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	11/13/2025

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to notify the medical doctor (MD 1) of clinical issues for one of two sampled residents (Resident 1) when Registered Nurse (RN) 2 and RN 3 did not inform MD 1 when they were unable to initiate an intravenous (IV) line (a thin, flexible tube inserted into a vein to deliver fluids, medications, blood, or nutrition directly into the bloodstream) and were therefore unable to administer Dextrose (sugar) 5% in Water (D5W - a fluid used to provide hydration through an IV line) ordered by MD 1 on 10/31/2025 for hydration. These failures had the potential to result in serious harm, including cardiac arrhythmias (when the heart beats too fast, too slow, or in an uneven way), worsening of Resident 1's condition, or death due to untreated low potassium levels and delayed fluid therapy. (Cross Reference F684)During a review of Resident 1's History and Physical (H&P) from the General Acute Care Hospital (GACH), dated 10/9/2025, timed at 11:20 PM, the H&P indicated that Resident 1 presented to the GACH's emergency department (ED) with persistent nausea and vomiting. During a review of Resident 1's Speech-Language Pathology Evaluation (SLP) from GACH, dated 10/17/2025, timed at 12:09 PM, the SLP indicated that Resident 1 exhibited nausea and vomiting while on a diet of clear liquid (a diet that consists of only clear liquids). The SLP indicated that during the evaluation, only a clear liquid diet was attempted due to the resident exhibiting nausea and vomiting. The SLP further indicated that during the cognitive evaluation, the resident had impaired cognitive function with deficits in orientation (a person's awareness of their surroundings), memory, insight, processing speed, and attention. During a review of Resident 1's Nutrition Reassessment (NR) from GACH, dated 10/20/2025, timed at 10:51 AM, the NR indicated a recommendation to start the resident on Glucerna oral nutrition supplement. The NR also indicated a plan to monitor Resident 1's oral intake, weight, labs, gastrointestinal function, and skin integrity. The NR further indicated a plan to monitor Resident 1's tolerance to the resident's diet. The NR indicated an added goal for Resident 1 to achieve and maintain oral intake of more than 75% of meals. The NR further indicated that Resident 1's Nutritional Risk Level was high. During a review of Resident 1's admission Record, the record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus (a disease characterized by high blood sugar levels), Fatty Liver disease (condition where an excessive amount of fat accumulates in the liver), Acute Kidney Failure (significant decline in kidney function that leads to the body's inability to effectively remove waste products, regulate fluids, and maintain electrolyte balance), hypertension (HTN, a condition where the force of your blood pushing against the walls of your arteries is consistently too high), and Cardiomegaly (an enlarged heart). During a review of Resident 1's History and Physical (H&P) from the facility, dated 10/21/2025, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. A review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 10/22/2025, indicated Resident 1 had moderately impaired cognition (the ability to process thoughts) and was dependent (helper does all of the effort) on activities such as eating, bathing/showering, toileting, and personal hygiene. During a review of Resident 1's doctor Progress Notes (PN), dated 10/30/2025, the Notes indicated that Resident 1 was observed resting in bed, drowsy, and sleepy. The Notes also indicated that Resident 1 had dry, peeling skin, dry mucosa (lining of mucous membranes such as the inside the mouth). The Notes also indicated that Resident 1 had diffuse anasarca (a condition in which a person has swelling all over the body that can be caused by underlying conditions such as the inability of the heart to pump blood effectively throughout the body or heart failure, kidney disease, and conditions related to low protein and albumin) and had +2 edema (swelling) (a +2 swelling indicates that when a healthcare provider presses on the swollen area for a few seconds, the indentation measures up to 4 millimeters in depth and lasts for up to 15 seconds). The Notes also indicated a plan for lab and skin care. During a review of Resident 1's doctor's orders for the month of October 2025, the orders included a Basic Metabolic Panel (BMP- a blood test, which measures glucose, electrolytes such as sodium and potassium, and kidney function), dated 10/30/2025, and confirmed by RN 2. During a review of Resident 1's Lab Results received from the Laboratory Facility (LF), dated 10/31/2025, the LF indicated that a nurse from the facility confirmed the receipt of the critical lab result on 10/31/2025 at 1:57 pm. The lab results indicated Resident 1's blood sodium (an electrolyte that helps control fluid balance, muscles, and nerves) level was 158 mEq/L (milliequivalents per liter- a unit used to measure the amount of an electrolyte in blood or fluid; normal range 135-145 mEq/L), chloride (an electrolyte that helps keep fluid balance, supports muscles, and digestion) level was 120 mEq/L (normal range: 90-109

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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 0684 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 interviews and record reviews, the facility failed to provide care in accordance with professional standards of practice for one of two residents sampled for quality of care (Resident 1) when:1. Licensed Vocational Nurse (LVN) 1 did not notify Resident 1's medical doctor (Medical Doctor [MD] 1) or assess Resident 1 for a change in condition when LVN 1 was informed of Resident 1's low blood potassium (an electrolyte that is essential to the normal functioning of muscles such as the heart) level of 2.7 mEq/L (milliequivalent per liter- a unit of measure; normal levels between 3.5 to 5.2 mEq/L) on [DATE] from 1:57 pm to 5:00 pm.2. LVN 2 and Registered Nurse (RN) 2 did not administer Resident 1's Potassium 40 mEq (milliequivalent- a measure of chemical concentration used in medicine) that was ordered by MD 1 in response to the resident's low blood potassium level on [DATE], as soon as the medication was made available in the facility's emergency drug kit (e-kit- a kit that contains essential medications that may be needed urgently before a pharmacy can deliver them).3. The facility did not administer Resident 1's Dextrose (sugar) 5% in Water ([D5W]- a fluid that is used to provide hydration to patients intravenously [IV- in the vein]) as ordered by MD 1 on [DATE] for hydration.4. The facility failed to increase Resident 1's assessments for possible complications of low potassium levels (hypokalemia) from [DATE] at 5:00 pm to [DATE] at 4:50 am.This deficient practice had the potential to result in serious harm, including cardiac arrhythmias (when the heart beats too fast, too slow, or in an uneven way) or death, due to failing to promptly address Resident 1's low potassium level and dehydration.During a review of Resident 1's History and Physical (H&P) from the General Acute Care Hospital (GACH), dated [DATE], timed at 11:20 PM, the H&P indicated that Resident 1 presented to the GACH's emergency department (ED) with persistent nausea and vomiting. The H&P also indicated that Resident 1's heart rate was 117 beats per minute which is above the normal range of 60 to 100 bpm. The H&P indicated abnormal laboratory results including creatinine (a waste product produced by muscle metabolism and marker for kidney disease, with normal ranges of 0.5 to 1.1) level of 1.29, a potassium (an electrolyte that is essential to the normal functioning of muscles such as the heart, with normal levels between 3.5 to 5.2 mEq/L) level of 3.3 mEq/L, and an alkaline phosphatase (a blood test that is used by clinicians to identify diseases, with normal levels between 35 to 104) level of 281. The H&P indicated Resident 1 had a potassium level of 3.3 mEq/L on [DATE] and a potassium level of 3.0 on [DATE]. The H&P further indicated that Resident 1 had a diagnosis of hypokalemia and the treatment plan included potassium replacement as needed. During a review of Resident 1's History and Physical (H&P) from General Acute Care Hospital (GACH), dated [DATE], timed at 2:31 PM, the H&P indicated that the resident possibly had a thrombus (a blood clot) in the left intrahepatic (in the liver) branches of the portal vein (a blood vessel that connects to the liver) that was noted on the resident's CT Scan (computed tomography scan- a medical imagining technique used to create images of the body) from [DATE]. The H&P included a suggestion by the doctor for either a CT scan or MRI Scan (magnetic resonance imaging- a medical imagining technique that uses strong magnetic field to create detailed images of the organs and soft tissues). The H&P also indicated that a follow-up colonoscopy (a procedure in which a camera is used to visually inspect the colon) should be considered for Resident 1. During a review of Resident 1's Speech-Language Pathology Evaluation (SLP) from GACH, dated [DATE], timed at 12:09 PM, the SLP indicated that Resident 1 exhibited nausea and vomiting while on a diet of clear liquid (a diet that consists of only clear liquids). The SLP indicated that during the evaluation, only a clear liquid diet was attempted due to the resident exhibiting nausea and vomiting. The SLP further indicated that during the cognitive evaluation, the resident had impaired cognitive function with deficits in orientation (a person's awareness of their surroundings), memory, insight, processing speed, and attention. During a review of Resident 1's Nutrition Reassessment (NR) from GACH, dated [DATE], timed at 10:51 AM, the NR indicated a recommendation to start the resident on Glucerna oral nutrition supplement. The NR also indicated a plan to monitor Resident 1's oral intake, weight, labs, gastrointestinal function, and skin integrity. The NR further indicated a plan to monitor Resident 1's tolerance to the resident's diet. The NR also included lab values for Resident 1's potassium on [DATE] at 3.9 mEq/L and on [DATE] at 3.5 mEq/L. The NR indicated an added goal for Resident 1 to achieve and maintain oral intake of more than 75% of meals. The NR further indicated that Resident 1's Nutritional Risk Level was high. During a review of Resident 1's admission Record, the record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus (a disease characterized by high blood