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	01/22/2026

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure effective pain management was provided for one out of three sample residents (Resident 1) by failing to: Re-evaluate the effectiveness of nonpharmacological interventions (non-chemical, and non-invasive health interventions that treat conditions without medication).Ensure Resident 1 received pain medications as ordered. This deficient practice had the potential to result in unmanaged pain which could delay recovery, decrease mobility, and reduce the quality of life. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis of displaced fracture of anterior process of right calcaneus(break in the front part of right heel bone that has moved out of place) , fracture of right talus (broken right ankle bone) , fracture of scaphoid of right foot (a small broken bone in right foot) and dislocation of tarsometatarsal joint (displacement of middle foot bones connected to the long foot bones or toes) of right foot . During a review of Resident 1's History and Physical (H&P) dated 12/10/2025, 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 12/13/2025, the MDS Resident 1 had pain present occasionally. During a review of Resident 1's Order Summary Report, dated 12/09/2025, the Report indicated to monitor for pain level on a pain scale (a tool used by healthcare professionals to objectively measure and quantify a patient's subjective experience of pain intensity. It typically uses a 0 to 10 scale (0 = no pain, 10 = worst possible pain) every shift. During a review of Resident 1's Order Summary Report, dated 12/09/2025, the Report indicated for non- prescription behavioral interventions to be done every shift, and to document if interventions were effective or not as indicated by a yes or no. During a review of Resident 1's Order Summary Report, dated 12/09/2025, the Report indicated an order for Lyrica (medication used for Nerve pain) 100 milligrams (mg a unit of measurement) oral tablet for severe pain (7-10 on pain scale) as needed (PRN). During a review of Resident 1's Order Summary Report, dated 12/09/2025, the Report indicated an order for Tramadol (medication used for moderate to moderately severe pain) 50 mg oral tablet for moderate pain (4-6 on pain scale) two times a day PRN. During a review of Resident 1's Order Summary Report, dated 12/09/2025, the Report indicated an order for Tylenol (medication used for mild to moderate pain and fever) 325mg oral tablet for mild pain (1-3 on pain scale) two times a day PRN. During a review of Resident 1's Care Plan (CP) titled the resident has fracture related to displaced avulsion chip of right talus (a fracture where a ligament or tendon pulls a small piece of bone away from the talus in the ankle, causing it to shift), displaced fracture of navicular right foot (a serious, often high-energy, injury where the boat-shaped, midfoot bone breaks and separates, risking chronic pain), dislocation of tarsometarsal joint (involves the disruption of ligaments and bones in the midfoot), and dislocation of right ankle (a serious injury where the ankle bones (tibia, fibula, talus) are forced out of alignment, causing severe pain, swelling, deformity, and inability to (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

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	01/22/2026

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bear weight, requiring immediate medical attention to prevent nerve/blood vessel damage, often treated with pain relief), initiated on 12/26/2025, the CP indicated interventions for monitoring and documenting any signs or symptoms of hip fracture complications such as pain. The CP intervention indicated to administer medications as ordered and monitor and document effectiveness. During a review of Resident 1's Care Plan for at Risk for Pain related to disease process, revised on 1/22/26, the Care Plan indicated interventions to administer medications as ordered, to assess the intensity of the pain, to evaluate effectiveness of pain interventions, and to monitor for pain characteristics and side effects. During a review of Resident 1's Medication Administration Record (MAR) for the month of January 2026, the MAR indicated to monitor for pain level on a pain scale (0-10) every shift. The MAR indicated during the 7 AM to 3 PM shift on 1/7/2026, Resident 1's pain level was documented as an 8 out of 10 pain. The MAR indicated only non-pharmacological interventions were performed by licensed vocational nurse (LVN) 2 by using reassurance and diversion. There was no medication administered for Resident 1's 8/10 pain and there was no reevaluation of effectiveness for the non-pharmacological interventions conducted. During an interview on 1/22/2026 at 11:06 AM with Resident 1, Resident 1 experiencing ongoing right ankle pain and swelling. Resident 1 stated he would report being in pain to nursing staff, but the nursing staff did not provide any medication to address Resident 1's pain. During an interview on 1/22/2026 at 11:56AM with LVN 2, LVN 2 stated never being informed of Resident 1 experiencing any pain. LVN 2 further stated it was the treatment nurse who monitored if the resident was having pain. During an interview on 1/22/2026 At 1:30 PM with Resident 1, Resident 1 stated when he reports experiencing pain to nursing staff, pain medications were not administered. Resident 1 stated he felt that his pain was not being addressed 'seriously' by facility staff. During a concurrent interview and record review on 1/22/2026 at 1:36 PM with Registered Nurse Supervisor (RN1), Resident 1's MAR from December 2025 to January 2026 was reviewed. The MAR indicated on 1/7/2026 during the 7 AM to 3 PM shift, Resident 1 reported an 8 out of 10 pain with no pain medication documented as being administered on 1/7/2026. RN1 stated no pharmacological intervention was provided. RN1 further stated no reevaluation was documented. During a concurrent interview and record review on 1/22/2026 at 2:29 PM with LVN 2, Resident 1's MAR dated 1/7/2026 was reviewed. The MAR indicated nonpharmacological interventions of redirection and diversion along with verbal cues and reassuring were provided without being reevaluated for effectiveness for a pain level reported of 8 out of 10. LVN 2 stated on 1/7/2026 at 10:58 AM she provided Resident 1 with non-pharmacological intervention since that was always the first step when a resident reported pain prior to administering any pain medications. LVN 2 stated she had not documented that the nonpharmacological interventions were effective. During a concurrent interview and record review on 1/22/2026 at 3:01 PM with RN1, Resident 1's MAR for January 2026 was reviewed. The MAR indicated no reassessment had been completed for nonpharmacological intervention conducted on 1/7/2026. RN1 stated if pain was not properly assessed, treated or monitored, the resident may experience unrelieved physical pain and suffering and could experience a change of condition. RN1 further stated that Resident 1 should have received pain medication, such as Tramadol which was ordered for pain levels from 7-10. RN 1 stated pain medications should have been administered. During a concurrent interview and record review on 1/22/2026 at 3:14 PM with the Director of Nursing (DON) Resident 1's MAR for January 2026 was reviewed. The MAR indicated, on 1/7/2026, for the 7 AM to 3 PM shift, no reevaluation for nonpharmacological interventions was conducted. The DON stated if Resident 1 still had pain after the nonpharmacological intervention was done, Resident 1 should have been administered pain medications. The DON further stated not managing Resident 1's pain effectively could result in the resident feeling increased anxiety and continued pain (continued on next page)

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	01/22/2026

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	without relief. During an interview on 1/22/2026 at 3:54 PM with Resident 1, Resident 1 stated he would like to receive pain medications for pain rather than nonpharmacological interventions, since non-pharmacological interventions did not relieve his pain. Resident 1 stated he would like for pain medications to be administered when Resident 1 complained of pain, and that no one cares about my pain. During a review of the facility's policy and procedure (P&P) titled, Pain Assessment and Management, dated October, 2022, the P&P indicated, the pain management program is based on a facility - wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management further indicating pain management is a multidisciplinary care process that includes monitoring for the effectiveness of interventions.