STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055523	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Post Acute Center	250 N. Verdugo Road 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to notify the physician and the responsible party (RP) for one of five sampled residents (Resident 1) when Resident 1 had a change of condition of new skin redness between the skin folds of the lower abdomen (belly). This deficient practice had the potential to result in worsening of Resident 1's skin condition and delayed provision of necessary care and services to maintain skin integrity and prevention of infection. During a review of Resident 1's admission Record (AR), the AR indicated the facility originally admitted Resident 1 on 5/15/2023 and readmitted her on 7/3/2023 with diagnoses that include dementia (A group of thinking and social symptoms that interferes with daily functioning) and difficulty in walking. During a review of a Minimum Data Set (MDS, a resident assessment tool), dated 4/24/2025, indicated Resident 1 had severely impaired cognition (ability to understand and make decisions) and memory. The MDS indicated Resident 1 required setup or clean-up assistance with eating, partial/moderate assistance with oral hygiene and personal hygiene, substantial/maximal assistance with chair/bed-to-chair transfer and was dependent with toileting hygiene and shower/bathe self. During a review of the undated facility's Shower Schedule, the Schedule indicated Resident 1 was scheduled to receive showers every Mondays and Thursdays. During an interview on 7/3/2025 at 9:35 AM with RP 1, RP 1 stated Resident 1 had multiple skin peeling spots on her lower abdominal area, extending to her vaginal area, but the staff did not inform RP 1 about Resident 1's skin peeling until RP 1requested an unnamed staff to assess Resident 1 and show him Resident 1's peeling skin. RP 1 stated the staff did not address Resident 1's skin issue properly and did not communicate the skin issue with the RP timely. RP 1 stated he was very concerned about the inadequate care Resident 1 received from the facility. During an interview on 7/3/2025 at 11:05 AM with Certified Nursing Assistant (CNA) 1, CNA 1 stated she noticed Resident 1's skin breakdown while showering Resident 1 on 6/26/25. CNA1 stated Resident 1's lower abdomen and between the skin folds, looked like wrinkled skin. CNA 1 stated she reported the abnormal skin condition to the Treatment Nurse (TXN) on 6/26/25 and the TXN applied a cream to help healing on 6/26/2025. CNA 1 stated she did not know if the TXN reported Resident 1's abnormal skin condition to RP 1 on 6/26/2025. During an interview on 7/3/2025 at 11:47 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he was not informed about any skin issues regarding Resident 1. During a concurrent interview and record review on 7/3/2025 at 12:13 PM with the TXN, Resident 1's Progress Notes, dated from 5/5/2025 to 6/30/2025, and Resident 1's Change in Condition Evaluation (COC), dated from 6/25/2025 to 6/30/2025, were reviewed. The TXN stated CNA 1 informed her and when TXN assessed Resident 1 on 6/26/25, there were two redness spots on Resident 1 abdomen, between the skin folds. The TXN stated she applied Zinc Oxide cream (treats or prevents skin irritation) to the reddened area on Resident 1 to promote healing on 6/26/2025 and 6/27/2025. The TXN stated she did not document the redness of skin on the COC or Progress Notes, and she did not report Resident 1's skin redness to the physician and RP 1 on 6/26/2025. The TXN stated she did not document the redness because she thought the redness was caused by the heat due to the hot weather recently and and that the skin redness would go away in one to two days. The TXN stated there was no order obtained to apply Zinc Oxide to Resident 1. During an interview on 7/3/2025 at 1:11 AM with CNA 2, CNA 2 stated she noticed there was a discoloration on Resident 1's skin on the lower abdomen between the skin folds and Resident 1 complained of itchiness to that area on 6/27/2025. CNA 2 stated she did not know when Resident 1 developed the discoloration. CNA 2 stated she reported the skin condition to LVN 1 and the TXN, then, the TXN applied a cream to the discoloration area. CNA 2 stated she was not sure if RP 1 was aware of the discoloration. During an interview on 7/3/2025 at 3:05 PM with the Director of Nursing (DON), the DON stated the nurses should document the redness of Resident 1's skin, and report to the changes to the physician and the RP. The DON stated the physician must be notified so that Resident 1's skin condition could be identified, and to promote an early intervention to prevent Resident 1's skin condition from becoming worse. The DON stated it was important to communicate with the RP, so the RP was informed about the residents' condition. During a review of the undated facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, the P&P indicated Our facility promptly notifies the resident, his or her attending physician, and the resident's medical/mental condition and/or status. The P&P also indicated The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review, the facility failed to ensure one of five sampled residents (Resident 1)'s was provided with a safe and functional wheelchair with brakes that prevented the wheelchair from moving when activated. This deficient practice had the potential to result in falls or injuries for Resident 1 f during transfers and while stationary. During a review of Resident 1's admission Record (AR), the AR indicated the facility originally admitted Resident 1 on 5/15/2023 and readmitted her on 7/3/2023 with diagnoses that include dementia (A group of thinking and social symptoms that interferes with daily functioning) and difficulty in walking. During a review of a Minimum Data Set (MDS, a resident assessment tool), dated 4/24/2025, indicated Resident 1 had severely impaired cognition (ability to understand and make decisions) and memory. The MDS indicated Resident 1 required setup or clean-up assistance with eating, partial/moderate assistance with oral hygiene and personal hygiene, substantial/maximal assistance with chair/bed-to-chair transfer and was dependent with toileting hygiene and shower/bathe self. During an interview on 7/3/2025 at 9:30 AM with the Responsible Party (RP) 1, RP 1 stated the brakes on Resident 1's wheelchair had not been working for a long time and that facility staff never fixed Resident 1's wheelchair brakes. During a concurrent observation and interview on 7/3/2025 at 10:43 AM with Restorative Nursing Assistant (RNA) 1, a wheelchair labeled with Resident 1's name was next to Resident 1's bed. When RNA 1 pushed down both brake handles of the wheelchair to lock the wheelchair, the left brake became loose and was unable to lock the left wheel tightly. RNA 1 stated this wheelchair belonged to Resident 1 and Resident 1 used this wheelchair everyday for her activities and transfers. RNA 1 stated the left brake of Resident 1's wheelchair was not working properly, and she did not know for how long the brake had been malfunctioning. RNA 1 stated if the wheelchair brakes could not stop Resident 1 wheelchair securely, the brake malfunction could lead to a fall while Resident 1 was seated in the wheelchair and/or an injury during transfers since Resident 1's wheelchair could not be locked in place. During an interview on 7/3/2025 at 11 AM with Certified Nursing Assistant (CNA) 1, CNA 1 stated she noticed the left brake of Resident 1's brake could not lock the wheel, and that CNA1 reported Resident 1's wheelchair brakes to the Maintenance Supervisor (MS) and Maintenance Supervisor Assistant (MSA) on 6/26/2025. CNA 1 stated Resident 1 used the wheelchair for transfers to move around the facility, and that Resident 1 would sit in the wheelchair everyday. CNA 1 stated it was important to have a functional brake for the wheelchair to prevent falls and injury to the resident. During a concurrent interview and record review on 7/3/2025 11:36 AM with the MSA, Maintenance Request Log, dated from 4/12/2025 to 7/3/2025, was reviewed. The MSA stated he did not know the brake of Resident 1's wheelchair was not functioning properly until today and that the staff did not inform MSA about it last week, and there was no documentation indicating any request to repair Resident 1's wheelchair for the past three months. During an interview on 7/3/2025 at 3:07 PM with the Director of Nursing (DON), the DON stated he was not informed that the brake of Resident 1's wheelchair was not working properly, and that a nonfunctioning wheelchair break could place the resident at risk for fall and injuries during transfers around the facility, and when Resident 1 was sitting in the wheelchair. The DON stated the staff should notify the maintenance staff immediately for any malfunction of the equipment to prevent accidents. During an interview on 7/3/2025 at 4:03 PM with the MS, the MS stated he had not received any report on Resident 1's wheelchair was not working properly until today. During a review of the undated facility's policy and procedure (P&P) titled, Assistvie Device and Equipment, the P&P indicated devices and equipment are maintained on schedule and according to manufacturer's instructions, and defective or worn devices are discarded or repaired.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document medications administered for three of five sampled residents (Resident 1, 3, and 4) onto the Medication Administration Record (MAR) on 6/15/2025 during the 3 PM to 11 PM. This deficient practice had the potential to result in medication errors for Resident 1, 3 and 4 and negatively impact the delivery of services for the residents. 1.During a review of Resident 1's admission Record (AR), the AR indicated the facility originally admitted Resident 1 on 5/15/2023 and readmitted her on 7/3/2023 with diagnoses that include dementia (A group of thinking and social symptoms that interferes with daily functioning) and seizure (a sudden, uncontrolled surge of electrical activity in the brain that can cause changes in behavior, movements, sensations, or levels of awareness). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 4/24/2025, indicated Resident 1 had severely impaired cognition (ability to understand and make decisions) and memory. The MDS indicated Resident 1 required setup or clean-up assistance with eating, partial/moderate assistance with oral hygiene and personal hygiene, substantial/maximal assistance with chair/bed-to-chair transfer, and was dependent with toileting hygiene and shower/bathe self. During a review of Resident 1's Order Summary Report, dated 7/3/2025, the Report indicated the following physician's orders: a. Atorvastatin Calcium (a medication to treat high cholesterol [fatty particles in the blood]) Oral Tablet 80 milligram (MG, a unit of measurement) one tablet by mouth at bedtime, starting on 10/27/2025 b. Gabapentin (a medication to treat seizure and nerve pain) Oral Capsule 100 MG one capsule by mouth two times a day, starting on 10/28/2025 c. Levetiracetam (a medication to treat seizure) 500 MG two tablet by mouth two times a day, starting on 10/28/2025 d. Lactulose 20 gram (GM, a unit of measurement)/milliliter (ML, a unit of measurement) 30 ML by mouth three times a day, starting on 6/12/2025 2.During a review of Resident 3's AR, the AR indicated the facility originally admitted Resident 3 on 6/10/2015 and readmitted on [DATE] with diagnoses that include hypertension (high blood pressure) and hyperlipidemia (high fatty particles in the blood). During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had intact cognition and memory. The MDS indicated Resident 3 required setup or clean-up assistance with eating and oral hygiene, supervision or touching assistance with toileting hygiene, shower/bathe self and personal hygiene, and partial/moderate assistance with chair/bed-to-chair transfer. During a review of Resident 3's Order Summary Report, dated 7/3/2025, the Report indicated the following physician's orders: a. Atorvastatin Calcium 20 MG one tablet by mouth at bedtime, starting on 11/18/2020 b. Latanoprost (a medication used to treat high pressure inside the eye) Solution 0.005% instill one drop in both eyes at bedtime, starting on 4/22/2021 c. Timolol Maleate (a medication used to treat high pressure inside the eye) Solution 0.5% instill one drop in both eyes at bedtime, starting on 4/22/2021 d. Carvedilol (a medication to treat high blood pressure) 25 MG one tablet by mouth two times a day, starting on 10/28/2021 e. Calcium Acetate (a medication to lower high phosphate (a chemical) level in body) 667 MG one tablet by mouth with meals, starting on 3/6/2024 f. Renvela (a medication used to manage high blood phosphate levels in the body) 800 MG one tablet by mouth with meals, starting on 11/3/2023 g. Retaine Carboxymethylcelliulose (a medication to relieve dry, scratchy and irritated eyes) Solution 0.5% instill one drop in both eyes four times a day, starting on 9/26/2022 3.During a review of Resident 4's AR, the AR indicated the facility originally admitted Resident 4 on 1/4/2025 and readmitted on [DATE] with diagnoses that include hyperlipidemia and cerebral infarction (a condition where part of the brain tissue dies due to a lack of blood supply). During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 had moderately impaired cognition and memory. The MDS indicated Resident 4 required setup or clean-up assistance with eating, partial/moderate assistance with oral hygiene, toileting hygiene, personal hygiene and chair/bed-to-chair transfer, and substantial/maximal assistance with shower/bathe self. During a review of Resident 4's Order Summary Report, dated 7/3/2025, the report indicated the following physician's orders: a.Atorvastatin Calcium 40 MG one tablet by mouth at bedtime, starting on 1/4/2025 b.PreserVision AREDS (a medication promote eye health) one capsule by mouth at bedtime, starting on 5/24/2025 c. Senna (a medication used to promote bowel movement) 8.6 MG one tablet by mouth at bedtime, starting on 1/27/2025 d. Amantadine hydrochloric acid (a medication to help manage symptoms like stiffness, tremors, shaking, and repetitive muscle movements) 100 MG one capsule by mouth two times a day, starting on 1/5/2025 e. Chlorhexidine Gluconate (a mouthwash commonly used to treat red and swollen gums) mouth/throat solution 0.12% 15 ML by mouth, do not swallow, rinse and spit, two times a

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview and record review, the facility failed to provide a sanitary environment for one of the five sampled residents (Resident 2) by not ensuring the wheelchair for Resident 2 was clean. This deficient practice had the potential to result in Resident 2' discomfort and the spread of infection. During a review of Resident 2's admission Record (AR), the AR indicated the facility originally admitted Resident 2 on 12/17/2018 and readmitted her on 1/15/2019 with diagnoses that include Alzheimer's Disease (a progressive brain disorder that gradually destroys memory and thinking skills) and hypertension (high blood pressure). During a review of a Minimum Data Set (MDS, a resident assessment tool), dated 6/3/2025, indicated Resident 2 had severely impaired cognitive (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 2 required supervision or touching assistance with eating, substantial/maximal assistance with oral hygiene and personal hygiene, was dependent with chair/bed-to-chair transfer, toileting hygiene and shower/bathe self. During a concurrent observation and interview on 7/3/2025 at 10:41 AM with Restorative Nursing Assistant (RNA) 1, in Resident 2's room, a wheelchair was observed next to Resident 2's bed. RNA 1 stated there were food particles to the right side of Resident 2's wheelchair. RNA 1 stated Resident 2 did not have her own wheelchair, so the facility used the shared wheelchair for residents to move Resident 2 from the room to the activity room. RNA 1 stated the staff who used the same wheelchair to transfer another resident had not cleaned or disinfect the wheelchair after use. RNA 1 stated the staff should clean and disinfect the wheelchair before and after each use to ensure the equipment was clean for the residents. During an interview on 7/3/2025 at 3:54 PM with the Infection Preventionist (IP), the IP stated the staff should clean and disinfect the wheelchair with the disinfectant wipes before and after each use to provide a sanitary environment for the residents and to prevent infection. During a review of the undated facility's policy and procedure (P&P) titled, Cleaning and Disinfection of Resident-Care Items and Equipment, the P&P indicated reusable items are cleaned and disinfected or sterilized between residents (e.g. stethoscopes, durable medical equipment) and single resident-use items are cleaned/disinfected between uses by a single resident.