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	05/19/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure care and services were provided to one of two sampled residents (Resident 1) as ordered by the physician by failing to: 1. Document Resident 1's high blood pressure (when the force of the blood pushing against the artery walls is too high) on 5/17/20262. Notify the physician of Resident 1's high blood pressure This deficient practice had the potential to delay assessment and treatment of uncontrolled hypertension Findings: During a review of Resident 1's admission Record (AR), the AR indicated the resident was originally admitted to the facility on [DATE], with diagnoses that included quadriplegia (partial or total paralysis of all four limbs (both arms and both legs) and the torso), atrial fibrillation (irregular heartbeat). During a review of Resident 1's History and Physical (H&P), dated 5/7/2025, the H&P indicated Resident 1 has the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/08/2026, the MDS indicated Resident 1is dependent (helper does all the effort. Resident does none of the effort to complete the activity) for toileting, shower, upper and lower body dressing and putting on and taking off footwear. The MDS further indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) for personal hygiene. During a review of Resident 1's Care plan for altered cardiovascular status at risk for hypertension/hypotension related to hypertension initiated on 4/07/2026, the care plan indicated to monitor vital signs as ordered, notify MD of significant abnormalities. Resident 1's care plan further indicated to monitor, document, report to MD as needed any signs and symptoms of malignant (very high blood pressure that comes on suddenly and quickly): headache, visual problems, confusion, disorientation, lethargy, nausea . During a review of Resident 1's Progress notes dated from 5/15/2026 to 5/18/206, the Notes did not indicate Resident 1's elevated blood pressure of 175/105, MD notification or monitoring for elevated blood pressure. During a review of Resident 1's Progress noted dated 5/18/2026 timed at 6:25 PM written by the Director of Nursing (DON), the note indicated Resident complained about care received on 5/17/2026. The Noted indicated Resident 1 stated he went to the nursing station around 4 PM because he did not feel good and asked why his call light was not answered and licensed vocational nurse (LVN) 2 was seated at the nurses' station. LVN 2 stated she was not on duty, and LVN 1 was walking back to the nurse's station. LVN 1 then went to address Resident 1's concerns. During an interview on 5/19/2026 at 1:53 PM with LVN 1, LVN 1 stated around 3:40 PM she was in a Residents room when she heard an overhead page asking for Resident 1's nurse to go to Resident 1's room. LVN 1 stated she was in the middle of passing medication and was unable to go to Resident 1's room right away. LVN 1 stated about 15 minutes later she was still passing medication and heard an over head page asking for Resident 1's nurse to go to Resident 1's room, LVN 1 stated she did not stop medication pass to go to Resident 1's room because she assumed another nurse would assist Resident 1 since it was the second time they were paging . LVN 1 stated once she finished passing medication she went towards Resident 1's room to see if he had been helped when she saw him in his wheelchair going towards the nursing station. LVN 1 stated she observed 3 licensed nurses sitting at the nurse's station then observed Resident 1 telling them he had been waiting for help because he wasn't feeling well and no one came to help him. LVN 1 (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she then assisted Resident 1 back to his room and Resident 1 told her he was not feeling well and asked her if he could check his BP. LVN 1 stated she checked Resident 1's BP and it was 178/105 and she asked Resident 1 if he was feeling ok to which Resident responded he was upset and not feeling well then proceeded to ask her to give him his medication for his Angina (chest pain or discomfort that happens when your heart muscle doesn't get enough oxygen-rich blood) diagnosis. LVN 1 stated she administered Resident 1's medication and then returned one hour later to re-check Resident 1BP and it had returned to Resident 1's baseline. During an interview on 5/19/2026 at 2:31 PM with Resident 1, Resident 1 stated on Sunday. 5/17/2026 in the afternoon he was not feeling well and pressed the call light to ask for help. Resident 1 stated no one came to help him, so he decided to call the facility phone and told the nurse who answered he had pressed his call light because he was not feeling well and needed help. Resident 1 stated he heard them overhead page 2 times, but no one came to help him. Resident 1 stated he could hear the nurses sitting at the nursing station talking. Resident 1 stated his head was hurting and felt like it was pounding in pain, so he decided to go to the nursing station himself to ask for help since no one was coming to help him. Resident 1 stated when he got to the nurse's station, he saw 3 nurses sitting there talking and that's when his assigned nurse LVN 1 came out of another patient's room to ask if he still needed help. Resident 1 stated his nurse LVN 1 helped him back to his room and took his BP which was 178/105. Resident 1 started LVN 1 then gave him his medication. Resident 1 stated during the time he was calling for help he felt his heart racing, his head was hurting and terrified because he could hear the nurse talking and laughing in the nurse's station while he was calling for help and no one would come to help him. During a concurrent interview and record review on 5/19/2026 at 4:08 PM with LVN 1, Resident 1's records were reviewed. LVN 1 stated she forgot to document Resident 1's elevated BP on 5/17/2026. LVN 1 stated she did not notify Resident 1's physician (MD) of Resident 1's elevated BP because she assumed it was high because Resident 1 was upset. LVN 1 stated Resident 1's usual BP was low, and she had never seen it that high before. LVN 1 stated she should have made a progress note of Resident 1's condition and elevated BP and notified Resident 1's MD but she forgot. During an interview and concurrent record review on 5/19/2026 at 4:50 PM with the DON, DON stated there was no documentation on Resident 1's medical record of an elevated BP on 517/2026. The DON stated LVN 1 should have notified Resident 1's MD of Resident 1's elevated BP and symptoms immediately. DON stated LVN 1 should have documented Resident 1's vitals and assessment in Resident 1's medical record. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status , with a revision date of 2/19/2021, the P&P indicated The nurse will notify the resident's attending physician or physician on call when there has been a(an): significant change in the resident's physical/emotional/mental condition, specific instructions to notify the physician of changes in the resident's condition.