STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055523	A. BUILDING _____ B. WING _____ POC reviewed and Accepted on 10/17/22 HFEN #44429	C 09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENDALEPOSTACUTECENTER	250 N. VERDUGO ROAD GLENDALE, CA 91206

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F 000	INITIAL COMMENTS The following represents the findings of the California Department of Public Health during the investigation of a Facility Reported Incident (FRI). Facility Reported Incident Number: CA00799942 Representing the Department: Health Facilities Evaluator Nurse: 44429 The inspection was limited to the specific Facility Reported Incident investigated and does not represent the findings of a full inspection of the facility. One deficiency was identified for the Facility Reported Incident: CA00799942 (Refer to Flag 842).	F 000	By submitting this POC, Glendale Post-Acute Center does not admit or concede the facts and contentions cited, or the existence or scope or severity of the deficiencies and conditions cited in the 2567. The POC is submitted to comply with federal and state law. Glendale Post-Acute Center respects the allegations made in the 2567 have acted and will continue to act to implement this POC.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483. 70(i) Medical records. §483. 70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 842	**F-842 Resident Records** **How corrective action will be accomplished for those residents found to have been affected by the deficient practice:** • No resident was affected to the said deficient practice that will potentially result in the spread of Coronavirus (Covid-19) infection in the facility. • Infection Preventionist (IP) provided an in-service to the Receptionist/ Front desk personnel regarding the following topics: o Entry Screening of Staff and Visitors - utilizing Staff/ Visitor Screening Log (monitoring and maintaining)	9/8/2022 9/17/2022

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

Administrator 10/13/22

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.

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F 842	Continued From page 1 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 842	• IP / Administrator / Designee completed in service to all Department Heads regarding the topic: o Entry Screening of Staff and Visitors – utilizing Staff / Visitor Screening Log (monitoring and maintaining) • IP / Designee conducted an in-service to all staff including licensed nurses regarding the topic: o Entry Screening of Staff and Visitors – utilizing Staff / Visitor Screening Log (monitoring and maintaining) • IP / Designee continues to oversee and ensure compliance of Staff and Visitor Screening Log completion through audits brought to QAPI quarterly x 2 quarters.	9/17/2022 9/17/2022

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F 842	Continued From page 2 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the facility ' s Staff and Visitor Screening Log were completed timely and accurately. This deficient practice had the potential to result in the spread of Coronavirus (COVID-19) infection in the facility. Findings: During an interview on 9/8/22, at 11:12 AM, the Infection Preventionist Nurse (IPN) stated on 8/25/22, one resident tested positive but since that date (8/25/22), an additional 12 residents starting from 8/26/22 to 9/8/22 have tested positive for COVID 19 using the rapid test. The IPN stated that there are there are 10 COVVID 19 positive residents residing in the facility ' s Red Zone (an area in the facility where all positive COVID 19 residents are housed). During an observation in the facility ' s Red Zone area, on 9/8/22, at 1:30 PM, the facility ' s Red Zone had its own separate entrance and had its own break room with its own restroom for the Red Zone facility staff.	F 842	**How the facility will identify other residents having the potential to be affected by the same deficient practice does not recur:** • No resident was affected to the said deficient practice that will potentially result in the spread of Coronavirus (Covid-19) infection in the facility. • Facility to adhere to the compliance of Staff and Visitor Screening Log completion. Audits to be conducted monthly x 3 months brought to QAPI if with findings. • IP / Designee conducted an in-service to all staff including licensed nurses regarding the topic: ◦ Entry Screening of Staff and Visitors – utilizing Staff / Visitor Screening Log (monitoring and maintaining) • IP / Designee continues to oversee and ensure compliance of Staff and Visitor Screening Log completion through audits brought to QAPI quarterly x 2 quarters. • All findings, progress or lack of progress will be discussed on the monthly QA committee meetings for further necessary recommendations and further corrective actions.	

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F 842	Continued From page 3 A review of the Staff Screening Log dated from 9/1/22 to 9/7/22 indicated the following entries: a. On 9/1/22 page 1 of 3, entry #17, No temperature entered upon arrival. b. On 9/2/22 page 2 of 3, entry #23, Unable to determine temperature upon departure. c. On 9/2/22 page 3 of 4, entry #6, Temperature of 92.5 was entered (Normal temp 97.0 - 99.0). d. On 9/2/22 page 3 of 4, entry #27, Temperature of 93.0 was entered upon departure. e. On 9/2/22 page 4 of 4, entry #2, Unable to determine temperature upon arrival. f. On 9/4/22 page 1 of 2, entry #22, Temperature of 92.3 was entered upon arrival. g. On 9/5/22 page 1 of 3, entry #23, Unable to determine temperature upon departure. h. On 9/5/22 page 2 of 3, entry #23 Temperature of 91.8 was entered upon departure. i. On 9/6/22 page 1 of 3, entry #16 Unable to determine temperature upon departure. j. On 9/6/22 page 1 of 3, entry #17 Temperature of 94.1 was entered upon departure. k. On 9/6/22 page 3 of 3, entry #1 Temperature of 87.6 was entered upon arrival. l. On 9/7/22 page 3 of 3, entry #15 Temperature of 90.0 was entered upon arrival. A review of the Visitor Screening Log dated from 9/1/22 to 9/7/22 indicated the following entries: a. On 9/2/22 page 3 of 3, entry #12 Temperature of 99.1 was entered upon arrival. b. On 9/3/22 page 2 of 3, entry #5 Temperature of 95.0 was entered upon arrival. c. On 9/3/22 page 3 of 3, entry #10 Temperature of 99.3 was entered upon arrival. d. On 9/4/22 page 2 of 3, entry #8 Temperature of 93.2 was entered upon arrival. e. On 9/5/22 page 4 of 4, entry #1 No temperature was entered upon arrival.	F 842	**What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:** • IP / Designee will check the Visitors Screening Log and Staff Screening Log daily. Any findings will be reported to IDT during the Daily Stand-up meeting for recommendations. • IP / Designee continues to oversee and ensure compliance of Staff and Visitor Screening Log completion through audits brought to QAPI quarterly x 2 quarters. • Facility to adhere to the compliance of Staff and Visitor Screening Log completion. Audits to be conducted monthly x 3 months brought to QAPI if with findings. • All findings, progress or lack of progress will be discussed on the monthly QA committee meetings for further necessary recommendations and further corrective actions.	

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F 842	Continued From page 4 f. On 9/6/22 page 1 of 3, entry #9 Unable to determine temperature upon arrival. g. On 9/6/22 page 1 of 3, entry #10 No temperature was entered upon arrival. h. On 9/6/22 page 2 of 3, entry #5 No temperature was entered upon arrival. i. On 9/6/22 page 2 of 3, entry #9 No temperature was entered upon arrival. j. On 9/6/22 page 2 of 3, entry #10 No temperature was entered upon arrival. k. On 9/7/22 page 1 of 4, entry #13 Temperature of 94.4 was entered upon arrival. l. On 9/7/22 page 2 of 4, entry #10 Temperature of 91.9 was entered upon arrival. m. On 9/7/22 page 3 of 4, entry #8 No temperature was entered upon arrival. n. On 9/7/22 page 4 of 4, entry #3 Unable to determine temperature upon arrival. During a concurrent interview and record review on 9/14/22 at 10:30 AM with the IPN, the IPN acknowledged the incorrect and missing temperature entries from the facility ' s Staff and Visitor logbook dated from 9/1/22 to 9/7/22. The IPN stated the incorrect or missing entries had the potential to be the source of the current COVID 19 outbreak in the facility. The IPN stated he would in-service the facility receptionist on how to monitor and maintain the temperature logbook accurately. A review of the facility ' s policy and procedure, titled "Coronavirus Disease - Infection Prevention Control Measures" dated 6/2020, indicated anyone entering the facility (including staff) is screened and triaged for sign and symptoms of and exposure to others with SARS-CoV-2 infection.	F 842	**How the facility plans to monitor its performance to make sure that solutions are sustained.** • IP / Designee will check the Visitors Screening Log and Staff Screening Log daily. Any findings will be reported to IDT during the Daily Stand-up meeting for recommendations. • IP / Designee continues to oversee and ensure compliance of Staff and Visitor Screening Log completion through audits brought to QAPI quarterly x 2 quarters. • Facility to adhere to the compliance of Staff and Visitor Screening Log completion. Audits to be conducted monthly x 3 months brought to QAPI if with findings. • All findings, progress or lack of progress will be discussed on the monthly QA committee meetings for further necessary recommendations and further corrective actions.	