM, Resident 12 stated she did not have an AD and did not remember if the facility provided information regarding an AD. During a concurrent interview and record review with the DON on 6/18/2025 at 3:52 PM of the facility ' s policy and procedure (P&P) titled, ADs dated September 2022, the P&P indicated Prior to or upon admission of a resident, the social services director or designees inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written ADs. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an AD if he or she chooses to do so. Written information about the right to accept or refuse medical or surgical treatment, and the right to formulate an AD is provided in a manner that I easily understood by the resident or representative. The DON stated the facility was not following the P&P but should have been. The DON stated if the facility was not following the P&P, Resident 12 ' s wishes would not be met and that could affect the resident emotionally.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop a person-centered care plan (a treatment plan that focused on the needs and preferences of a resident or individual) for five of 14 sampled residents (Resident 47, Resident 44, Resident 56, Resident 41, and Resident 14) by failing to: 1. Develop a resident specific care plan for Resident 47 ' s specific food preferences and dietary needs. 2. Develop a resident specific care plan for Resident 44, 56, and 41 oxygen therapy. 3. Develop a resident specific care plan for Resident 14's epilepsy medications: Lacosamide (medication used to control certain types of seizures in people with epilepsy), Keppra (medication used to treat seizures caused by epilepsy), and Lamictal (medication primarily used as an anticonvulsant, often prescribed for epilepsy). These deficient practices had the potential for a lack of individualized care and to affect the quality of services provided to Resident 44, Resident 56, Resident 41, and Resident 14, and negatively impact Resident 47's nutritional status and place the resident at risk for weight loss. Findings: 1. During a review of resident 47's admission Record (AR), indicated the resident was admitted on [DATE] with a diagnosis of chronic pulmonary edema (fluid accumulation in the tissue or spaces of the lungs) and acute respiratory failure (a condition where you don ' t have enough oxygen in the tissues in your body). During a review of Resident 47's History and physical (H&P), dated 5/18/2025, indicated the resident has the capacity to understand and make decisions. During a review of Resident 47's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 5/12/2025, indicated the resident ' s cognition (ability to reason and think normally) was intact. During a review of Resident 47's Weight and Vitals Summary report indicated from 5/8/2025 to 6/11/2025 Resident 47 had a 75.4 lbs. weight loss. During a review of Resident 47' Intake of meals indicated from 5/19/2025 to 6/17/2025 Resident 47 ate an average 25 - 50 % of all meals. During a review of Resident 47's Nutritional Screening record on admission dated 5/13/2025, did not include to indicate resident ' s food preferences. During a review of Resident 47's Comprehensive Nutritional Screening record, dated 6/1/2025, the record did not indicate the resident ' s food preferences. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/17/2025 at 12:04 PM with Resident 47, the resident stated, No one has ever asked what food I like Resident 47 explained he does not like the food at the facility because it was not cooked right. During a concurrent interview and record review on 6/17/2025 at 12:13PM with the Director of Nursing (DON), Resident 47 ' s care plans (CP) dated 5/13/2025, titled Nutritional Status were reviewed. The DON stated no CP for food preferences was created for Resident 47. The DON stated Resident 47 ' s CP did not include interventions specific to the resident ' s food preferences or detail how staff should accommodate or monitor the resident ' s food preferences and acceptance of meals. During a concurrent interview and record review on 6/17/2025 at 12:13 with the DON, Resident 47 ' s Nutritional Screening on admission dated 5/13/2025 and reevaluation dated 6/4/24 was reviewed. The DON stated the Registered Dietitian (RD) did not include Resident 47 ' s food preferences in the CP. During an interview with on 6/17/2025 at 12:59PM with the Dietary Supervisor (DS), the DS stated he was responsible for creating nutritional CP, but he did not create a CP for Resident 47 ' s food preferences. During a review of the facility ' s policy and procedure (P&P) titled, Care plans, Comprehensive person-Centered, dated 2025, the P&P 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. 2a. During a review of Resident 44 ' s AR, indicated the resident was admitted to the facility on [DATE] and readmitted to the facility on [DATE], with diagnoses that included acute respiratory failure with hypoxia (a sudden and life-threatening condition where the respiratory system cannot adequately exchange gases, resulting in insufficient oxygen or excessive carbon dioxide in the blood), end stage renal disease (ESRD, the final, irreversible stage of chronic kidney disease [CKD, kidneys were so damaged and could not filter blood as well as they should have]), and heart failure (a condition where the heart was unable to pump enough blood to meet the body ' s needs). During a review of Resident 44's H&P, dated 1/17/2025, the H&P indicated the resident had capacity to understand and make decisions. During a review of Resident 44's MDS, dated [DATE], indicated the resident ' s cognition was intact (sufficient judgment and self-control to manage the normal demands of the environment). The MDS indicated the resident ' s health conditions included shortness of breath (SOB) or trouble breathing with exertion (e.g., walking, bathing, and transferring), when sitting at rest, and when lying flat. During a review of Resident 44's Physician ' s Order (PO) dated 6/4/2025 at 1:28 PM, the PO indicated oxygen (O2) therapy (routine): May administer O2 at 3 liters per minute (L/min) via nasal cannula. Goal saturation (the percentage of hemoglobin [protein found in red blood cells] in your blood that was carrying oxygen) greater than 92%. During a review of Resident 44 ' s Comprehensive (Complete) Care Plan (CP) for 6/4/2025, the CP indicated there was no oxygen care plan initiated after Resident 44 ' s oxygen order was placed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/17/2025 at 4:18 PM, Licensed Vocational Nurse (LVN) 4 stated Resident 44 did not have a care plan for oxygen but there should have been one. LVN 4 stated if there was no care plan for oxygen, there could be a delay in care and the resident would be at risk for hypoxemia (when your body or parts of your body were not getting enough oxygen) and lead to several things like distress and cause cardiac dysrhythmias (a condition where the heart ' s rhythm was irregular, either too fast, too slow, or with an uneven pattern). During a concurrent interview and record review of Resident 44 ' s Comprehensive CP on 6/18/2025 at 9:26 AM, the DON stated there should have been an oxygen CP for Resident 44. The DON stated without a CP the facility staff would not know the resident ' s whole oxygen therapy and not know the specific plan of care, interventions, and what the goals were for the resident which could lead to respiratory issues like low oxygen saturation or shortness of breath. 2b. During a review of Resident 56 ' s AR, the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included dementia (a progressive state of decline in mental abilities), type 2 diabetes (a condition where the body did not use insulin properly, meaning the body could not get enough sugar from the blood into cells for energy), and hypothyroidism (a condition where the thyroid gland did not produce enough thyroid hormones). During a review of Resident 56 ' s H&P dated 5/9/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 56 ' s MDS dated [DATE], the MDS indicated the resident had severe cognitive impairment (problems with a person ' s ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident required substantial/maximal assistance (helper did more than half the effort) from facility staff for oral/toileting hygiene, rolling from the left and right side and was dependent (helper did all of the effort) from facility staff for showering and personal hygiene. During a review of Resident 56 ' s PO dated 5/30/2025 at 6:08 PM, the PO indicated oxygen therapy, as needed (PRN): May administer O2 at 2 L/min via nasal cannula as needed for SOB or O2 saturation lower than 92%. May titrate to achieve O2 saturation above 92%. During a review of Resident 56 ' s Comprehensive CP for 5/30/2025, the CP indicated there was no oxygen care plan initiated after Resident 56 ' s oxygen order was placed. During a concurrent interview and record review of Resident 56 ' s Comprehensive CP on 6/18/2025 at 1 PM, the DON stated Resident 56 did not have an oxygen CP but should have had one. The DON stated if the resident did not have a CP, Resident 56 might not receive the full regimen for oxygen therapy and could develop respiratory issues like low oxygen saturation or SOB. 2c. During a review of Resident 41 ' s AR, the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), dependence on supplemental oxygen, and atherosclerosis (a condition where fatty deposits [plaque] build up in the inner lining of the arteries). During a review of Resident 41 ' s H&P dated 11/1/2024, the H&P indicated the resident had capacity to understand and make decisions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 41 ' s MDS dated [DATE], the MDS indicated the resident ' s cognition was intact. The MDS indicated the resident ' s health conditions included shortness of breath (SOB) or trouble breathing with exertion, when sitting at rest, and when lying flat. The MDS indicated the was receiving oxygen therapy. During a review of Resident 41 ' s PO dated 5/30/2025, the PO indicated oxygen therapy (routine): May administer O2 at 2 L/min via nasal cannula every shift for SOB or hypoxia. May titrate to achieve O2 saturation above 92%. During a review of Resident 41 ' s Comprehensive CP for 5/30/2025, the CP indicated there was no oxygen care plan initiated after Resident 41 ' s oxygen order was placed. During a concurrent interview and record review of Resident 41 ' s Comprehensive CP on 6/18/2025 at 1:05 PM, the DON stated Resident 41 did not have an oxygen CP but should have had one. The DON stated if the resident did not have a care plan, Resident 41 might not receive the full regimen for oxygen therapy and could develop respiratory issues like low oxygen saturation or SOB. 3. During a review of Resident 14 ' s AR, the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included chronic COPD, epilepsy (a brain disorder characterized by recurrent, unprovoked seizures [a sudden uncontrolled surge of electrical activity in the brain that could cause a range of symptoms from brief lapses in awareness to convulsions]), and gastro-esophageal reflux disease (GERD, a condition where stomach acid frequently flows back into the esophagus, causing irritation and discomfort). During a review of Resident 14 ' s H&P dated 2/8/2025, the H&P indicated the resident had capacity to understand and make decisions. During a review of Resident 14 ' s PO dated 3/11/2025 at 5:11 AM, the PO indicated Lacosamide oral tablet 200 milligrams (mg, unit of measurement), give one tablet by mouth every 12 hours for seizure. During a review of Resident 14 ' s Comprehensive Care Plan for 3/11/2025, the Care Plan indicated there was no care plan for Lacosamide initiated after Resident 14 ' s Lacosamide order was placed. During a review of Resident 14 ' s PO dated 3/27/2025 at 10 AM, the PO indicated Keppra oral tablet 500 mg, give one tablet by mouth two times a day for seizure, do not crush. During a review of Resident 14 ' s Comprehensive CP for 3/27/2025, the CP indicated there was no CP for Keppra initiated after Resident 14 ' s Keppra order was placed. During a review of Resident 14 ' s MDS dated [DATE], the MDS indicated the resident ' s cognition was intact. The MDS indicated the resident required supervision or touching assistance (helper provided verbal cues and/or contact guard assistance) from facility staff for toileting hygiene, showering, and transfers. The MDS indicated the resident was independent with eating, oral/personal hygiene, and upper body dressing. During a review of Resident 14 ' s PO dated 6/4/2025 at 10:16 PM, the PO indicated Lamictal oral tablet 25 mg give three tablets by mouth two times a day for seizures. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 14 ' s Comprehensive CP for 6/4/2025, the CP indicated there was no care plan for Lamictal initiated after Resident 14 ' s Lamictal order was placed. During a concurrent interview and record review of Resident 14 ' s Comprehensive CP on 6/18/2025 at 12:30 PM, the DON stated Resident 14 did not have a care plan for Lacosamide, Keppra, and Lamictal but should have had one to know what side effects to monitor for. The DON stated if the resident did not have a care plan there was risk for Resident 14 to experience adverse side effects or reactions and develop a change of condition related to the medications. During a review of the facility ' s policy and procedure (P&P) titled, Oxygen Administration dated February 2014, the P&P indicated in preparation of oxygen administration, the facility must Review the resident ' s care plan to assess for any special needs of the resident. The P&P indicated to Verify that there is a physician ' s order for this procedure. Review the physician ' s orders or facility protocol for oxygen administration. During a concurrent interview and record review with the DON on 6/18/2025 at 1:27 PM of the facility ' s P&P titled, Care Plans, Comprehensive Person-Centered dated March 2022 , the P&P indicated The comprehensive, person-centered care plan: 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; and includes the resident ' s stated goals upon admission and desired outcomes. The P&P indicated Assessment of resident are ongoing, and care plans are revised as information about the residents and the resident ' s conditions change. The interdisciplinary team reviews and updates the care plan: when there has been a significant change in the resident ' s condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay, and at least quarterly. The DON stated the facility was not following the facility ' s P&P but should have been. The DON stated otherwise there would be potential gaps on the resident ' s care and the resident may potentially not receive the care that was specific to their diagnosis or medication.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 17) received Restorative Nursing Services (RNA, an exercise program to maintain or prevent decline in the resident's joint mobility) as indicated in the care plan and the facility ' s policy and procedure to prevent decrease in range of motion (ROM- how far you can move or stretch a part of your body). This deficient practice had the potential to place Resident 17 at increased risk for ROM decline and development of contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints). Findings: During a review of Resident 17 ' s admission Record (AR), the AR indicated that Resident 17 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including metabolic encephalopathy (a change in how a person ' s brain dysfunctions due to an underlying condition), generalized muscle weakness, and epilepsy (is a brain condition that causes recurring seizures). During a review of Resident 17 ' s Joint Mobility Assessment (JMA) dated 12/15/2024, the JMA indicated the following: 1. Resident 17 had moderate limitation (50%-> 75%) on both sides of upper extremities [BUE (bilateral upper extremities)- shoulder, elbow, wrist, hand] 2. Resident 17 had full ROM (0%) / variance up to 25% due to normal aging process on both hips. 3. Resident 17 had minimal limitation (25%-> 50%) on both knees. 4. Resident 17 had severe limitation (75%-> 100%) on both ankles. During a review of Resident 17 ' s Care Plan dated 4/23/2024, the Care Plan indicated that Resident 17 needed RNA Program due to the resident ' s limitation in ROM. During a review of Resident 17 ' s Physician Orders, dated 2/11/2025, indicated the physician order for RNA exercises for BUE and BLE were discontinued on 2/10/2025 due to readmission. During a review of Resident 17 ' s Quarterly Assessment for JMA, dated 3/15/2025, the JMA indicated to provide RNA for PROM exercises (passive range of motion exercises, to move a joint through its full range of motion by an external force, such as a therapist or caregiver, without the individual actively using their muscles) to prevent further decrease in ROM. (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	06/18/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 17 ' s Minimal Data Sheet (MDS- a federally mandated resident assessment tool) dated 3/24/2025, the MDS indicated that Resident 17 was severely cognitively impaired (never/rarely made decisions.) The MDS indicated that Resident 17 had impaired range of motion on both sides of upper extremities and lower extremities (hip, knee, ankle, foot.) The MDS also indicated that Resident 17 was dependent (helper does all of the effort) on oral hygiene, toilet hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, rolling left and right, sitting to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer. During a concurrent observation and interview on 6/17/2025 at 10:20 AM with the Certified Nurse Assistant (CNA) 2, Resident 17 was observed with limited ROM on BUE, and ankles. CNA 2 stated she did not see any therapy or RNA assisted exercises done at bedside for Resident 17 for the past three months. During a concurrent record review and interview on 6/17/2025 at 10:30 AM with the Licensed Vocational Nurse (LVN) 1, Resident 17 ' s Physician Orders were reviewed. LVN 1 stated she can ' t find RNA program in the resident ' s active orders. LVN 1 also stated she couldn ' t recall the last time she saw Resident 17 received RNA program, but the resident had limited ROM and should be on RNA Program. During a concurrent record review and interview on 6/17/2025 at 11:20 AM with the Registered Nurse Supervisor (RNS) 1, Resident 17 ' s active Physician Orders were reviewed. RNS 1 stated Resident 17 was on RNA program before the facility transferred her to GACH (general acute care hospital) and returned on 2/10/2025. RNS 1 stated the RNA order was discontinued when the resident was transferred and a new physician order had to be placed when the resident returned to the facility. RNS 1 stated Resident 17 had limited ROM and RNA program should have been resumed. RNS 1 also stated by not providing RNA services, the resident could become more immobile, skin issues and contracture could occur. During a phone interview on 6/18/2025 at 3:15 PM with the Director of Rehabilitation (DOR, a leader of a team that helps clients recover and regain their independence after an injury, illness, or surgery), DOR stated that she recalled Resident 17 had been discharged from rehab therapy last year and was referred to RNA program. DOR stated she performed joint mobility assessment quarterly and referred Resident 17 to RNA services. DOR stated she was not aware that Resident 17 returned to the facility and did not have active RNA program order since 2/10/2025. DOR also stated Resident 17 needed RNA for PROM exercises to prevent further decline in ROM. During a concurrent record review and interview on 6/18/2025 at 3:35 PM with the Director of Nursing (DON), Resident 17 ' s active physician orders and care plan were reviewed. DON stated that she could not answer why RNA program was not ordered or provided when Resident 17 was readmitted on [DATE]. DON stated RNA program should have been continued for Resident 17 to promote the individual ' s safety and independence, maintain the resident ' s dignity, and/or to prevent further decrease of ROM. During a review of the facility ' s Policy and Procedure (P&P) titled Restorative Nursing Services revised in 7/2017, the P&P indicated that residents would receive restorative nursing care as needed to help promote optimal safety and independence. Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care. (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	06/18/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s P&P titled Resident Mobility and Range of Motion revised in 7/2017, the P&P indicated that residents with limited range of motion will receive treatment and services to increase and/or to prevent a decrease in ROM. The P&P also indicated that (care plan) interventions may include therapies, the provision of necessary equipment, and/or exercises and will be based on professional standards of practice and be consistent with state laws and practice acts.

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	555839	A. Building B. Wing	06/18/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of eight sampled residents (Resident 47) with weight loss received a comprehensive nutritional assessment and provided the resident ' s food preferences. This deficient practice had the potential to result in unmet nutritional need, poor meal acceptance, and increased risk for further weight loss. Findings: During a review of resident 47's admission Record indicated the resident was admitted on [DATE] with a diagnosis of Chronic pulmonary edema (fluid accumulation in the tissue or spaces of the lungs) and acute respiratory failure (a condition where you don ' t have enough oxygen in the tissues in your body). During a review of Resident 47's History and physical (H&P), dated 5/18/2025, indicated the resident has the capacity to understand and make decisions. During a review of Resident 47's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 5/12/2025, indicated the resident ' s cognition was intact (ability to reason and think normally). During an interview on 6/17/2025 at 12:04PM with Resident 47, Resident 47 stated No one has ever asked what food I like. Resident 47 stated not liking the food at the facility, stating it was not cooked right. Resident 47 stated he would like to eat more meat, fresh vegestables and not over cooked or not salty. During a concurrent interview and record review on 6/17/2025 at 12:13 PM with the DON, Resident 47 ' s Nutritional Screening on admission dated 5/13/2025 and reevaluation dated 6/4/24 was reviewed. The DON stated the Registered Dietitian (RD) did not include Resident 47 ' s food preferences. During a food test tray on 6/17/25 at 12:48 PM. the following were observed: -Vegetables were salty and mushy -Chicken was salty -Rice wasclumpy During a concurrent interview and record review on 6/17/2025 at 12:59 PM with Dietary Supervisor (DS), the following records were reviewed: -Resident 47's Nutritional screening dated 5/13/2025, Description admission did not include to indicate resident's food preferences. (continued on next page)

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	555839	A. Building B. Wing	06/18/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident 47 ' s Weight and vitals summary indicated from 5/8/2025 to 6/11/2025 Resident 47 had a 75.4 lb weight loss -Resident 47 ' s Intake of meals indicated from 5/19/2025 to 6/17/2025 Resident 47 ate on average 25 - 50 % of all meals. -Resident 47 Nutritional screening dated 6/1/2025 description comprehensive did not include to indicate resident food preferences In a concurrent interview on 6/17/2025 at 12:59PM with the DS, the DS stated he did not assess Resident 47 ' s food preferences and did not develop a care plan to indicate measures to determine the resident ' s preferred food to eat to prevent further weight loss. During a review of the facility ' policy and procedure (P&P) Titled, Nutritional Assessment, dated 2002, the P&P indicated, as part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factors for impaired nutrition, shall be conducted for each resident. The nutritional assessment shall identify food preferences and dislikes including flavors, textures and forms.

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	555839	A. Building B. Wing	06/18/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide necessary respiratory care services for two of six sampled residents (Resident 44 and Resident 41) reviewed receiving oxygen therapy by failing to: 1. Ensure Resident 44 received three liters (L, unit of volume used to measure how much oxygen gas was being delivered) of oxygen routinely according to physician ' s orders, and displayed a No Smoking/Oxygen in Use sign for Resident 44. 2. Follow the facility' s P&P for displaying a No Smoking/Oxygen in Use sign for Resident 41. This deficient practice had the potential to cause complications associated with oxygen therapy and result in respiratory distress and place residents at risk of injury due to a fire hazard. Findings: 1. During a review of Resident 44 ' s admission Record (AR), indicated the resident was admitted to the facility on [DATE] and readmitted to the facility on [DATE], with diagnoses that included acute respiratory failure with hypoxia (a sudden and life-threatening condition where the respiratory system cannot adequately exchange gases, resulting in insufficient oxygen or excessive carbon dioxide in the blood), end stage renal disease (ESRD, the final, irreversible stage of chronic kidney disease [CKD, kidneys were so damaged and could not filter blood as well as they should have]), and heart failure (a condition where the heart was unable to pump enough blood to meet the body ' s needs). During a review of Resident 44 ' s History and Physical (H&P) dated 1/17/2025, the H&P indicated the resident had capacity to understand and make decisions. During a review of Resident 44 ' s Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 4/7/2025, indicated the resident ' s cognition was intact (sufficient judgment and self-control to manage the normal demands of the environment). The MDS indicated the resident ' s health conditions included shortness of breath (SOB) or trouble breathing with exertion (e.g., walking, bathing, and transferring), when sitting at rest, and when lying flat. The MDS did not indicate the resident was receiving oxygen therapy. During a review of Resident 44 ' s Physician ' s Order (PO) dated 6/4/2025 at 1:28 PM, the PO indicated oxygen (O2) therapy (routine): May administer O2 at 3 L per minute (L/min) via nasal cannula. Goal saturation (the percentage of hemoglobin [protein found in red blood cells] in your blood that was carrying oxygen) greater than 92%. During a review of Resident 44 ' s O2 Saturation Summary for June 2025, the O2 Saturation Summary indicated the resident used oxygen 12 times from 6/2/2025 to 6/15/2025 and was not on routine oxygen therapy. During an observation on 6/16/2025 at 10:56 AM, Resident 44 ' s room did not display signage indicating there was oxygen in use. (continued on next page)

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	555839	A. Building B. Wing	06/18/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 44 ' s Physician ' s Order on 6/17/2025 at 3:57 PM, the Licensed Vocational Nurse (LVN) 4 stated the resident ' s oxygen order was inappropriate and should have been clarified with the physician to include the resident ' s diagnosis. During an interview on 6/17/2025 at 4:18 PM, LVN 4 stated residents on oxygen should have a sign posted outside of the door with red lettering stating oxygen was in use and no smoking was allowed. LVN 4 stated signs should have been posted so other people would be aware, otherwise that was a safety hazard. During a concurrent interview and record review of Resident 44 ' s Physician ' s Order on 6/18/2025 at 9:18 AM, the Director of Nursing (DON) stated the resident ' s oxygen order was incomplete and did not state Resident 44 ' s actual diagnosis of why the resident needed oxygen. The DON stated the facility staff was not following Physician ' s Orders because the resident was not on routine oxygen and should have been. The DON stated if the facility staff were not following Physician ' s Orders there could be a risk for respiratory issues for Resident 44 such as developing low oxygen saturation or SOB. During an observation and interview of Resident 44 ' s room on 6/18/2025 at 9:35 AM, the DON stated there should have been a sign posted outside of the resident ' s room indicating No smoking or Oxygen use for the safety of the resident, staff, and the building. The DON stated without the appropriate signs posted there was potential for hazard including a fire which could cause injury. 2. During a review of Resident 41 ' s AR, the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), dependence on supplemental oxygen, and atherosclerosis (a condition where fatty deposits [plaque] build up in the inner lining of the arteries). During a review of Resident 41 ' s H&P dated 11/1/2024, the H&P indicated the resident had capacity to understand and make decisions. During a review of Resident 41 ' s MDS dated [DATE], the MDS indicated the resident ' s cognition was intact. The MDS indicated the resident ' s health conditions included shortness of breath (SOB) or trouble breathing with exertion, when sitting at rest, and when lying flat. The MDS indicated the was receiving oxygen therapy. During a review of Resident 41 ' s PO dated 5/30/2025, the PO indicated oxygen therapy (routine): May administer O2 at 2 L/min via nasal cannula every shift for SOB or hypoxia. May titrate to achieve O2 saturation above 92%. During an observation on 6/16/2025 at 10:56 AM, Resident 41 ' s room did not display signage indicating there was oxygen in use. During an interview on 6/17/2025 at 4:18 PM, LVN 4 stated residents on oxygen should have a sign posted outside of the door with red lettering stating oxygen was in use and no smoking was allowed. LVN 4 stated signs should have been posted so other people would be aware, otherwise that was a safety hazard. (continued on next page)

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	555839	A. Building B. Wing	06/18/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview of Resident 41 ' s room on 6/18/2025 at 9:35 AM, the DON stated there should have been a sign posted outside of the resident ' s room indicating No smoking or Oxygen use for the safety of the resident, staff, and the building. The DON stated without the appropriate signs posted there was potential for hazard including a fire which could cause injury. During a review of the facility ' s P&P titled, Oxygen Administration dated October 2010, the P&P indicated The following equipment and supplies will be necessary when performing this procedure – No Smoking/Oxygen in Use signs. During a review of the facility ' s P&P titled, Verbal Orders dated February 2014, the P&P indicated, The individual receiving the verbal order will: read the order back to the practitioner to ensure that the information is clearly understood and correctly transcribed.

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	555839	A. Building B. Wing	06/18/2025

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 3 had sufficient skills sets and competency to accurately aspirate (removal of fluid from the body part) and check the gastric residual volume (GRV, the amount of fluid remaining in the stomach at a specific time) of one out of one sampled resident (Resident 15) who had a gastrostomy tube (G-tube, a feeding tube inserted through the abdominal wall directly into the stomach) when: 1. LVN 3 was observed only aspirating 20 mL (milliliters, unit of measurement) of gastric contents from Resident 15 ' s G-tube. 2. LVN 3 verbally stated he only aspirates up to 20 mL of gastric contents when measuring the resident ' s GRV. This deficient practice had the potential for Resident 15 to be at risk of aspiration pneumonia (food or liquid inhaled into the lungs when the fluid from stomach backs up from the stomach due to vomiting) and abdominal distension (bloating or swelling of the stomach) or discomfort. Findings: During a review of Resident 15 ' s admission Record indicated the resident was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included dysphagia (difficulty swallowing), muscle weakness, and gastrostomy tube placement. During a review of Resident 15 ' s History and Physical (H&P), dated 10/20/2022, indicated the resident does not have the capacity to understand and make decisions. The H&P indicated for the resident to receive all medications via G-tube. The H&P indicated a plan regarding Resident 15 ' s G-tube to continue monitoring the resident ' s GRV. During a review of Resident 15 ' s Minimum Data Set (MDS, a resident assessment tool), dated 4/1/2025, the MDS indicated Resident 15 had severely impaired cognition (ability to process thoughts). The MDS also indicated that the resident has a feeding tube (G-tube). During a review of Resident 15 ' s physician orders, for June 2025, included orders to check the resident ' s GRV every shift and to hold tube feeding if the GRV is more than 100 mL (milliliters, unit of measuring liquid volume). During a review of Resident 15 ' s care plan for nutritional status on g-tube feeding, initiated 10/6/2021, revised on 11/23/2024, indicated that the resident will not have an episode of choking until the next review date, 9/13/2025. During a concurrent medication pass observation and interview with LVN 3 on 6/17/2025 at 9:04 AM, LVN 3 was observed checking Resident 15 ' s GRV prior to the start of the medication administration. LVN 3 aspirated 20 mL from Resident 15 ' s G-tube and stated that he usually take[s] out 15 to 20 mL when he checked Resident 15 ' s GRV. LVN 3 stated he does not aspirate more than 20 mL when checking the GRV and he does not know if he has to aspirate more than 20 mL. (continued on next page)

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	555839	A. Building B. Wing	06/18/2025

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/17/2025 at 9:22 AM with LVN 5, LVN 5 stated when checking the resident ' s GRV, the nurse must aspirate as much liquid as possible from the resident ' s G-tube and should not stop aspirating just 20 mL. LVN 5 stated checking the GRV accurately is important to prevent the resident from choking. LVN 5 added the facility ' s P&P indicates if the residual volume is above 500 mL, the nurse must not continue with the medications administration. During a review of a concurrent observation and interview with LVN 3 on 6/17/2025 at 9:22 AM, LVN 3 resumed to check Resident 15 ' s GRV. LVN 3 stated the correct GRV of Resident 15 was 110 mL and was actually significantly more than his initial assessment. LVN 3 added that only aspirating 20 mL was a mistake and did not provide the actual GRV of the resident. During a concurrent interview and record review on 6/18/2025 at 11:40 AM with the Director of Staffing Development (DSD), LVN 3 ' s employee records were reviewed. The DSD stated LVN 3 was trained on how to check for a resident ' s GRV. DSD stated LVN 3 was observed on 2/12/2025 and demonstrated the correct procedure, as indicated in the Med pass Observation competency checklist in LVN 3 ' s files. During an interview on 6/18/2025 at 1:31 PM with the Director of Nursing (DON), the DON stated it is important for the nurses to accurately check the residents ' GRV to prevent residents from potentially aspirating or choking from feedings or when medication is administered. DON stated the correct procedure for checking the GRV is that the nurse would connect a syringe (a tube with a nozzle and a plunger that is used for sucking in and ejecting liquid) into the resident ' s G-tube and the nurse would aspirate as much gastric contents as possible until the nurse is no longer able to or meets resistance. During a concurrent interview and record review on 6/18/2025 at 1:31 PM with the DON, the facility ' s P&P titled, Checking Gastric Residual Volume (GRV), revised 11/2018, was reviewed. DON stated the P&P does not indicate for the nurse to only aspirate 20 mL of gastric contents. DON stated the P&P indicated for instructions if the GRV is more than 250 mL, therefore, the nurse must continue to aspirate until there are no more gastric contents. During a review of the facility ' s P&P titled, Checking Gastric Residual Volume (GRV), revised 11/2018 indicated for the facility staff to aspirate stomach contents (GRV) and: a. if GRV is between 250-500 mL, take measures to reduce the risk of aspiration. b. if the GRV is greater than 500 mL, notify the physician. Assess resident for feeding intolerance. During a review of the facility's P&P titled, Enteral Feedings- Safety Precautions, revised 11/2018, indicated, under the section preventing aspiration, for the facility staff to check the GRV as ordered. During a review of the facility's P&P titled, Staffing, Sufficient, and Competent Nursing, revised 8/2022, indicated staff must demonstrate the skills and techniques necessary to care for resident needs including medication management.

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	555839	A. Building B. Wing	06/18/2025

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one of three Certified Nursing Assistant (CNA) 3 ' s certificate was not expired and not permitted to perform resident care when CNA 3 ' s CNA certification expired on [DATE]. As a result of this deficient practice, the residents were at risk to receive substandard quality of care from CNA 3 with incompetent nursing skills. Findings: During a concurrent interview and record review on [DATE] at 10:34 AM with the Director of Staffing Development (DSD), CNA 3 ' s employee files were reviewed. CNA 3 ' s employee files indicated the CNA ' s certification expiration date was [DATE]. The DSD confirmed that CNA 3 ' s certification was expired and has not been renewed. The DSD stated CNA 3 was currently working and providing resident care. The DSD added that since CNA 3 ' s certification was expired, the CNA must be sent home until the certification has been renewed. During an interview on [DATE] at 10:49 AM with CNA 3, CNA 3 stated she is currently working with the residents and providing direct resident care. CNA 3 stated she has worked the days when she was scheduled to work since her certification expired. CNA 3 stated she is aware that her certification expired on [DATE] and has submitted the application to renew her certification on [DATE] but has not received her renewal yet. During a concurrent interview and record review on [DATE] at 10:49 AM with CNA 3, the monthly schedule for CNAs was reviewed with CNA 3. CNA 3 stated she worked the following days indicated in the schedule: a. [DATE] to [DATE] (3 days) b. [DATE] to [DATE] (5 days) c. [DATE] to [DATE] (5 days) During an interview on [DATE] at 11:01 AM with the DSD, the DSD stated it was his responsibility to ensure the CNAs ' certifications are not expired. The DSD further stated he reviewed the employee files of the CNAs and follows up with them if they have their certification was about to expire. The DSD stated he informed CNA 3 that her certification needed to be renewed prior to [DATE], but the DSD added he did not follow up with CNA 3. The DSD stated it is the CNA ' s responsibility to renew their certification. The DSD stated it is important that the facility only allow CNAs with non-expired certification to provide resident care because CNAs with expired certifications could be incompetent or could have other reasons as to why their certification cannot be renewed such as they could be under abuse investigations. (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	06/18/2025

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 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:31 PM with the Director of Nursing (DON), the DON stated that the facility only allows nursing staff who have current and non-expired licenses or certifications to provide resident care. The DON added it is important to ensure nursing staff have their licenses current because it proves that they are legally able to perform their duties in their field. During a review of the facility ' s job description (JD) for a CNA, dated 2003, indicated the CNA must be a licensed Certified Nursing Assistant in accordance with laws of the state. During a review of the facility ' s policy and procedures (P&P) titled, Credentialing of Nursing Service Personnel, revised 5/2019, indicated nursing personnel who require a certification to perform resident care must present verification of such certification prior to or upon employment.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a medication error rate of five percent or (5%) or less during medication pass in accordance with the professional standard of practice and facility ' s policy and procedure on medication administration for two of four observed residents (Residents 17 and 31) in which three (3) medication errors were identified out of 29 opportunities which yielded a cumulative error rate of 10.3 %. The facility failed to ensure: 1. Licensed Vocational Nurse (LVN) 1 did not flush Resident 17 ' s gastrostomy tube (G-tube, a feeding tube inserted through the abdominal wall directly into the stomach) after administering the medication methimazole (medication to treat hyperthyroidism, a condition where the thyroid gland produces too much thyroid hormone). 2. LVN 3 administered Resident 31's ophthalmic medication including Brimonidine and Brinzolamide (medications specifically formulated to decrease the pressure in the eyes) and did not apply pressure to Resident 31's inner eyes. Findings: 1. During a review of Resident 17 ' s admission Record (AR), indicated the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness and hyperthyroidism (also known as overactive thyroid, is a condition where the thyroid gland produces too much thyroid hormone). During a review of Resident 17 ' s History and Physical (H&P), dated 1/16/2024, indicated the resident does not have the capacity to understand and make decisions. The H&P also indicated that the resident was to receive medications via G-tube. During a review of Resident 17 ' s Minimum Data Set (MDS- a Federally mandated resident assessment tool), dated 3/24/2025, indicated the resident had severely impaired cognition (the ability to process thoughts). The MDS also indicated the resident had a feeding tube. During a review of Resident 17 ' s physician orders, for June 2025, included the following orders: Crush all crushable [medications] or give liquid medications via feeding tube, use a slow push to facilitate consumption. Flush G-tube with 30-50 [ml] (ml, milliliters, a unit of measuring liquid) of [water] with 15 ml of warm purified water (or prescribed amount) [before] and [after] medication administration. Every shift. Methimazole Tablet 5 mg (milligram, a unit of measuring weight) Give 1 tablet via G-tube one time a day for hyperthyroidism). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 17 ' s care plan for hyperthyroidism, initiated on 4/12/2025, included interventions for facility staff to administer medications as ordered by the physician. During a medication pass observation and concurrent interview with LVN 1 on 6/17/2025 at 8:17 AM, LVN 1 was observed administering medications to Resident 17 through the resident ' s G-tube. After LVN 1 administered Resident 17 ' s Methimazole into the GT, LVN 1 did not flush the G-tube after the administration. LVN 1 walked away from the resident and stated the medication administration of Resident 17 was finished. During an interview on 6/17/2025 at 8:19 AM with LVN 1, LVN 1 stated she forgot to flush Resident 17 ' s G-tube after the Methimazole was administered. LVN 1 stated the G-tube must be flushed after administering medications to ensure that the resident received the medication. LVN 1 added the medication stays in the G-tube if the G-tube is not flushed. During an interview at 6/18/2025 at 1:31 PM with the Director of Nursing (DON), the DON stated the G-tube must be flushed with the prescribed amount of water after the administration of medications. The DON stated failure to flush the G-tube is a medication error because the resident might not receive the correct dose and amount of medication because some medication may get stuck in the G-tube. DON added some medications would still be inside of the G-tube, and not in the resident ' s stomach. During a review of the facility ' s policy and procedures (P&P) titled, Administering Medications through an Enteral Tube, dated 2001, indicated to use warm, purified water for diluting medications and for flushing. The P&P also indicated when the last of the medication begins to drain from the tubing, flush the tubing with 15 ml of warm purified water (or prescribed amount). 2. During a review of Resident 31 ' s AR, indicated the resident was originally admitted on [DATE], readmitted on [DATE], with diagnoses that included glaucoma (eye disease that can cause vision loss and blindness) and diabetes mellitus. During a review of Resident 31 ' s H&P, dated 7/19/2024, indicated the resident has fluctuating capacity to understand and make medical decisions. During a review of Resident 31 ' s MDS, dated [DATE], indicated the resident has intact cognition. The MDS also indicated the resident has moderately impaired vision (limited vision; not able to see newspaper headlines but can identify objects). During a review of Resident 31 ' s physician orders, for June 2025, included the following orders: a. Brimonidine Tartrate Solution 0.2% Instill 1 drop in both eyes two times a day for Glaucoma wait 5 min between ophthalmic medications. b. Brinzolamide Ophthalmic Suspension 1% Instill 1 drop in both eyes two times a day for Glaucoma wait 5 minutes between ophthalmic medications. During a review of Resident 31 ' s care plan for impaired visual function related to glaucoma, initiated on 3/22/2023, indicated for staff to explain all procedures done to the resident and responsible party. (continued on next page)

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	555839	A. Building B. Wing	06/18/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a medication pass observation and concurrent interview with LVN 3 on 6/17/2025 at 9:55 AM, LVN 3 was observed administering Brimonidine and Brinzolamide to Resident 31 without applying pressure to Resident 31 ' s inner eyes. During an interview on 6/17/2025 at 10:08 AM with LVN 3, LVN 3 stated he forgot to apply pressure to Resident 31 ' s inner eyes after administering Brimonidine and Brinzolamide. LVN 3 stated applying pressure over the inner eyes ensures the proper deliver of the resident ' s ophthalmic medication. During an interview on 6/18/2025 at 1:31 PM with the DON, the DON stated it is important for the medication to stay on the eyes because ophthalmic medications, such as Brimonidine and Brinzolamide, treat conditions of the eyes. The DON stated after the administration of ophthalmic medications, the nurse must apply pressure over the resident ' s inner eye ensure the medication stays on the resident ' s eye. During a review of the manufacturer's package leaflet and recommendations for the application of Brimonidine and Brinzolamide, revised 6/2023, indicated after applying the medication to the eyes to press a finger to the corner of your eye, by the nose for at least 1 minute. This helps to stop [medication] getting into the rest of the body.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to safely store, discard drugs and biologicals in accordance with the professional standard of practice and facility ' s policy and procedure for two of two sampled residents (Resident 2 and 25) by failing to: 1. Medication Cart (MC) 1 was found to have one insulin pen (a device used to inject insulin, a medication that is used to control the blood sugar), belonging to Resident 25, that was not labeled with the opened date. 2. MC 2 was found to have 2 bottles of over-the-counter medications, Naproxen Sodium (an over-the-counter pain medication) 220 mg (unit of measuring weight) and Vitamin B1 (a supplement) 100 mg, that were not labeled with the opened dates. These deficient practices had the potential for staff to administer potentially expired medications to residents and the insulin pens, which may have less efficacy, could lead to the mismanagement of the blood sugar of Resident 25. Findings: 1. During a review of Resident 25 ' s admission Record, indicated the resident was admitted on [DATE] with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control, or high blood sugar and result in poor wound healing) and pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence). During a review of Resident 25 ' s History and Physical (H&P), dated 5/30/2025, indicated the resident does have the capacity to understand and make decisions. During a review of Resident 25 ' s Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 6/4/2025, indicated the resident has moderately impaired cognition (ability to process thoughts). The MDS also indicated that the residents receive medications that lower the blood sugar, such as insulin. During a review of Resident 25 ' s physician orders for June 2025, included insulin Regular Human Injection Solution, inject as per sliding scale, administer subcutaneously (a method of administering medication into the fatty tissue layer just beneath the skin, but not into the muscle) before meals and at bedtime for DM. During a concurrent observation of MC 1 and interview on 6/17/2025 at 1:40 PM with Licensed Vocational Nurse (LVN) 5, one opened Insulin pen labeled with Resident 25 ' s name was without a label for the date it was first opened or when the Insulin will be discarded. LVN 5 stated she was not aware who opened the medication first because all medications, including insulin, must be labeled with the opened date. LVN 5 stated insulin must be discarded 28 days after the insulin was opened because insulin loses efficacy over time. (continued on next page)

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	555839	A. Building B. Wing	06/18/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent observation of MC 2 and interview on 6/17/2025 at 1:24 PM with LVN 5, the facility ' s MC 2 was inspected and one bottle of Naproxen Sodium 220 mg and Vitamin B1 100 mg was observed opened, without label indicating the date the medications were opened. LVN 5 stated the bottles of medications must be labeled with opened date because some medications need to be discarded earlier than the manufacturer-printed expiration date once they have been opened. During an interview on 6/18/2025 at 1:31 PM with the Director of Nursing (DON), the DON stated multi-dose medications (medication container that holds enough medication for more than one use or patient) must be labeled with the date they were opened. The DON stated insulin must be discarded 28 days after the initial opened date because insulin loses efficacy over time. The DON added if insulin with decreased efficacy is administered, it could lead to the mismanagement of the resident ' s blood sugar. During a review of the facility ' s P&P titled, Medication Labeling and Storage, revised 2/2023, indicated nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. The P&P also indicated labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. The P&P also indicated multi-dose vials that have been opened or accessed are dated and discarded within 28 days unless. During a review of the facility ' s P&P titled, Administering Medications, revised 4/2019, indicated the expiration date on the medication label is checked prior to the administration of medications. The P&P also indicated when opening a multi-dose container, the date opened is recorded on the container.

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	555839	A. Building B. Wing	06/18/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards of practice for food service safety by failing to: 1. Monitor and document in the temperature log the refrigerator and dry storage room temperatures to ensure temperatures were within the federal guidelines. 2. Ensure that refrigerated prune juice in the jar was discarded after five days after opening in accordance with the facility ' s policy and procedure titled, Dry Goods Storage Guidelines. These deficient practices placed the facility ' s residents at risk for foodborne illness (an illness that comes from eating contaminated food) by serving expired fruit juice and due to inconsistent refrigerator temperature monitoring and documentation. Findings: During an initial kitchen tour on 6/16/2025 at 8:10 AM, the walk-in refrigerator, one regular refrigerator, and one regular freezer were observed in the kitchen were observed with one thermometer inside. Two Refrigerator/ Freezer Temperature Log, Kitchen dated June 2025 were observed hanging on the door of the regular refrigerator and freezer, and the temperature logs were filled through 6/15/2025 and no temperature was logged for 6/26/2025. During the same observation on 6/16/2025 at 8:11 AM, a plastic jar with liquids labeled prune dated 6/3/25 was observed in the regular refrigerator. During the same observation on 6/16/2025 at 8:12 AM, a plastic container with food labeled apple sauce and dated 6/12/25 was observed in the regular refrigerator. During an interview with the Dietary Supervisor (DS) on 6/16/2025 at 8:15 AM, the DS stated the [NAME] who worked in the morning (Cook 1) was assigned to check all the temperature in the refrigerators and freezers and document in the temperature log every morning. The DS stated he was not sure if [NAME] 1 checked the refrigerator and freezer, but he should have not missed daily inspection and logging the temperature. The DS stated he was not sure whether the dates labeled for the prune juice and apple sauce were the date opened or the use-by date. The DS stated every staff should label and write appropriately, clearly open or use-by date. The DS stated the prune juice should have been discarded after five days. The DS also stated he was responsible for checking the logs, overseeing the food storage, and supervising the staffs for keep the log to ensure all the temperature in the refrigerators and freezers being monitored, and food is stored following the food code for safe food storage. During an interview on 6/17/2025 at 8:29 AM with [NAME] 1, [NAME] 1 stated meal preparation activity started at 5 AM. [NAME] 1 stated it ' s her responsibility to monitor and log the temperature when she starts her shift. The [NAME] 1 also stated she checked the temperatures including dry storage room, the refrigerators, and freezer but she forgot to log some of the temperatures yesterday (6/16/2025) and today (6/17/2025). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Dietary Supervisor (DS) on 6/17/2025 at 8:35 AM, the DS stated that daily inspection before meal preparation activity like checking temperatures and logging should never be missed. The DS also stated it was necessary to ensure all food were stored at appropriate temperature to prevent foodborne illnesses on the residents. During a review of the facility ' s Policy and Procedure (P&P) titled, Dry Goods Storage Guidelines dated 2018, the guideline indicated that This storage length is to be followed unless you have manufacturers recommendation showing it can be kept longer. This guideline also indicated that opened fruit juices may be stored refrigerated up to five days. During a review of the facility's P&P titled, Food Receiving and Storage, revised in 11/2022, the P&P indicated the following: Unused portions of canned fruits and vegetables must be transferred to clean, approved storage containers. Do not store in open cans. Remove any serving utensils and cover tightly. Label and date container. Functioning of the refrigeration and food temperatures are monitored daily and at designated intervals throughout the day by the food and nutrition services manager or designee and documented according to state-specific requirements.

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	555839	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain appropriate infection prevention and control practices for two of six sampled residents (Resident 35 and 109) by failing to: 1. Ensure Resident 35 who was on contact precautions for a multidrug – resistant organism (MDRO) had alcohol- based hand sanitizer that was readily available and accessible at the point of care. 2. Ensure Resident 109 ' s peripheral IV (Intravenous- a tube inserted into a needle used to infuse medication into the vein) line port that inserted into the IV was uncapped (not covered) after the administration of intravenous antibiotics (medication used to treat infection) and was touching the bedside curtain. 3. Ensure the port of Resident 22 ' s enteral nutrition administration set [known as gastrostomy tube (GT) feeding, a tube surgically inserted into the stomach to allow access for food fluids and medications] was covered and exposed when not in use while hanging on the IV (intravenous, administered within or into a vein) pole. These deficient practices had the potential for cross- contamination (spread of infection from one area to another) and increased the risk for the residents to acquire infection that could be spread into the bloodstream. Findings: 1. During a review of resident 35 ' s admission Record (AR) indicated the resident was admitted to the facility on [DATE] with diagnosis that included acute osteomyelitis (inflammation or swelling of bone tissue), left ankle and foot. During a review of resident 35 ' s History and Physical (H&P), dated 1/20/2025 indicated the resident has the capacity to understand and make decisions. During a review of resident 35 ' s Minimum Data Set (MDS – a standardized assessment and screening tool), indicated the resident is cognitively intact (ability to think normally). During a review of Resident 35 ' s Order Summary Report (OSR), dated 6/5/2025, indicated the resident was placed on contact isolation for extended spectrum beta – lactamase ESBL - (producing bacteria that can ' t be killed by many of the antibiotics that doctors use to treat infections) of foot wound. During an observation on 6/16/2025 at 10:22 AM of Resident 35 ' s room, a signage indicated Contact Isolation Precaution (infection control measure used by healthcare setting to prevent spread of germs that could be contacted by direct or indirect contact) for MDRO was posted outside of Resident 35 ' s room. The observation revealed that inside the Resident 35 ' s room, the alcohol-based hand sanitizer was not functional. Additionally, the pump lever fell off when trying to use the hand sanitizer dispenser. (continued on next page)

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	555839	A. Building B. Wing	06/18/2025

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Dreier's Nursing Care Center	1400 West Glenoaks Blvd Glendale, CA 91201

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/16/2025 at 10:35 AM with Licensed Vocational nurse (LVN) 2. LVN 2 stated the importance of having a functional hand sanitizer is to protect the staff and residents and prevent the spread of infection. During an interview on 6/16/2025 at 10:38 AM with Registered Nurse (RN) 1, RN1 stated that the hand sanitizer should be working in the resident ' s room. RN 1 also stated it is important for infection control and to prevent spread of germs. During an interview on 6/17/2025 at 08:52AM with the Activity Director (AD), the AD stated in a Contact Isolation room, we take off our personal protection by removing our gloves, gown and mask and then use the hand sanitizer in room prior to exiting. During a review of the Facility ' s policy and procedure (P&P) titled, Hand washing/ Hand Hygiene, dated 2023, indicated this facility considers hand hygiene the primary means to prevent the spread of healthcare -associated infections and to promote hand hygiene the hand hygiene products and supplies such as alcohol-based hand rub will be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. Dispensers are placed in areas of high visibility and consistent with workflow throw-out the facility. 2. During a review of Resident 109 ' s AR, the AR indicated resident 109 was admitted on [DATE] with a diagnosis including Acute osteomyelitis (infection of the bone) or the right and left ankle and foot. During a review of Resident 109 ' s H&P, dated 5/30/2025, indicated Resident 109 has the capacity to understand and make his own decisions. During a review of Resident 109 ' s MDS, dated [DATE] indicated, Resident 109 ' s cognition was intact (no mental impairment). During a review of Resident 109 ' s OSR, dated 5/29/2025, indicated resident 109 was contact Isolation due Methicillin Resistant Staphylococcus aureus MRSA (a type of bacteria resistant to medications that used to treat infection) of the left leg. During a review of Resident 109 ' s OSR, dated 6/6/2025, indicated IV tubing will be changed every 24 hours. During a review of Resident 109 ' s OSR, dated 5/29/2025, indicated Linezolid (a medication to treat infection) IV solution 600 mg to be administered intravenously every 12 hours for left foot wound ESBL. During a review of Resident 109 ' s Care plan titled The resident is on antibiotic therapy dated 5/29/2025, with a goal the resident will be free of any discomfort or adverse side effects (undesired effect) of antibiotic therapy through the review date of 7/5/2025. During an observation on 6/16/2025 at 10:47 AM, Resident 109 ' s IV tubing was uncapped and hanging from IV pole without protective cover on the distal end that was touching the beside curtains. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 6/16/2025 at 11:03 AM with Registered Nurse 1 (RN) 1, RN1 stated there was no cap on tip of Intravenous line. RN1 stated there should be a cap on the end of line for infection control and stated the resident could be infected by the contaminated IV. RN1 stated the reason she did not place a cap on the line was because she could not find one. During a review of Facility ' s policy and procedure, undated, indicated all administration set connections will be secured with tape, a Luer locking system (typically used with male connectors on syringes and female connectors on needles or other medical devices. These connectors can be twisted together, creating a secure and leak-proof connection), or a line- connection securing device. 3. During a review of Resident 22 ' s AR, the AR indicated that Resident 22 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) with acute exacerbation (a sudden worsening of symptoms), dysphagia (difficulty swallowing), and gastrostomy status (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 22 ' s Physician Orders dated 5/6/2025, the Physician Orders indicated to continue GT feeding of Jevity 1.5 Formula (a product containing calorically-dense, high-protein, fibre-fortified liquid formula) at 60cc/hr [cubic centimeter (unit of volume) per hour (unit of time)] x (for) 20 hours to provide 1200cc 1800 Kcal (kilocalories, unit of energy) in 24 hours via enteral feeding pump. During a review of Resident 22 ' s MDS, dated [DATE] indicated that Resident 22 was severely cognitively impaired (a condition that makes it very difficult for a person to think, learn, and remember). The MDS also indicated Resident 22 required substantial/maximal assistance (helper does more than half the effort) on personal hygiene, rolling left and right, sitting to lying, and lying to sitting on side of bed. During a review of Resident 22 ' s Care Plan dated 4/27/2025, the care plan indicated Resident 22 was placed on Enhanced Barrier Precautions with a feeding tube, and the interventions included to adhere to facility guidelines on infection control protocol. During an observation on 6/17/2025 at 11:01 AM in Resident 22 ' s room, Resident 22 ' s GT administration set, labeled with the resident's name and dated 6/17/2025, was connected to a GT feeding pump that was turned off. Resident 22 ' s GT administration set was not connected to the resident ' s GT site and was hanging on an IV pole while the GT administration tube port was uncapped/uncovered. During the same concurrent observation and interview on 6/17/2025 at 11:10 AM with the Licensed Vocational Nurse (LVN) 2 in Resident 22 ' s room, LVN 2 stated the uncapped/uncovered GT administration tube port would be reconnected to Resident 22 when feeding was to be resumed at 12:30 PM as ordered. LVN 2 stated she did not cap or cover GT port to ensure it was not exposed to prevent contamination and infection as she was responsible to. (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	06/18/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/18/2025 at 11:55 AM with the Director of Nursing (DON), the DON stated that all licensed nurses need to follow the facility ' s infection prevention and control protocol included proper and safe handling of Resident 22's feeding tube and feeding bag, such as the GT administration tube port should be properly covered/capped when not in use. The DON stated any likely contaminated equipment should never be used on residents due to concerns of infections. During a review of the facility ' s Policy and Procedure (P&P) titled Enteral Tube Feeding via Continuous Pump revised in 11/2018. The P&P indicated to use aseptic technique when preparing or administering enteral feedings.