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	09/22/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 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 observation, interview, and record review, the facility failed to ensure a resident specific care plan was initiated for one of three sampled resident (Resident 1), when Resident 1 verbalized feelings of being upset, angry and threatened during an incident that occurred on 9/7/25 after Responsible Party 1 told Resident 1 to lower the telephone volume. This deficient practice had the potential to result in Resident 1 not being monitored adequately by facility staff and not meeting Resident 1's specific needs.During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] , with a diagnosis of End Stage Renal Disease (ESRD - the kidneys can no longer filter waste and extra fluid from the blood the way they should) and dependence on renal dialysis (a process that uses a machine to clean the blood and remove extra fluid in order to stay alive). During a review of Resident 1's History and Physical (H&P), dated 3/21/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 07/10/2025, indicated the resident is cognitively intact (fully alert, oriented, and able to make decisions and participate in care planning) requiring verbal cues and /or touching/ steadying and/ or contact guard assistance for most activities of daily living such as personal hygiene and dressing. During a review of Resident 2's AR, the AR indicated the resident was admitted on [DATE] with diagnoses that included but not limited to Acute systolic congestive heart failure (the heart is weaker than normal and can't pump blood as well as the body needs, because the heart isn't pumping strongly, blood and fluid can back up into the lungs, feet, ankles, or abdomen). During a review of Resident 2's MDS, dated [DATE], the MDS indicated the resident has sever cognitive impairment (having sever loss of ability to think, remember, and may not be able to recall words, or answer basic questions) and requires moderate assistance - helper does more than half the effort with personal hygiene activities. During a review of the facility provided document titled Grievance/Complaint Report Form, dated 9/8/25, the Form indicated that Resident 1 felt threatened and intimidated from Resident 2's Responsible Party (RP) 1, after Resident 1 did not lower the volume on her phone. During a review of Resident 1's Social Service Note, dated 9/10/2025 at 6 PM, the Note indicated facility staff would conduct frequent observations in Resident 1's room to ensure Resident 1's comfort and reinforce Resident 1's sense of safety. There was not indication on how frequent staff would perform the observations. During an interview on 9/22/2025 at 9:07AM with Resident 1, Resident 1 stated RP 1 had complained about her personal phone being too loud , and RP 1 demanded Resident 1 to lower the phone volume, or RP 1 would call the police. Resident 1 stated RP 1's voice was loud and threatening which made Resident 1 feel scared . Resident 1 stated the incident left her feeling upset, mad, and uncomfortable. Resident 1 stated I feel like I have no privacy since RP 1 was always in the room. During an interview on 9/22/25 at 9:57 AM with the Social Worker (SW), SW stated after Resident 1 verbalized the incident to the SW, the interventions that were implemented was that a wellness check was provided for three days. The SW stated facility staff were to conduct ongoing checks to ensure Resident 1 felt safe. During a concurrent interview and record review on 9/22/2025 at 12:51PM with the Director of Nursing (DON), Resident 1's care plans were reviewed. DON stated, there was no care plan that was initiated for Resident 1 regarding the incident of RP 1 telling Resident 1 to lower the phone volume. The DON stated a care plan should have been initiated for the incident, however the DON stated that this incident was different, and we were not sure how to handle this. The DON stated creating a care plan would ensure interventions were followed, so facility staff knew to monitor Resident 1 when RP 1 was visiting Resident 2. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 2002, indicates a comprehensive , person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional need is developed and implemented for each resident . A comprehensive, person-centered care plan is developed within seven (7) days after a significant change in status with care plan interventions chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.