STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055288	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Hills Health Care Center	430 N.Glendale Ave 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview, and record review, n 12/14/2025, the facility failed to ensure one of two sampled residents (Resident 1) received timely assistance with activities of daily living (ADLs), specifically incontinence care (timely assistance with personal hygiene, support , maintaining comfort, dignity, skin integrity, and health). This deficient practice resulted in Resident 1 experiencing moisture - associated skin damage (MASD a medical term for inflammation, redness, and erosion of the skin from prolonged contact with moisture (urine, sweat, wound drainage, saliva, stool), often worsened by friction, pH, or microbes, leading to skin breakdown, especially in folds or around stomas/wounds0 and having the potential for further skin breakdown, pain, discomfort, and possible infection.During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was originally admitted to the facility on [DATE], with a diagnosis of Heart failure(heart is not able to pump blood as well as it should), diabetes(high blood sugar) , acute embolism(sudden blockage of the blood vessel). During a review of Resident 1's History and Physical (H&P) , dated 10/28/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) , the MDS indicated Resident 1 has moderate cognitive impairment (trouble with memory, and may be confused at times) requiring total assistance with toileting hygiene (personal hygiene, adjust clothes before and after voiding or having a bowel movement). During a review of Resident 1's care plans titled Non - pressure non - surgical wound: MASD type of wound site: coccyx (tailbone), dated 12/16/2025 indicated a goal that Resident 1 would experience timely healing of the wounds without complications. The Care Plan indicated resident's risk for wound infection would be minimized by intervention of Calmoseptine (protects skin from irritants like urine, feces, and sweat) topical ointment to coccyx MASD. During a review of Resident 1's care plan titled Pressure Ulcer Risk dated 10/29/2025, the Care Plan indicated a goal to minimize the development of pressure ulcers and or skin breakdown by assisting in turning and repositioning, encourage mobility and change of position when in bed or in chair, and provide skin care. During a review of Resident 1's Point of Care Responses (documentation of toileting assistance by certified nurse assistance (CNA), the responses indicated Resident 1 received toileting assistance on 12/14/2025 at 11:57 AM. The response indicated the next documented episode of assistance for toileting did not occur until 6:30 PM, 6.5 hours in- between toileting or incontinence care. During a review of Resident 1' s Situation, Background, Assessment and Recommendation (SBAR) form , dated 12/16/2025, the SBAR indicated Resident 1 had frequent bowel and bladder (B &B) incontinence (inability to control urination or bowel movements), with small amount of bleeding on coccyx area and superficial skin breakdown. During a review of Resident 1's Physician Order Report, dated 12/16/2025, the Report indicated Calmoseptine (topical skin protectant)ointment was ordered to be applied daily to the Coccyx MASD. During an interview on 12/18/2025 at 10:40AM, with Resident 1 and Family Member (FM1), Resident 1 stated on Sunday 12/14/2025, Resident 1 felt she was not being cared for. Resident 1 stated after lunch she asked for help, since she was wet and needed to be changed, but no one ever came to assist Resident 1. During an interview on 12/18/2025 at 10:50AM, with FM 1, FM 1 stated that on 12/14/2025 at approximately 4 PM, Resident 1 called FM 1and reported she was not being taken care for at the facility. FM1 stated arriving at the facility at 4:15PM and observed Resident 1's brief wet. FM1 stated asking the assigned CNA (CNA2) if her mother had been changed and that CNA 2 stated she had already checked the resident and stated she was okay, and would change the resident after dinner. FM1 stated from the time she arrived at 4:15 pm to approximately 7 PM, Resident 1's wet brief had not been changed. FM1 stated pressing the call light at 4:15 pm and no staff responded . FM1 stated she then went to the nursing station, where staff informed her the assigned CNA was on break. No other CNA provided brief change for Resident 1 for approximately 3 hours and 45 minutes. During an interview on 12/18/2025 at 11 AM, with FM 1, FM 1 stated on 12/15/2025 during the evening, the CNA showed her the buttock area of Resident 1 and informed her that the resident had a wound. Family member (FM1) stated the CNA told her the wound had been observed the prior night on 12/14/2025. FM 1 stated on 12/16/2025 ,she was not notified by the facility regarding the wound and believed the wound care nurse would have contacted her by then. FM stated she personally went to the wound care nurse with CNA on 12/16/2025 to report the wound to the buttock area, at which time the wound care nurse applied cream to the area. During an interview on 12/18/2025 at 12:03 PM with LVN 1, LVN 1 stated Resident 1 was incontinent of Bowel and Bladder (B&B)