

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555911	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER Glendale Adventist Medical Center Dp/Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (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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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Resident 6 and 45) received appropriate treatment and services to prevent urinary tract infections (UTI a infection of the urinary tract that includes urethra, ureters, bladder and kidneys resulting when microorganism gets into the urine and travels to the urinary tract) by failing to ensure: 1. Resident 6's suction tubing that connects to Resident 6's Pure Wick System (PWS- an external female catheter use for urine collection for residents that are incontinent [no control] of bladder when urinating) was covered and placed in a plastic bag when disconnected from Resident 6 was not left on top of Resident 6's pillow and the urine collection cannister connected to the tubing was labeled or dated of the last time it was changed. 2. Resident 45's tubing that connects to Resident 45's [NAME] Fit (PF-external male catheter for urine collection for residents that are incontinent of bladder when urinating) tubing was observed disconnected with uncovered opening end set on top of Resident 45's chair, and the urine collection cannister connected to the tubing was not labeled or dated of the last time it was changed. These deficient practices had the potential for Resident 6's and Resident 45's to develop UTI and negatively affect their quality of life. Findings: A review of the facility's policy and procedures indicated to minimize the risk for residents from urinary tract infection by hygiene and precaution, the facility will use aseptic technique (hand washing, use single use equipment and avoid contamination etc.) when disconnecting, reconnecting and storing bedside drainage tubing. 1. During a review of Resident 6's, Physician Face Sheet (PFS), indicated Resident 6 was admitted to the unit on 7/30/2025. During a review of Resident 6's History and Physical Examination (H&P), dated 7/31/2025, indicated diagnoses includes hypertension (elevated blood pressure), encephalopathy (a disease or condition that affects the brain's structure or function, causing it to not work properly), and acute kidney injury/failure (the rapid loss of kidneys' ability to remove waste and help balance fluids and electrolytes in the body). The H&P indicated Resident 6 was alert and oriented x 3 (awake and oriented to person, place, and time). During a review of Resident 6's Minimum Data Set (MDS-a resident assessment tool) dated 8/3/2025, the MDS indicated Resident 6's needs some help (Resident need partial assistance from another person to complete any activities) with bathing, dressing, using the toilet or eating, indoor mobility, and planning regular task. The MDS indicated Resident 6 was always incontinent (no control) of bladder. During a concurrent observation and interview on 8/13/2025 at 10AM with Licensed Vocational Nurse (LVN) 1 in Resident 6's room, Resident 6's PWS suction tubing was on top of Resident 6's bed without a cover and not in a plastic bag, also the suction cannister had slight yellow liquid and was without a label or date. LVN 1 stated, Resident 6 was probably picked up by rehabilitation staff (helps with walking, balance, and regaining strength and mobility in the arms and legs). LVN stated, Resident 6 uses PWS that connects to the suction tubing and the cannister collects urine. LVN 1 stated, suction tubing should be in a plastic bag when disconnected from Resident 6, and the cannister should have a label of the date it was changed. LVN 1 stated, it could cause bacterial growth to the tubing and the cannister that could potentially cause UTI to Resident 6 and spread infection in the unit. During an interview on 8/14/2025 at 8:20 AM with Registered Nurse (RN) 1, RN 1 stated, the suction tubing that connects to the external catheter part of the PWS and PF should be in a placed in a plastic bag, and the cannister should be labeled and dated with the day it was changed because to prevent the bacteria to harbor and could cause UTI to the Resident who are using it and potentially spread infection in the unit. During a concurrent interview and record review, on 8/14/2025 at 9:00 AM, with the DON (Director of Nurses), Resident 6's physical chart and Electronic Health Record (EHR) dated from admission date 7/30/2025 until present on 8/14/2025 was reviewed. Resident 6's EHR indicated no physician order for the use of the use of PWS and a plan of care was not developed for Resident 6's use of PWS.DON stated, a care plan should had been developed and implemented that address potential concern such as prevention of UTI and widespread infection. 2. During a review of Resident 45's, Physician Face Sheet (PFS), indicated Resident 45 was admitted to the unit on 8/12/2025. During a review of Resident 45's History and Physical Examination (H&P), dated 8/13/2025, indicated the resident was alert and oriented with diagnoses that included hypertension, abdominal aortic aneurysm (a swelling of the aorta [the largest artery in the human body]), peripheral artery disease(a narrowing of the inside of the peripheral arteries that carry blood away from the heart to other parts of the body) and dyspnea on exertion (shortness of breath that occurs during nphysical activity). During a review of Resident 45's MDS dated [DATE] the MDS indicated Resident 45</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations, 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 procedures titled Food Storage for food service safety by ensuring the hospital food was properly labeled and dated with the product name, date product was opened or prepared and use by date by: An open box of Dark Chocolate Cocoa Mix with individually wrapped packets had no open date. 2. An open plastic container with lentils had no label to identify its contents or indicate the use-by date. 3. A multi-rack with metal trays that had food items without label or use-by-dated. 4. A bag of carrots with a large tear on the package had no label and use-by-date. These deficient practices placed the residents at the risk of widespread foodborne illness (infections caused by consuming contaminated food, beverages, or water containing harmful microbes, pathogens, or toxins). Findings: During an initial kitchen observation conducted with the Dietary Director (DD) on 8/13/2025 at 9:18 AM included the following: 1. The dry storage area had an open box of Nestle Dark Chocolate Hot Cocoa Mix with individually wrapped packets, in active used to serve the residents in active use, were not labeled and when to use-by-date. 2. A plastic container containing lentils, with partially opened red lid had no label and no used by date. In a concurrent interview on 8/13/2025 at 9:18 AM, the DD stated the hot cocoa mix in the dry storage area that had been opened and an opened plastic container containing lentils should had been labeled to identify the contents and and the use by date. DD stated by not properly labeling and dating food items increases the risk of product misidentification, and use of expired items. During a concurrent observation and interview on 8/13/2025 at 9:30 AM with the DM, the walk-in refrigerator had multi-rack, stainless steel holding cabinet containing several metal trays, some of which are covered with plastic wrap. The top tray contained food item that was covered with a plastic wrap with a label and date use by date. The second tray/or middle tray holds what looks like a mixture of nuts, dried fruit, and beans without visible label indicating the contents, preparation date, or a use by date. In addition, there was a bag of carrots that was found with a large tear at the top that was not sealed, labeled and use-by-date. In a concurrent interview the DD stated he observed that he observed the metal trays with food items that were not labeled and dated. The DD stated the bag of carrots with a large tear should had been sealed, labeled and dated. The DD stated that by not sealing, labeling and dating this food items had the potential to compromise food safety and quality. During review of the facility's policy and procedure titled Food Storage, indicated that all stored food must be properly labeled and dated with: Product name, date product was opened or prepared date, use by date.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement facility's policy and procedure to prevent spread of infection for two of two sampled residents at risk or with infection by failing to: 1. Resident 34's nasal cannula (NC-a flexible tube with two prongs that rest in the nostrils to deliver supplemental oxygen) was observed in her room without a plastic bag and a label or date of the last time it was changed. The facility's policy indicated to changed NC every 7 days. 2. Biomedical Technician (BT) did not perform hand hygiene and don (put on) PPE (Protective equipment and clothing such as gown and gloves used to prevent the spread of infectious organisms) before and after entering Resident 44's, who was placed on contact isolation (precautions taken in healthcare settings to prevent the spread of infections). These deficient practices had the potential to transmit infection (spread from one person to person or from contaminated surface or object) and result in widespread of infection (a process when a microorganism, such as bacteria, fungi, or a virus, enters a person's body and causes harm) in the unit. Findings: 1. During a review of Resident 34's, Physician Face Sheet (PFS), indicated Resident 34 was admitted to the unit on 7/28/2025. During a review of Resident 34's History and Physical Examination (H&P), dated 7/29/2025, indicated Resident 34 was alert and oriented with the diagnoses that included hypertension (having high blood pressure), history of atrial fibrillation (irregular heart rhythm), and diabetes a condition of having high blood sugar). During a review of Resident 34's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 8/1/2025, the MDS indicated Resident 34's needs partial assistance from another person to complete any activities with using the toilet or eating and was always incontinent of bladder. During a concurrent observation and interview on 8/13/2025 at 10:30 AM with Registered Nurse (RN)2 in Resident 34's room, Resident 34's NC was observed hanging above her bed, without a plastic bag and label or date of the last time it was changed. RN 2 stated, Resident 34 uses the oxygen as needed, it should be in a clear plastic bag and a label or date the last time it was changed to identify if the NC was new or old and not changed after 7 days. RN 2 stated, Resident 34's NC should be changed every 7-days as per facility's policy. RN 2 stated, if the NC was old, it had the potential to harbor virus and/or bacteria that could cause infection or sickness to Resident 34 and spread the infection to other residents in the unit. During an interview on 8/14/2025 at 10AM with the Director of Nurses (DON), DON stated, Resident 34's NC in her room should be in a bag and with a label and date the last time it was changed as per policy. DON stated, since Resident 34's NC did not have a date, there was no way to identify if the NC was new or old. DON stated, an old NC tubing had the potential to harbor bacteria and viruses, that can cause infection to Resident 34 and spread to other residents in the unit. 2. A review of Resident 44's admission Record [AR] indicated Resident 44 was admitted to the facility on [DATE], with diagnoses that included sepsis (severe infection of the blood) and nausea (a feeling of sickness and stomach upset). A review of Resident 44's History and Physical Examination (HPE, a comprehensive physician's note regarding the assessment of the Patient's health status) signed by the attending physician on 8/8/2025, the HPE indicated Resident 44 had the capacity to understand and make decisions. A review of Resident 44's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/11/2025, the MDS indicated that Resident 44 had an intact cognition (thought process). A review of Resident 44's Care Plan titled Infectious Disease dated 8/7/2025, indicated that Resident 44 was placed on contact isolation for Methicillin-Resistant Staphylococcus Aureus (MRSA - a type of bacteria that is resistant to the antibiotic methicillin and other antibiotics) wound to her left foot. During an observation on 8/13/2025 at 10:17 AM, Biomed Technician (BT) entered Resident 44 room, a designated contact isolation room, without donning (putting on) the required personal protective equipment PPE or performed hand hygiene. The BT touched the wall-mounted suction device, exited the room without performing hand hygiene, and then returned to the room a second time without donning PPE or performing hand hygiene. The BT again exited the room without performing hand hygiene and proceeded to use the portable workstation. During an interview on 8/13/2025 at 10:25 AM, the BT stated he was aware of the contact isolation signage on the doorway of Resident 44 but failed to follow the required isolation signage instructions at the doorway. BT stated he should have donned a gown, gloves, and mask prior to entering the room and performed hand hygiene before entering and after exiting the resident's room. BT stated by not following the isolation signage he had the potential to transmit and spread infections to other residents. During an interview on 8/13/2025 at 3:15 PM the Infection Prevention Nurse (IPN) stated Resident 44's was</p>		