

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/17/2026
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)		
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 reviews, the facility failed to ensure the prescribers obtained informed consent (communication process where a healthcare provider explains the risks, benefits, and alternatives of a treatment so a resident can choose whether to agree) from the resident or the resident's representative before administering psychotropic medications (medications that affects mood and behavior) for two of the five sampled residents (Residents 3 and 5) in accordance with the facility's policy and procedures titled Informed Consent. This deficient practice had the potential for Resident 3 and 5 to receive psychotropic medications without proper consent, which could result in unwanted treatment and violation of resident rights. Furthermore, this exposed residents to psychotropic medications without being fully informed of risks, benefits, and side effects, which may increase the likelihood of unrecognized or unmanaged adverse drug reactions. Findings: 1. During a review of Resident 5's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included Parkinson's disease without dyskinesia (a disorder of the nervous system that affects movement), schizophrenia (a mental illness that was characterized by disturbances in thought). During a review of Resident 5's History and Physical (H&P) dated 10/24/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 5's Physician's Order dated 7/16/2026, the order indicated to administer one tablet of Ativan 0.5 mg (a unit of measurement), by mouth every 8 hours as needed [PRN] for Anxiety manifested by inability to calm down for 14 days with a start date of 7/09/2026. During a review of Resident 5's Psychotherapeutic Drug Informed Consent form for Ativan 0.5 mg every 8 hours as needed for 14 days, orally for anxiety disorder, the form was reviewed with the prescriber's name written on it, dated 7/08/2026. However, the prescriber's required signature section was blank. During a review of Resident 5's progress notes dated 7/09/2026 authored by Licensed Vocational Nurse (LVN) 4, the note indicated writer spoke to Resident 5's Responsible Party (RP), verbal consent (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	obtained for Resident 5's Ativan 0.5 mg every 8 hours continuation for 14 days. The Psychotherapeutic Drug Informed Consent form for Ativan 0.5 mg was completed and signed by LVN 4 and witnessed by the Registered Nurse Supervisor. During a telephone interview on 7/16/2026 at 12:28 PM with Resident 5's Responsible Party (RP 1), RP 1 stated she remember receiving a call from a facility nurse asking for consent for Ativan 0.5 mg medication for [Resident 5]. RP 1 stated she always gets phone calls from the facility nurses for medication informed consents. RP 1 stated she had never spoken to a facility provider [prescribing physician] for consents she only receives calls from the nurses. During a concurrent interview and record review of Resident 5's Psychotherapeutic Drug Informed Consent for Ativan 0.5 mg with the Director of Nursing (DON), the DON stated that per facility policy, the prescribing physician must sign and date psychotropic medication consents immediately upon obtaining consent from the resident or resident representative. The DON stated the consent should be obtained by the prescribing physician and not the facility nurses. 2. During a review of Resident 3's admission record, the record indicated the facility initially admitted Resident 3 on 1/30/2026 and re-admitted on [DATE], with diagnoses that included encephalopathy (a group of conditions that cause brain dysfunction, with symptoms such as altered mental state ranging from mild confusion to coma), hemiplegia (severe or complete paralysis of one entire side of the body, usually caused by damage to the brain or spinal cord resulting from a stroke, traumatic brain injury, or other causes) and hemiparesis (partial weakness or reduced control on one side of the body) following cerebral infarction (a type of ischemic stroke that occurs when a blocked blood vessel deprives brain tissue of oxygen and vital nutrients, causing cell death), aphasia (a neurological language disorder caused by damage to the brain's language centers (most commonly after a stroke or head injury) which impairs a person's ability to comprehend, speak, read, or write, with symptoms including trouble with expressing oneself). During a review of Resident 3's informed consent forms, Resident 3 had two such forms for lorazepam (a psychotropic medication that is used to treat anxiety), dated 6/18/2026 and 7/9/2026. Both forms were missing the prescriber's signatures indicating the prescriber did not obtain an informed consent from the resident or the responsible party. During a concurrent interview on 7/16/2026 at 10:41 AM, the director of nursing (DON) stated the prescriber for Resident 3's lorazepam was the psychiatric nurse practitioner (NP 1). DON stated the informed consent forms for Resident 3 indicated a facility nurse obtained consent from the responsible party. During an interview on 7/16/2026 at 12:09 PM, the registered nurse (RN 1) stated the process of informed consent was that facility nurses obtained the consent from the residents or responsible parties (RP). RN 1 stated nurse provide information on psychotropics to the residents or RP. If the doctor (or prescriber) had obtained consent from the resident/RP, the doctor would let the nurses (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	know and document it in the progress note. During an interview on 7/16/2026 at 12:22 PM, and a concurrent review of Resident 3's Nurses' Notes (dated 7/9/2026 at 8:08 AM), RN 1 stated the notes indicated the nurse obtained the consent from Resident 3's family. During an interview on 7/16/2026 at 12:28 PM, and a concurrent review of Resident 3's Nurses' Notes (dated 4/27/26 at 9:33 PM), RN 1 stated the nurse author of the note obtained the consent from Resident 3's family. During an interview on 7/16/2026 at 2:39 PM, DON acknowledged the licensed practitioner who prescribed or ordered the psychotropic meds should be the person obtaining consent from the resident or the family. During a review of the facility's policy and procedures, the policy titled, Informed Consent (dated 7/2011) indicated the facility to . Request the physician to obtain informed consent for the appropriate treatment (psychotherapeutic drug). Inform the physician to notify nursing with the treatment order upon receipt of the informed consent. Document the following . Date, time, name of physician called.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interviews, and record review, the facility failed to provide pharmacy services that ensure non-controlled medication disposition log (log used for drugs that do not have a high risk of abuse or dependence and are not regulated by special government schedules) was completed with the date of disposition and with witnessing nurse's signature. The facility also failed to keep a separate record of emergency drug supplies emergency kit (E-kit- a targeted supply of prescription drugs or emergency gear used for urgent medical needs, severe acute symptoms, or home hospice care) usage. These deficient practices had the potential of misappropriation (misuse or unauthorized taking, use, or sharing of prescription drugs) of medications, and/or medication loss and errors. Findings: 1. During an interview and record review on 7/14/2026 at 11:35 AM, the registered nurse (RN 1) stated the night shifts performed the task of conducting the non-controlled medication disposition process. During a review of the facility's non-controlled medication disposition log, the top page of the log (dated 7/13) had 1 nurse's signature. Then, after a few pages, and in between pages dated 6/25 and 6/30, there was a page without a disposition date. During a concurrent interview, RN 1 stated there should be a date. During a review of the facility's policy and procedures, the policy titled, Discarding and Destroying Medications (dated in 2001), indicated Non-controlled and Schedule V (non-hazardous) substances are disposed of in accordance with state regulations. The medication disposition record contains. date medication destroyed. signature of witnesses. During the review of the state regulations, California Cod of Regulations Title 22 section 72371(c)(2), the state regulation indicated Drugs not listed under Schedules II, III or IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 shall be destroyed by the facility in the presence of a pharmacist or licensed nurse. The name of the patient, the name and strength of the drug, the prescription number if applicable, the amount destroyed, the date of destruction and the signatures of the person named above, and one other person shall be recorded . 2. During an interview on 7/14/2026 at 11:44 AM, RN 1 she did not know where the facility E-kit usage log was. RN 1 stated she could not find such log in the one (1) of 1 medication room, nor at the nursing station. During an interview on 7/14/2026 at 12 PM, the Director of Nursing (DON) stated the licensed nurses would fill out the E-kit slip (which has a carbon copy), leave the copy in the e-kit for pharmacy record, and keep the original to be filed by medical record. DON stated there was no separate log for the E-kit usage. During an interview on 7/15/2026 at 12:01 PM, DON stated the facility could not reconcile (compare medication list) or verify medication that were removed from the E-kits, which included controlled substances (a chemical or medication that are strictly used and regulated by the government due to their potential for abuse, addiction, and physical or psychological dependence), without knowing who accessed the E-kit at what time, removed which medication, and for which resident. DON stated the facility's policy did not mention keeping such record. During a review of the facility's policy and procedures, the policy titled, Emergency Pharmacy Service and Emergency Kits (no date provided) indicated the Pharmaceutical Services Committee and Quality Assessment and Assurance Committee are responsible for ensuring the use of emergency supply is in compliance with applicable state regulations. During a concurrent review of the California Cod of Regulations Title 22 section 72377(b)(5) with the DON, the state regulations indicated Separate records of use shall be maintained for drugs administered from the [emergency] supply .		

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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 and interview, the facility failed to store, prepare, distribute and serve food for 47 sampled residents in accordance with professional standards and the facility's policy and procedures for food service safety by ensuring the facility were properly labeled and dated with the product name, date product was opened or prepared and to be use by date for the following: 1. 17 cups of milk that were not labeled and dated 2. 30 cups of juice (including red and yellow-colored juices) not labeled and dated As a result of these deficient practices exposed residents to the risk of widespread foodborne illness (infections caused by consuming contaminated food, beverages, or water containing harmful microbes, pathogens [disease causing organism] or toxins). Findings: During an initial kitchen observation conducted with the Dietary Supervisor (DS) on 7/14/2026 at 9:10 AM, Refrigerator #1 revealed multiple cups of milk and juice stored on pink meal trays without resident identifiers, preparation dates, or discard dates. There were approximately 17 cups of milk, and 30 cups of juice (including red and yellow-colored juices) covered with plastic wrap or lids; however, none were labeled to identify the date and time the beverages were prepared. During an interview on 7/14/2026 at 9:12 AM with the DS, DS stated that without appropriate labeling and dating, dietary staff were unable to verify the age of the beverages or ensure they were discarded within safe food storage timeframes. The DS stated that they did not ensure properly label and dated resident beverages which would increase the risk of residents being served expired or contaminated food items, compromising food safety and infection prevention practices. During a review of the facility P&P titled Food Receiving and Storage revised 11/2022, indicated that all foods stored in the refrigerator or freezer are covered, labeled and dated (use by" date). The P&P indicated refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded.		

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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 observation, interview, and record review, the facility failed to provide information on their rights to formulate an advanced directive (AD-a written legal document that explains your choices for medical care if you become unable to speak or make decisions for yourself) for one out of eleven sampled residents (Resident 5) in accordance with the facility's policy and procedure (P&P) Advance Directives. This deficient practice had the potential for the facility not to honor the resident's preference and/wishes for their medical care and treatments when they can no longer have the capacity to make their own decisions. Findings: During a review of Resident 5's admission Record (AR), the AR indicated that the resident was originally admitted [DATE], and readmitted on [DATE], with diagnoses that included depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), schizophrenia (a mental illness that affects how a person thinks, feels, and acts, characterized by key signs like hallucinations, delusions, and disorganized thinking), and hypertension (elevated blood pressure). During a review of Resident 5's History and Physical (H&P), dated 10/24/2025, the H&P indicated that the resident does not have the capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 4/15/2026, the MDS indicated that the resident has intact cognition (the ability to process thoughts and emotions). The MDS also indicated that Resident 5 has not completed an advanced directive. During a review of Resident 5's Advance Directive Acknowledgement (ADA), the ADA document indicated for the resident to place an initial on each statement. The ADA included a statement that indicated if the resident has been informed of their rights to formulate AD. Further review of the document indicated that Resident 5 has neither placed her initials on the document nor signed the ADA. During a concurrent interview and record review on 7/15/2026 at 1:38 PM with the Social Services Director (SSD), Resident 5's medical records, including the document titled, Advance Directive Acknowledgement, was reviewed. The SSD stated that the document was not complete because there were no initials and signatures on the document. The SSD stated that the AD should have been completed upon admission. The SSD added that she has not offered Resident 5 the choice to formulate an advanced directive. The SSD stated that the advanced directive was important because the AD instructs staff on how to care for the resident if the resident no longer has the capacity to make their own decisions. During an interview on 7/15/2026 at 3:40 PM with Resident 5, Resident 5 stated that she does not recall if the facility has offered to help her formulate an advanced directive. During an interview on 7/17/2026 at 10:18 AM with the Director of Nursing (DON), the DON stated that an advanced directive is a document where residents place their wishes on how they would want to be treated or cared for when they can no longer make decisions for themselves. The DON stated that if the resident was not offered the opportunity to formulate an advanced directive, the resident's care may not be what they would want it to be when they can no longer make their own decisions. During a review of the facility's policy and procedure (P&P) titled, Advance Directives, revised 9/2022, the P&P indicated that the resident has the right to formulate an advance directive. The P&P indicated that prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. The P&P also indicated that the resident or representative is provided with written information concerning the right to formulate an advance directive if he or she chooses to do so.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote a homelike environment for one out of five sampled residents (Resident 45) in accordance with the facility's policy and procedure titled Homelike Environment when the wall clock in Resident 45's room did not show the correct time. This deficient practice had a potential to disorient Resident 45, which could lead to agitation. Findings: During a review of Resident 45's admission Record (AR), the AR indicated that the resident was originally admitted on [DATE] , and readmitted on [DATE], with diagnoses that included psychosis (a mental state where a person loses touch with reality), insomnia (a sleep disorder that involves trouble falling asleep, staying asleep, or waking up too early), and visual hallucinations. During a review of Resident 45's History and Physical (H&P), dated 2/14/2026, the H&P indicated that the resident does not have the capacity to understand and make decisions. During a review of Resident 45's Minimum Data Set (MDS, a resident assessment tool), dated 5/19/2026, the MDS indicated that the resident has severely impaired cognition (the ability to process thoughts and emotions). During a concurrent observation and interview on 7/14/2026 at 11:20 AM with Registered Nurse (RN) 1 inside Resident 45's room, Resident 45's wall clock was observed. RN 1 stated that the wall clock is not showing the correct time because it is showing 10:20 AM and not 11:20 AM, which is one hour late. RN 1 stated that a wrong clock could potentially disorient the resident. During an interview on 7/17/2026 at 10:18 AM with the Director of Nursing (DON), the DON stated that when providing care to a resident who is cognitively impaired such as Resident 45, it is important to ensure that clocks show the correct time. The DON further stated that clocks that are not set to the correct time could disorient the resident further, which could lead to agitation. During an interview on 7/17/2026 at 10:55 AM with the Maintenance Supervisor (MS), the MS stated that he is responsible for ensuring that clocks show the correct time. The MS stated that the clock in Resident 45's room is an old clock that needs to be replaced. During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, revised 2/2021, the P&P indicated that residents are provided with a safe, clean, comfortable and homelike environment. The P&P indicated that facility staff maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting such as a clean, sanitary and orderly environment.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a psychotropic (chemical substances that alter brain function, affecting perception, mood, behavior, and consciousness) medication prescribed for as needed (PRN, not routine) usage had adequate indication for its use and treat specific behaviors, documented descriptions on significant episodes, and documented reasons to administer the as needed psychotropic for one (1) of 5 sampled residents (Resident 3). This deficient practice had the potential to use medications, and/or chemical restraints, unnecessarily. Findings: During a review of Resident 3's admission record, the record indicated the facility initially admitted Resident 3 on 1/30/2026 and re-admitted on [DATE] with diagnoses that included, encephalopathy (a group of conditions that cause brain dysfunction, with symptoms such as altered mental state ranging from mild confusion to coma), hemiplegia (severe or complete paralysis of one entire side of the body, usually caused by damage to the brain or spinal cord resulting from a stroke, traumatic brain injury, or other causes) and hemiparesis (partial weakness or reduced control on one side of the body) following cerebral infarction (a type of ischemic stroke that occurs when a blocked blood vessel deprives brain tissue of oxygen and vital nutrients, causing cell death), aphasia (a neurological language disorder caused by damage to the brain's language centers (most commonly after a stroke or head injury) which impairs a person's ability to comprehend, speak, read, or write, with symptoms including trouble with expressing oneself, though it does not affect a person's general intelligence). During a review of Resident 3's History and Physical (H & P) dated 4/28/2026, the H&P indicated Resident 3 was nonverbal, aphasic (language or communication disorder caused by brain damage from strokes, tumors, or head injuries) due to CVA. During an interview on 7/16/2026 at 10:41 AM, the director of nursing (DON) stated Resident 3 had a history of cerebrovascular accident (CVA, also known as stroke) which resulted in severe cognitive impairment and Resident 3 could not express or verbalize their needs. During a review Resident 3's Minimum Data Set (MDS, a Federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) dated 4/27/2026, MDS indicated Resident 3 had unclear speech (slurred or mumbled words), rarely or never made self understood, rarely or never understood others, and fully dependent on others for everyday activities. During a review of Resident 3's medication order, an order dated 7/9/2026 indicated lorazepam (a psychotropic medication that is used to treat anxiety) 0.5 milligrams (mg, unit to measure dosage), every 6 hours as needed (PRN) for anxiety manifested by excessive restlessness for 14 days. During a review of Resident 3's medication order, an order dated 5/5/2026 at 10:23 AM indicated to administer quetiapine (generic for Seroquel, an antipsychotic medication to manage psychosis, severe behavioral disorders) 25 mg half a tablet (12.5 mg) via G-tube every 6 hours for psychosis manifested by paranoia, physical outburst. During an interview on 7/16/2026 at 2:29 PM, and a concurrent review of Resident 3's electronic medication administration record (eMAR) for July 2026 under the medication lorazepam, the DON stated that there were 10 behavior episodes marked and one dose of lorazepam 0.5 mg administered on 7/12/2026 at 5 PM. The DON reviewed Resident 3's nurses' notes and stated there was no documentation describing what the behavior was or what might have triggered the behavior that led to administering the lorazepam. During the same interview, the DON stated that on 7/14/2026, there were four behavior episodes noted and two doses of lorazepam administered. The DON also stated there was no documentation supporting the reason for administering lorazepam on that date. The DON acknowledged there was a lack of documentation (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to report to the State agencies and police department and thoroughly investigate an abuse (intentional actions or practices that cause one's harm and distress) allegation as required for 1 out 1 sampled resident (Resident 59), who alleged that on 7/11/26, Certified Nursing Assistant (CNA) 1 struck Resident 59's right foot while stopping his wheelchair that rapidly rolled down a ramp towards his room in accordance with the facility's policy and procedure titled Abuse, Neglect, Exploitation (treating a person unfairly to gain an advantage) or Misappropriation (misuse of funds)- Reporting and Investigating. This deficient practice resulted in delayed reporting that can potentially hinder the timely investigation and protection of Resident 59 due to preservation of evidence, collection of witness statements, and prompt determination of whether abuse had occurred. Findings: During a review of Resident 59's admission Record (AR), the AR indicated Resident 59 was readmitted to the facility on [DATE] with a diagnosis fracture (broken bone) of lower end of right femur (largest bone in the body) and psychoactive substance abuse (the harmful or excessive use of any chemical substance-such as drugs or alcohol-that alters brain function). During a review of Resident 59's History and Physical (H&P) signed and dated 7/6/2026, indicated that Resident 59 had the capacity to understand and make decisions. During a review of Resident 59's MDS dated [DATE], the MDS indicated that Resident 59 had an intact cognition (ability to think and reason and thought process). During a review of Resident 59's Change of Condition (COC) dated 7/11/2026, indicated the Resident 59 did not follow staff instructions to wait for assistance before wheeling himself down a ramp. The COC indicated that Certified Nursing Assistant (CNA 1) intervened in an attempt to prevent a fall and maintain Resident 59's safety. The COC indicated that Resident 59 had alleged that the CNA 1 struck his right foot during the intervention; however, the assessment documented that Licensed Vocation Nurse (LVN 2) had witnessed the incident and reported no contact with the resident's right foot. The COC indicated that an RN completed an assessment following the allegation and documented no new changes or injuries. During a review of Resident 59's COC dated 7/13/2026, indicated that Resident 59 had alleged that a CNA 1 struck his right foot while intervening after the Resident 59 wheeled himself down the Station 2 ramp without assistance. The COC indicated that LVN 2 had witnessed the incident and reported that the CNA 1 did not make contact with the resident's right foot. The COC indicated that the primary clinician was notified and recommended following the facility's abuse allegation protocol and monitoring the resident for signs and symptoms of emotional distress or sudden physical changes pending hospital transfer for evaluation of the resident's right lower leg surgical wound. During an interview on 7/14/2026 at 11:40 AM with Resident 59, the resident stated that on 7/11/2026 between approximately 3 PM to 4 PM., he was attempting to wheel himself down the ramp to use the restroom when CNA 1 rushed toward him to stop him. Resident 59 alleged that CNA 1 struck his right foot while attempting to stop the wheelchair. During an observation on 7/14/2026 at 11:44 AM of Resident 59's right lower extremity, which had an external fixator (a medical device used to stabilize broken bones and/or lengthen the limb) in place, revealed no visible injuries, redness, or swelling. During an interview on 7/14/2026 at 12:45 PM with the Social Services Designee (SSD), the SSD stated that Resident 59, who was admitted on [DATE] with a history of substance abuse and behavioral issues, rapidly propelled his wheelchair down the ramp on 7/11/2026. The SSD stated that CNA 1 stopped the resident's wheelchair by holding the footrest (a flat plate on the wheelchair used to put the foot) of (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Dreier's Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 West Glenoaks Blvd Glendale, CA 91201	
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the wheelchair to prevent injury. The SSD stated that the facility did not initiate its abuse investigation until 7/13/2026 and SSD was unable to explain why the investigation was not started on 7/11/2026. The SSD acknowledged that the delay may have allowed staff to discuss the incident before being interviewed, potentially influencing or altering their recollection of events to determine if the allegation of abuse was substantiated or not. During an interview on 7/14/2026 at 1:30 PM with Resident 38, Resident 38 stated that Resident 59 frequently used profanity toward residents and staff. Resident 38 stated that he observed Resident 59 propel his wheelchair rapidly toward the stairwell and observed CNA 1 stop the wheelchair by holding the footrest. Resident 38 stated that CNA 1 did not strike Resident 59's foot and that Resident 59 subsequently yelled and directed profanity toward CNA 1. During a review of Resident 38's AR, the AR indicated Resident 38 was admitted to the facility on [DATE] with a diagnoses that included type 2 diabetes mellitus (DM - body does not produce enough insulin to control blood sugar levels) and atrial fibrillation (abnormal heart rhythm). During a review of Resident 38's H&P signed and dated 6/7/2026, indicated that Resident 38 had the capacity to understand and make decisions. During an interview on 7/16/2026 at 3:30 PM with CNA 1, CNA 1 stated that he had observed Resident 59 attempting to rapidly propel his wheelchair down the ramp while requesting to use the restroom. CNA 1 stated that he intervened by stopping the resident's wheelchair to prevent further injury to the resident's surgically repaired right leg. CNA 1 stated that Resident 59 responded by shouting racial slurs, sexist remarks, and profanity. CNA 1 stated that after ensuring the resident was safe, he assisted Resident 59 to the restroom. CNA 1 further stated that he was not suspended on 7/11/2026 pending the outcome of the facility's investigation. During an interview on 7/16/2026 at 3:56 PM with LVN 2, LVN 2 stated that she was the charge nurse on 7/11/2026 during the 3 PM-11:00 PM shift and witnessed the entire incident involving Resident 59 and CNA 1. LVN 2 stated that Resident 59 requested assistance to use the restroom and was informed that CNA 1 was assisting another resident and would help him shortly. LVN 2 stated that Resident 59 became impatient, directed profanity toward her, and rapidly propelled his wheelchair down the ramp. LVN 2 stated that, due to the resident's erratic wheelchair movements and surgically repaired right leg, CNA 1 intervened by stopping the wheelchair while holding the underside of both wheelchair footrests. LVN 2 stated that Resident 59 then loudly alleged that CNA 1 had almost hit him before accusing CNA 1 of striking his foot. LVN 2 further stated that the DON was notified of the incident; however, the allegation was not reported to the State agencies, and the facility investigation was not initiated until 7/13/2026. During an interview on 07/16/2026 at 4:15 PM with the Director of Nursing (DON), the DON stated that Resident 59 alleged CNA 1 struck his right foot while staff attempted to stop the resident from propelling his wheelchair rapidly down the facility ramp without assistance. The DON stated that Resident 59 had previously been instructed not to use the ramp independently because of safety concerns and non-weight-bearing (placing zero weight on affected extremity) restrictions. The DON stated that witness statements indicated no contact occurred between CNA 1 and the resident's right foot and that the RN assessment completed on 7/11/2026 identified no significant changes or injuries related to the allegation. The DON stated that monitoring orders and a care plan were initiated, and Resident 59 had been observed for changes in condition. The DON stated that the facility initiated an abuse investigation on 7/13/2026 and notified the physician, psychiatrist, California Department of Public Health (CDPH), the Ombudsman, and local law enforcement. The DON stated that the allegation of physical abuse occurring on 7/11/2026 was not reported to CDPH or the Ombudsman until 7/13/2026. The DON acknowledged that the allegation should have been reported within two hours or within 24 hours of an allegation of abuse that did not result in serious bodily injury, in accordance with abuse reporting requirements but could not recall (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	why the report was delayed. The DON stated that the delayed reporting did not comply with facility policy or regulatory requirements and could have delayed regulatory oversight, timely staff interviews, preservation of witness recollections, and identification of corrective actions, including staff re-education and suspension pending the investigation. During a review of the facility P&P titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating revised 9/2022, indicated that if resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The P&P indicated that the administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: the state licensing/certification agency responsible for surveying/licensing the facility and the local/state ombudsman. The P&P indicated that the reporting within two hours of an allegation involving abuse which resulted in serious bodily injury; or within 24 hours of an allegation of abuse that did not result in serious bodily injury.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS-a resident assessment and care-screening tool) assessment was completed and submitted timely to the Centers for Medicare and Medicaid Services (CMS) system for 1 of two sampled residents (Resident 36 and Resident 40) in accordance with the facility's policy and procedure titled Electronic Transmission of the MDS. This deficient practice had the potential to result in confusion regarding the care and services provided to the residents, and a potential to affect the facility's quality of care monitoring system that measures the effective, safe, efficient, patient's centered, equitable (fair), and timely care. Findings: During a review of Resident 36's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] with diagnoses including asthma (a condition that causes your airways to swell, narrow and fill with mucus), lymphedema (a condition in which lymph builds up in tissues and causes swelling). During a review of resident 36's MDS Summary, indicated Discharge-return not anticipated MDS with assessment reference date (ARD-date should be completed) of 3 /21/2024, but was completed on 3/07/2026, but was not transmitted to CMS when completed. During a review of Resident 40's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] with diagnoses including peripheral vascular disease (reduced circulation of blood to a body part), type 2 diabetes mellitus (your body doesn't use insulin well and can't keep blood sugar at normal levels.) During a review of resident 40's MDS Summary, indicated Discharge-return not anticipated MDS with assessment reference date (ARD-date should be completed) of 3 /17/2026, but was completed on 3/03/2026, but was not transmitted to CMS when completed. During an interview and concurrent record review of Resident 36 and Resident 40's Discharge MDS on 7/16/2026 at 3:50 PM with the MDS Nurse (MDSN), MDSN stated she was responsible to make sure all the residents' MDS assessments were completed. The MDSN stated once the Resident 36 and 40's MDS were completed the facility had 14 days from Resident 36 and 40's discharge to complete and submit Resident 36 and 40's Discharge MDS to CMS. MDSN stated Resident 36 and Resident 40's discharge MDS had been completed on time, but the Director of Nursing (DON) had signed and chosen the option to not transmit Resident 36 and 40's MDS to CMS. The MDSN stated the late transmission of the MDS's would delay the accuracy of the resident's assessment and affect resident's care negatively. During an interview and concurrent record review of Resident 36 and Resident 40's Discharge MDS on 7/16/2026 at 4:12 PM with the DON, DON stated Resident 36 and Resident 40's Discharge MDS should have been transmitted immediately after it was completed. DON stated she did not notice that she chooses the option to not transmit Resident 36's and 40's Discharge MDS to CMS when she reviewed them as complete. During a review of the facility's Policy and Procedure (P&P), titled Electronic Transmission of the MDS, with a revision date of October 2023, the P&P indicated, All MDS assessments (e.g. admission, annual, significant change, quarterly review, etc.) and discharge and re-entry records are completed and electronically encoded into our facility's MDS information system and transmitted to CMS Internet Quality Improvement and Evaluation System (IQIES) in accordance with current OBRA regulations governing transmission of MDS data.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, and record review the facility failed to develop a comprehensive care plan for one out of five sampled residents (Resident 3) who had a diagnosis of cerebrovascular accident (CVA, also known as stroke) and who was also placed on enhanced barrier precautions (EBP, an infection control strategy used in nursing homes and skilled nursing facilities to prevent the spread of multidrug-resistant organisms) in accordance with the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered. This deficient practice placed Resident 3 at risk of receiving care that is not consistent with the resident's goals and health status. 1. During a review of Resident 3's admission Record (AR), the AR indicated that the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included dysphagia (difficulty in swallowing), gastrostomy (a surgical opening created in the abdominal wall and stomach to insert a feeding tube), and sepsis (the body's extreme, life-threatening response to an infection). During a review of Resident 3's History and Physical (H&P), dated 4/28/2026, the H&P indicated that the resident does not have the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 5/28/2026, the MDS indicated that the resident has severely impaired cognition (the ability to process thoughts and emotions) and was dependent (the helper does all the effort) on activities such as personal hygiene, bathing, and rolling in bed left and right. The MDS also indicated that the resident has a feeding tube. During a review of Resident 3's physicians order, dated 4/27/2026, the order indicated Enteral Order: [G-Tube] Site: Cleanse with [Normal Saline] (a sterile liquid solution that is often used for cleaning open wounds), oat dry, cover with dry dressing everyday shift. During a concurrent interview and record review on 7/16/2026 at 3:25 PM with Registered Nurse (RN) 1, Resident 3's care plans were reviewed. RN 1 stated that there was no care plan developed for EBP. RN 1 stated that a care plan for EBP should have been initiated upon Resident 3's admission on [DATE] because the resident had a G-tube upon admission. RN 1 added that care plans are used by staff as a guide to know what interventions to implement when providing care to the resident. During an interview on 7/16/2026 at 3:45 PM with the Infection Preventionist Nurse (IPN), the IPN stated that when a resident with a G-tube is admitted to the facility, the admitting nurse must initiate a care plan for EBP. The IPN stated that EBP is used to prevent the spread of infections to other residents. The IPN further indicated that the care plan for EBP should include interventions such as for staff to wear gloves and a gown prior to providing care to the resident. During an interview on 7/17/2026 at 10:18 AM with the Director of Nursing (DON), the DON stated that residents who are admitted to the facility with a G-tube must have a care plan for EBP. The DON added that care plans are important because care plans guide staff on how to render care to the resident. The DON stated that not following EBP increases the likelihood of the spread of infections to residents. During a review of the facility's policy and procedure (P&P), titled Enhanced Barrier Precautions, revised 3/2024, the P&P indicated that EBPs are utilized to reduce the transmission of multi-drug-resistant organisms (infection-causing organisms that are resistant to one or more medications) to residents. The P&P indicated that gloves and gowns are applied prior to performing the high contact resident care activity. The P&P indicated that EBP is indicated for residents with indwelling medical devices such as feeding tubes. The P&P also indicated that EBP is to remain in place for the duration of the resident's stay or until the discontinuation of the indwelling medical device. During a review of the facility's P&P, titled Care Plans, Comprehensive (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Person-Centered, revised 3/2022, the P&P indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P indicated that the comprehensive, person-centered care plan is developed within seven days of the completion of the required MDS assessment and no more than 21 days after admission. The P&P also indicated that the care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 2. During a review of Resident 3's admission record, the record indicated the facility initially admitted Resident 3 on 1/30/2026 and re-admitted on [DATE]. Resident 3's admitting diagnoses included, but not limited to: encephalopathy (a group of conditions that cause brain dysfunction, with symptoms such as altered mental state ranging from mild confusion to coma), hemiplegia (severe or complete paralysis of one entire side of the body, usually caused by damage to the brain or spinal cord resulting from a stroke, traumatic brain injury, or other causes) and hemiparesis (partial weakness or reduced control on one side of the body) following cerebral infarction (a type of ischemic stroke that occurs when a blocked blood vessel deprives brain tissue of oxygen and vital nutrients, causing cell death), aphasia (a neurological language disorder caused by damage to the brain's language centers (most commonly after a stroke or head injury) which impairs a person's ability to comprehend, speak, read, or write, with symptoms including trouble with expressing oneself, though it does not affect a person's general intelligence). During an interview on 7/16/2026 at 10:41 AM, the director of nursing (DON) stated Resident 3 had a history of cerebrovascular accident (CVA, also known as stroke) which resulted in severe cognitive impairment and Resident 3 could not express or verbalize their needs. During an interview on 7/16/2026 at 2:36 PM, and a concurrent review of Resident 3's care plan regarding non-pharmacological intervention, DON stated there was a lack of documentation on the types of non-pharm intervention catered to Resident 3 that would reduce or alleviate anxiety, or underlying conditions that triggered physical behavior (such as severe cognitive impairment due to stroke). DON acknowledge the interventions listed in Resident 3's care plan was generic. During a review of the facility's policy and procedures, the policy titled Care Plans, Comprehensive Person-Centered (dated March 2022) indicated when possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the licensed nursing staff and physician failed to act upon the pharmacist's recommendations documented in the Medication Regimen Review (MRR)-a comprehensive evaluation of a resident's medication regimen intended to promote positive outcomes and minimize adverse effects-for one of five sampled residents (Residents 5) reviewed for MRR. The facility failed to follow the pharmacists' recommendation to clarify the diagnosis for Resident 5's aspirin EC (a form of aspirin with a special enteric coating designed to resist stomach acid) 81 mg (a unit of measurement). This deficient practice had the potential for delayed identification of clinical changes, ineffective medication administration, and adverse effects that could lead to acute medical events requiring emergency care or hospitalization. Findings: During a review of Resident 5's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE]. During a review of Resident 5's History and Physical (H&P) dated 10/24/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 5's Consultant Pharmacist's MRR dated 5/18/2026 to 5/19/2026, the pharmacist recommended to clarify the resident's diagnosis for Aspirin EC 81 mg and assess and consider clarifying the diagnosis. During a review of Resident 5's Physician's Order dated 7/16/2026, the order indicated Aspirin EC oral tablet delayed release 81 mg, give 1 tablet by mouth one time a day for Cardiovascular prophylaxis with an order start date of 5/20/2026. During a concurrent interview and record review of Resident 5's MRR on 7/16/2026 at 4:35 PM, the Director of Nursing (DON) stated that Resident 5's Aspirin EC 81 mg order did not include a proper diagnosis. DON stated the current orders indication of Cardiovascular prophylaxis was not appropriate because Cardiovascular is a system not a diagnosis. The DON further stated that failure to follow the Pharmacist's recommendations posed a potential risk of harm to Resident 5 if she was not assessed and prescribed the correct medication for her current diagnoses. During a review of the facility's Policy and Procedure (P&P), titled Medication Therapy, with a revision date of April 2007, the P&P indicated, each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risk.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to accurately and document in the Dialysis (a medical procedure of removing toxins and excess fluid in the blood with the use of a specialized machine) Communication log (a form used by the facility to communicate the resident's condition to the dialysis center prior to receiving dialysis) for one of three residents (Resident 35) the blood glucose (sugar) levels on 7/4/2026, 7/8/2026, and 7/14/2026 in accordance with the facility's policy and procedure titled Care of a Resident with End-Stage Renal Disease. This deficient practice had the potential for Resident 35 to be at risk of miscommunication between the facility and the dialysis provider and potentially affecting continuity of care, such as delayed identification of signs and symptoms of hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar), placing the resident at risk for confusion, dizziness, falls, loss of consciousness, or death if left untreated. During a review of Resident 35's admission Record (AR), the AR indicated Resident 35 was readmitted to the facility on [DATE] with a diagnosis of type 2 diabetes mellitus (DM - body does not produce enough insulin to control blood sugar levels) and End Stage Renal Disease (ESRD- failure of the kidney to remove toxins and excess fluid in the body). During a review of Resident 35's History and Physical (H&P) signed and dated 10/4/2025, indicated that Resident 35 had the capacity to understand and make decisions. The H&P further indicated that Resident 58 had a history type 2 DM. During a review of Resident 35's MDS dated [DATE], the MDS indicated that Resident 35 had an intact cognition (thinking). During a review of Resident 35's Order Summary Report dated 7/2026, the summary report indicated Resident 35 had dialysis every Tuesdays, Thursdays and Saturdays. During a review of Resident 35's Dialysis Communication Forms dated 7/4/2026, 7/8/2026, and 7/14/2026, indicated no documented evidence the blood sugar was checked, the section on the form designated for Blood Sugar if Diabetic were left blank. During a concurrent interview and record review on 7/16/2026 at 2:03 PM with Licensed Vocational Nurse (LVN 1), Resident 35's Dialysis Communication Forms dated 7/4/2026, 7/8/2026, and 7/14/2026 were reviewed. LVN 1 stated that the Blood Sugar if Diabetic section was left blank on each form. LVN 1 confirmed that the Resident 35's blood glucose levels were not documented on those dates. LVN 1 stated that failure to document blood glucose levels could delay the identification of hypoglycemia or hyperglycemia, placing the resident at risk for confusion, dizziness, falls, loss of consciousness, or death if left untreated. During a concurrent interview and record review on 7/16/2026 at 2:20 PM with the Director of Nursing (DON), Resident 35's Dialysis Communication Forms dated 7/4/2026, 7/8/2026, and 7/14/2026 were reviewed. The DON stated that she acknowledged and confirmed that Resident 35's blood glucose levels were not documented. The DON stated that without documented blood glucose levels, nursing staff would be unable to effectively identify if the resident had episodes of hypoglycemia or hyperglycemia. The DON further stated that incomplete dialysis communication documentation could lead to communication between the facility and the dialysis provider, affect coordination of the resident's care, and limit the interdisciplinary team's ability to monitor the resident's diabetes management and identify clinical trends over time. During a concurrent interview and record review on 7/16/2026 2:03 PM, LVN 1 and concurrent record review with of Resident 35's clinical record (Hard Chart) indicated that Resident 35 had a diagnosis of Type 2 diabetes mellitus, ESRD and was dependent on Dialysis. Review of the Resident 35's Dialysis Communication Forms dated 7/4, 7/8, and 7/14 with LVN 1 indicated that the Resident 35's blood glucose levels were not documented on those dates in the communication form. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 1 stated that he confirmed that the blood glucose values were not recorded on the Dialysis Communication Forms. LVN 1 stated that failing to record blood glucose levels would create several clinical risks, like by not being able to identify hypoglycemia (low blood sugar), which may lead to confusion, dizziness, falls, loss of consciousness, or death if untreated. During an interview with the DON and concurrent record review 07/16/2026 2:20 PM - with of Resident 35's clinical record (Hard Chart) indicated that Resident 35 had a diagnosis of Type 2 diabetes mellitus, ESRD and was dependent on Dialysis. Review of the Resident 35's Dialysis Communication Forms dated 7/4/2026, 7/8/2026, and 7/14/2026 with LVN 1 indicated that the Resident 35's blood glucose levels were not documented on those dates in the communication form. DON stated that confirmed that the blood sugars were not recorded of the dialysis communication form. DON stated by failing to record Resident 35 blood sugar level, the nursing staff would not be able to identify if Resident 35 was having blood sugar issues such as hyperglycemia and hypoglycemia. DON stated that inaccurate or incomplete communication between the nursing facility and the dialysis center, which may affect coordination of the resident's care and incomplete clinical documentation would limit the ability of the interdisciplinary team to monitor diabetes management and identify trends over time. During a review of the facility P&P titled End-Stage Renal Disease, Care of a Resident with revised 9/2010, indicated agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including: how information will be exchanged between the facilities. During a review of the facility P&P titled Documentation Principles dated 1/2004, indicated that resident's health record shall be current and kept in detail consistent with good medical and professional practice based on the service provided to each resident.		

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 07/17/2026
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 prevent the spread of multidrug-resistant organism (MDRO- infection-causing organisms that are resistant to one or more medications that treat infection)) for one out of five sampled residents (Resident 3) who was placed on for enhanced barrier precautions (EBP, an infection control strategy used in nursing homes and skilled nursing facilities) in accordance with the facility's policy and procedure (P&P) titled Enhanced Barrier Precautions. The facility failed to ensure: 1. Two Certified Nursing Assistants (CNAs) don (put on) an isolation gown (or gown, a piece of clothing that is worn to protect both the wearer and the residents from the transfer of microorganisms and bodily fluids) while repositioning Resident 3 in bed. 2. The facility placed an order for EBP when Resident 3 was readmitted to the facility on [DATE]. This deficient practice placed Resident 3 and other residents at risk spreading and contracting infections (a condition when bacteria, viruses, or other microorganisms enter the body and grow) at the facility. Findings: During a review of Resident 3's admission Record (AR), the AR indicated that the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included dysphagia (difficulty in swallowing), gastrostomy (a surgical opening created in the abdominal wall and stomach to insert a feeding tube (a medical device used to deliver liquid food, fluids, and medicines directly to the resident's stomach or intestine), and sepsis (the body's extreme, life-threatening response to an infection). During a review of Resident 3's History and Physical (H&P), dated 4/28/2026, the H&P indicated that the resident does not have the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 5/28/2026, the MDS indicated that the resident has severely impaired cognition (the ability to process thoughts and emotions). The MDS also indicated that the resident is dependent (the helper does all the effort) on activities such as personal hygiene, bathing, and rolling in bed left and right. The MDS also indicated that the resident has a feeding tube. During a review of Resident 3's physicians order, dated 4/27/2026, the order indicated Enteral Order: [G-Tube] Site: Cleanse with [Normal Saline] (a sterile liquid solution that is often used for cleaning open wounds), pat dry, cover with dry dressing everyday shift. During a review of Resident 3's entire physicians orders as of 7/16/2026, the orders did not include an order to implement enhanced barrier precautions. During an observation on 7/14/2026 at 10:51 AM in front of the entrance to Resident 3's room, the wall next to the door into the resident's room had a signage, titled Enhanced Barrier Precautions. The signage indicated that providers and staff must wear gloves and a gown for high contact resident care activities. During an observation on 7/14/2026 at 11:12 AM inside Resident 3's room, CNA 2 and CNA 3 were observed changing Resident 3's position in bed. CNA 2 and CNA 3 did not wear a gown. Both CNAs were observed in close contact with Resident 3, and the CNA's clothes were observed in physical contact with Resident 3's body and clothing. During a follow-up interview on 7/14/2026 at 11:13 AM with CNA 2 and CNA 3, the CNA's stated that they forgot to wear a gown. The CNA's stated that they should have worn a gown because the resident is on EBP. During an interview on 7/14/2026 at 11:14 AM with Licensed Vocational Nurse (LVN) 3, LVN 3 stated that staff must wear gloves and a gown when providing care to Resident 3 because Resident 3 was on EBP which aids in the prevention of the spread of bacteria and viruses. During a concurrent interview and record review on 7/16/2026 at 3:25 PM with Registered Nurse (RN) 1, Resident 3's physician's orders were reviewed. RN 1 stated that there was no physician's order to place Resident 3 on EBP. RN 1 stated that there should have been a physician's order for EBP upon Resident 3's admission. RN 1 stated that there should be a (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Dreier's Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Few	physician's order for EBP so that staff are aware of the need to use the proper equipment when taking care of Resident 3. RN 1 stated that Resident 3 had a G-tube when the resident was readmitted [DATE]. During an interview on 7/16/2026 at 3:45 PM with the Infection Preventionist Nurse (IPN), the IPN stated that residents with a G-tube who are admitted to the facility must have an order for EBP upon admission. The IPN stated that EBP is used to prevent the spread of infections to other residents. During an interview on 7/17/2026 at 10:18 AM with the Director of Nursing (DON), the DON stated that residents who are admitted to the facility with a G-tube must be placed on EBP. The DON added that an order must be placed for EBP to notify staff that EBP must be used when caring for the resident. The DON further added that staff are expected to wear gloves and a gown when repositioning residents who are on EBP. The DON further stated that EBP is used to prevent the likelihood of spreading infections to staff and residents. During a review of the facility's policy and procedure (P&P), titled Enhanced Barrier Precautions, revised 3/2024, the P&P indicated that EBPs are utilized to reduce the transmission of multi-drug-resistant organisms (infection-causing organisms that are resistant to one or more medications) to residents. The P&P indicated that gloves and gowns are applied prior to performing the high contact resident care activity. The P&P indicated that EBP is indicated for residents with indwelling medical devices such as feeding tubes. The P&P also indicated that EBP is to remain in place for the duration of the resident's stay or until the discontinuation of the indwelling medical device.		