STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555911	A. Building B. Wing	08/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Adventist Medical Center Dp/Snf	1509 Wilson Ter Glendale, CA 91206

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on observation, interview, and record review, the facility failed to promote dignity and respect while dining when staff was observed standing over two of two sampled residents (Resident 102 and Resident 153) while assisting them to eat. This deficient practice had the potential to cause a decline in the resident's individuality, self-esteem, and self-worth. Findings: 1. A review of Resident 102's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included generalized weakness, hypertension (high blood pressure), and dyspepsia (indigestion, upper abdominal discomfort, described as burning sensation, bloating or gassiness, nausea or feeling fool too quickly after starting to eat). A review of Resident 102's Minimum Data Set (MDS, an assessment and screen tool) dated 8/17/24, indicated the resident had moderately impaired cognitive skills for daily decision making. A review of Resident 102's Physician Orders dated 8/12/24 indicated Resident 102 was ordered a Pureed Diet (pudding-like texture, smooth, blended, pureed diet needed for people who have trouble chewing or swallowing). During a dining observation with Licensed Vocational Nurse (LVN) 1 on 8/17/24 at 8:44 AM, LVN 1 was observed standing beside Resident 102 while assisting the resident in eating breakfast. Resident 102's bed was below LVN 1's waist and LVN 1 was not at eye level with the resident. During an interview with LVN 1 on 8/17/24 at 11:18 PM, LVN 1 stated she was looking for a certified nursing assistant and was helping to feed Resident 102. LVN 1 could not recall why she did not feed Resident 102 at eve level. LVN 1 stated it was important to feed resident at eye level so that the resident can see the feeder and so that the feeder can see how the resident is while eating. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident 153's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and sepsis (a life-threatening medical emergency that occurs when the body's immune system has an extreme response to an infection). A review of Resident 153's Orders dated 8/14/24, Orders indicated Resident 153 was ordered a Dysphagia Diet (a diet for people who have difficulty swallowing). During a concurrent observation and interview on 8/17/24 at 8:48 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 was observed assiting Resident 153 to eat while standing. LVN 1 stated, I'm not sure if we have to be sitting at the same level of the resident when we are helping to feed residents. If the nursing assistants are busy assisting residents with feeding and another resident that requires assistance with feeding, we help them feed the resident. During an interview with the Director of Nursing on 8/18/24 at 10:21 AM, the DON stated the resident should be comfortable while eating. The DON stated staff assisting to feed resident should be at eye level or sitting with the resident so that the resident would not feel intimidate. The DON stated it was important to feed residents at eye level to provide them dignity and respect. A review of the facility's undated policy and procedure (P&P) titled Quality of Life- Dignity, indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling or self-worth and self-esteem. 48903 2. A review of Resident 153's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and sepsis (a life-threatening medical emergency that occurs when the body's immune system has an extreme response to an infection). A review of Resident 153's Orders dated 8/14/24, Orders indicated Resident 153 was ordered a Dysphagia Diet (a diet for people who have difficulty swallowing). During a concurrent observation and interview on 8/17/24 at 8:48 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 was observed standing while assisting Resident 153 to eat. LVN 1 stated, I'm not sure if we have to be sitting at the same level of the resident when we are helping to feed residents. If the nursing assistants are busy assisting residents with feeding and another resident that requires assistance with feeding, we help them feed the resident. During an interview with the Director of Nursing on 8/18/24 at 10:21 AM, the DON stated the resident should be comfortable while eating. The DON stated staff assisting to feed resident should be at eye level or sitting with the resident so that the resident would not feel intimidate. The DON stated it was important to feed residents at eye level to provide them dignity and respect. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's undated policy and procedure (P&P) titled Quality of Life- Dignity, indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling or self-worth and self-esteem.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48903 Based on observation, interview and record review, the facility failed to provide necessary care and services for one of eight sampled residents (Resident 149) who was at risk for developing blood clot by failing to apply sequential compression device (SCD- a device use on the legs to promote blood circulation and prevent blood clot to develop) as ordered by the physician. This deficient practice had the potential to cause a deep vein thrombosis (DVT; blood clot that forms in a deep vein, often in the legs, from lack of blood circulation and potentially cause pulmonary embolism (PE is when a blood clot breaks off from inside a vein and travels to the lungs and causes respiratory distress), heart attach (heart stop functioning) and stroke (interruption of blood flow to the brain) Findings: During a review of Resident 149's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included type 2 Diabetes (a disease that results in blood sugar being too high), morbid obesity (when a person 's weight is more than 80 to 100 pounds above their ideal body weight), and closed fracture (broken bone) of the right hip. During a review of Resident 149's Physician's Orders, dated 8/13/24 indicated, the physician ordered Resident 1 to have SCD to be applied now. During a concurrent observation and interview on 8/16/24 at 11:25 AM with Registered Nurse (RN) 1, Resident 149's SCD were observed on the floor. RN 1 stated, this resident should have had leg squeezers on to prevent DVT. The leg squeezers are not placed on the residents' legs. During an interview on 8/16/24 at 11:25 AM with Family Member (FM) 1. FM 1 stated, she (Resident 149) has not used the leg squeezers on for two days. I've been here two days and they have not been placed on her. During a concurrent interview and record review on 8/17/24 at 4:08 PM with the Director of Nursing (DON), Resident 149's Physician's Orders, dated 8/13/24, were reviewed. The Physician Order indicated Resident 149 was ordered by the physician to have SCDs. DON stated, There is an active doctor's order for SCDs for this resident and SCDs are for DVT prophylaxis (prevention). The DON stated the purpose of SCD was to ensure that blood is circulating well in in the resident legs who are bedbound (stay in bed for prolong period of time) and if resident's blood is not circulating well, it can cause a DVT. During an interview on 8/18/24 at 8:48 AM with RN 2, RN 2 stated, SCDs are important because they help prevent blood clots. If a blood clot forms it can travel to the heart or brain and cause a heart attack or stroke. During an interview on 8/18/24 at 10:21 AM with DON, the DON stated, DVT can travel to the lungs and cause pulmonary embolism which can be life threatening. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's undated policy and procedure (P&P) titled, SCD, indicated, The purpose of SCDs is to improve circulation to the feet and to prevent complications associated with DVTs and PEs. SCDs prevent blood clots. Verify that there is an MD order for SCD.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48903 Based on observation, interview and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards and the facility ' s policy and procedure for food service safety by ensuring the hospital food were properly labeled and dated with the product name, date product was opened or prepared and use by date. The facility failed to: 1. Label and put an expiration date on a tub of cookies in the freezer. 2. [NAME] the jar of slaw with open date or use by date. 3. Label food in cart trays 4. Dispose of expired veggies in cart 5. Dispose of dirty cans of soda in the refrigerator 6. Dispose of bag of cabbage that had two expiration date labels. 7. Label and date meat package 8. Store ice machine scoop not on the ice. As a result of these deficient practices the residents had the potential to result in a widespread food-borne illnesses (an infection caused by consuming contaminated food, beverages and water than can happen during food processing, production, or handling, caused by many different disease-causing microbes or pathogens such as bacteria, viruses, parasites, toxins, and chemicals) in the facility. Findings: During a concurrent observation and interview on [DATE] at 12:07 PM with the Interim Dietary Director (IDD) a tub of cookies was observed without an expiration date or label. IDD stated, there is no label on it or expiration date on the tub of cookies which residents can get sick if they eat expired food. During a concurrent observation and interview on [DATE] at 12:16 PM with IDD, an opened bottle of slaw was observed in the refrigerator without a date of when the bottle was opened. IDD stated, I don't know what will happen to residents if they eat this. During an observation on [DATE] at 12:22 PM, one cart labeled veggies was observed with an expiration date of [DATE]. Three carts with unlabeled foods were also observed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] at 12:25 PM with IDD, dirty soda cans were observed in a black bin next to regular sodas. IDD stated, It shouldn't be here. a pt can get sick if they drink from the dirty soda can. During a concurrent observation and interview on [DATE] at 12:29 PM with IDD, a bag of cabbage with two expiration date stickers (one dated [DATE] and another dated [DATE]) was observed in the refrigerator. IDD stated, it causes confusion to have two stickers on a bag and it can be potentially expired. A resident can get sick if they eat expired food. During a concurrent observation and interview on [DATE] at 12:32 PM with IDD, a package of meat was observed without a label or date in the refrigerator. IDD stated, it should have been labeled because it can cause illness if it's not labeled, and it is expired. During a concurrent observation and interview on [DATE] at 12:34 PM with IDD, an ice scoop was observed on top of the ice machine. IDD stated, the ice scoop should not be on top of the machine because it can be dirty and cause illness to residents. During a review of the facility's policy and procedure (P&P) titled, Food Storage dated [DATE], indicated, Policy is to ensure the hospital stores food using proper sanitation. Food shall be protected at all times from contamination by storing the food where it is protected from dust. All food must be properly labeled and dated with the product name, date product was opened or prepared and use by date.

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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** 42854 Based on observation, interview, and record review, the facility failed to provide safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases (one that is spread from one person to another through contact with blood and bodily fluids, or breathing in an airborne virus) for one of one sampled residents (Resident 8) by failing to label Resident 8's peripheral intravenous line (IV, a thin flexible tube was inserted through the skin into a small vein in the periphery to deliver fluid and medications) to indicate the date the IV was inserted. As a result of this deficient practice had the potential for the IV not to be changed timely and could result in phlebitis (inflammation/swelling of the vein) or develop infection in the peripheral IV site that could enter the blood stream and result in severe infection. Findings: 1. A review of Resident 8's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included obesity (caused by caloric intake greater than caloric expenditures), aortic stenosis (occurs when the aortic valve narrows and blood cannot flow normally), and left bundle branch block (condition in which there is a delay or blockage along the pathway that electrical impulses travel to make the heart beat). A review of Resident 8's Minimum Data Set (MDS, an assessment and screen tool) dated 8/8/24, indicated the resident had intact cognition (mental action or process of acquiring knowledge and understanding through thought, experience and the senses). A review of Resident 8's Physician Orders, dated 8/4/24 indicated, to assess Resident 8 peripheral IV-line every 8 hours and to change line/cap and dressing if soiled or as needed every 7 days. During a concurrent observation and interview in Resident 8's room on 8/16/24 at 1:23 PM, Resident 8's peripheral IV was observed on resident's right hand without a label to indicate the date IV was inserted. Resident 8 stated the staff inserted the IV line this morning (8/16/24). During a concurrent observation and interview with Registered Nurse (RN) 3 on 8/16/24 at 1:27 PM, RN 3 confirmed Resident 8's peripheral IV was not labeled with date. RN 3 stated she was told by the previous shift nurse that Resident 8's IV was inserted during the night shift. RN 3 stated it was important to label the IV with the date so that staff are aware when it was inserted and when to change the IV line. RN 3 stated the IV line should be changed every 72 hours. During an interview with the Director of Nursing (DON) on 8/18/24 at 10:20 AM, the DON stated it was important to label the peripheral IV line with the date to verify when staff will change the IV line. The DON stated if it was not labeled or labeled incorrectly, the IV will not be changed timely and it could cause phlebitis or other skin infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility ' s policy and procedure (P&P) titled Dressing Change for Vascular Access Devices, dated 8/2021 indicated part of the procedure for a short peripheral catheter dressing change was to apply label on dressing with date and nurse's initials.