STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555839	A. BUILDING _____ B. WING _____	**05/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DREIER'S NURSING CARE CENTER	**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 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 interviews and records review, the facility failed to report the results of all investigations to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken for one of three sampled residents (Resident 1) allegedly lost his money in the facility. This deficient practice has the potential to compromise the safety of the residents and their belongings. Findings: On 8/21/18 at 9:40 a.m., an unannounced visit was made to the facility to investigate a facility reported incident about an alleged abuse. A review of Resident 1's face sheet (admission record) indicated that the facility initially admitted Resident 1 on [DATE]8/18 and readmitted the resident on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS), a resident assessment and care-screening tool, dated 5/17/18, indicated that Resident 1's cognition was intact. The MDS indicated that Resident 1 required limited assistance from a staff when performing activities of daily living (ADLs) such as bed mobility, transferring from one surface to another, walking in corridors, and when performing personal hygiene. Resident 1 required extensive assistance from a staff when walking in the room, dressing, and when using the toilet. The MDS indicated that Resident 1 uses a walker or a wheelchair for mobility. A review of Resident 2's face sheet indicated that the facility admitted Resident 2 on [DATE]. Resident 2's [DIAGNOSES REDACTED]. A review of Resident 2's history and physical examination [REDACTED]. A review of Resident 3's face sheet indicated that the facility admitted Resident 3 on [DATE]. Resident 3's [DIAGNOSES REDACTED]. A review of Resident 3's history and physical examination [REDACTED]. During an interview on 8/21/18 at 2:30 p.m., Social Services Designee 1 (SSD 1) stated that while she was walking in the hallway on 8/7/18 at around 8:35 a.m., Resident 2 asked her to come over to Resident 1's room. When she arrived at the room, Resident 2 was at the door with Resident 1 and the latter stated, We have a problem. She found this envelope behind her bed. SSD 1 stated that Resident 2 used to stay in 2C and requested the facility to transfer her to 2A to have a better view of the television. Resident 3 used to occupy 2A before the facility discharged the resident. Resident 2 claimed that when she moved to 2A, she found an envelope behind her bed with Resident 1's name on it. The envelope did not contain money but had a piece of paper inside it, indicating that there was $355 inside the envelope. Resident 1 and 2 concluded that Resident 3 took the money. However, when Resident 2 left, Resident 1 stated that Resident 2 took his money. At around 11 a.m., Resident 1 informed SSD 1 that he had $755 inside the envelope. SSD 1 stated that she reported the incident to the state agency and to the ombudsman the following day, 8/8/18 at 3:37 p.m. During a telephone interview on 9/5/18 at 8 a.m., SSD 1 stated that she immediately reported Resident 1's allegation to the DON and to the Administrator (ADM) after the conversation she had with Resident 1 and 2. She stated that she interviewed the residents but did not document, date, and sign the conversation accordingly. She also stated that she failed to provide the state agency with the results of her investigation within the five-day period because she was not aware of that requirement. During an interview on 8/21/18, the Director of Nurses (DON) stated that the facility failed to provide the state agency with the conclusion of their investigation. A review of the facility's undated policy titled, Abuse Investigations, version 1.2 (H5MAPL0005) indicated the following: 1. Facility management shall promptly and thoroughly investigate all reports of resident abuse, neglect, and injuries of unknown source. 2. The individual conducting the investigation will as a minimum interview the resident, person(s) reporting the incident, review all events leading up to the alleged incident, and obtain witness reports in writing. 3. The results of the investigation would be recorded on approved documentation forms. 4. The Administrator would provide a written report to the state survey and certification agency the results of all abuse investigations and appropriate action taken within five (5) working days of the reported incident. 5. Should the investigation reveal that a false report was made or filed, the investigation would cease while residents, family members, ombudsmen, and state agencies would be notified of the findings.

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