

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRN/ELC: 08/02/2018
FORM APPROVED
OMB NO. 0938-0391

accepted 5/15/18 HFEN 36202

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055523	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/26/2018
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NAME OF PROVIDER OR SUPPLIER

GLENDALE POST ACUTE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

250 N. VERDUGO ROAD
GLENDALE, CA 91206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

The following reflects the findings of the California Department of Public Health during a complaint investigation.

Complaint Number: CA00572860

Representing the Department: HFEN # 36202

The inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility.

One deficiency was written as a result of complaint number: CA00572860

F 552 Right to be Informed/Make Treatment Decisions
SS-D CFR(s): 483.10(c)(1)(4)(5)

§483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including:

§483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.

§483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.

§483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.

This REQUIREMENT is not met as evidenced

F 000

Glendale Post Acute Center submits this response and plan of correction as part of the requirements under state and federal law. The plan of correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil or criminal action or proceedings against the provider or its employees, agents, officers, directors, or shareholders.

F 552

The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party. Any changes to provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and California evidence Code Section 1151 and should be inadmissible in any proceeding on that basis.

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

[Signature]

TITLE

Adminis Trator

(X5) DATE

5/17/18

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

02:39:27 p.m.

03-02-2018

PRINTED: 03/02/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065523	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/25/2018
NAME OF PROVIDER OR SUPPLIER GLENDALE POST ACUTE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 250 N. VERDUGO ROAD GLENDALE, CA 91206		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F-552	<p>Continued From page 1</p> <p>by:</p> <p>Based on interview and record review, the facility failed to implement its policy and procedure in change of condition by failing to inform resident representatives or family members for one of three sampled residents (Resident 1).</p> <p>Resident 1 was transferred to a General Acute Care Hospital (GACH) on 2/5/18 due to a fall on 2/4/18, and Resident 1's family was not informed.</p> <p>This deficient practice resulted in Resident 1's family was not informed of the resident's condition.</p> <p>Findings:</p> <p>On 2/21/18, at 10:30 a.m., an unannounced visit was conducted to the facility to investigate an allegation regarding quality of care.</p> <p>A review of Resident 1's Admission Record, indicated Resident 1 was admitted to facility on 2/3/18 with diagnoses that includes muscle weakness, and dementia (gradual decrease in the ability to think and remember that is great enough to affect a person's daily functioning).</p> <p>A review of Resident 1's Initial History and Physical, dated 2/4/18, indicated Resident 1 has the capacity to understand and make decisions.</p> <p>A review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR- a tool used by health care professionals when they communicate with each other about critical changes in a patient's status) Communication Form, dated 2/4/18, indicated Resident 1 had a fall and the resident's Physician was notified. The</p>	F 552	<p>Resident was transferred to Acute Care on 02/05/2018.</p> <p>Medical records/Designee conducted an audit of in-house residents with change of condition for the month of April 2018 completed on 05/03/2018. No other residents were found to be affected by this deficient practice.</p> <p>An in-service to License nurses was provided by DON/DSD on 04/25/2018 on proper notification of change of condition status to family/Emergency Contact even if resident is self responsible. The IDT initiated and will continue to review all change of conditions during IDT Clinical Meeting every morning to ensure that notification of family/Emergency Contact is done. Medical Records will continue to conduct Audits Monday to Friday to ensure compliancy. Findings will be reported to the DON for further action if required.</p>		

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NAME OF PROVIDER OR SUPPLIER GLENDALE POST ACUTE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 280 N. VERDUGO ROAD GLENDALE, CA 91206		
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F 552	<p>Continued From page 2</p> <p>SBAR communication form indicated Resident 1's Physician recommended for staff to follow the facility's protocols. Resident 1's SBAR communication form did not indicate an evidence that Resident 1's family was notified of the fall incident.</p> <p>A review of Resident 1's Nursing Progress Notes, dated 2/5/18, indicated on 2/4/18, at 11:10 p.m., Resident 1 was found on the floor beside the bed with minor bruise on the left eye brow. The notes indicated Resident 1 was alert but confused. Resident 1's nursing progress notes did not indicate Resident 1's family was made aware of Resident 1's fall. The notes indicated on 2/5/18, at 9:10 a.m., Resident 1 was observed lethargic (weak) and unable to grasp staff's hands. The notes indicated Resident 1 was transferred to a GACH via 911. The notes did not indicate Resident 1's family was notified regarding the fall incident, the change of condition, and the hospitalization.</p> <p>On 4/25/18, at 3 p.m., during a review of Resident 1's record and a concurrent interview with the Director of Nurses (DON), she stated Resident 1's family should had been informed of the fall incident and the hospital transfer due to a change in condition. The DON stated there was an admission record from a previous GACH with Resident 1's family member contact phone number but staff members did not attempt to contact the listed phone number.</p> <p>A review of the facility's policy and procedure titled "Falls and Fall Risk," revised date 10/2010 indicated when the resident falls the following information should be recorded in the resident's medical record: notification of the Physician and</p>	F 552	<p>The Director of Nursing and or designee will provide a summary trend analysis of negative findings to the monthly QAPI Committee meeting. If there are no negative findings reported after one quarter, issue is considered resolved. DON/Designee will be responsible for Compliancy.</p>		

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F 552	Continued From page 3 family members. A review of the facility's policy and procedure titled "Change in Resident's Condition or Status," revised date 12/2016, indicated facility's staff shall promptly notify the resident, his or her Physician and representative (sponsor) when there is a changes in resident's medical/mental condition and/or status (e.g. change in level of care, billing/payment, residents rights).	F 552			