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	06/01/2026

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** Based on interview and record review, the facility failed to identify resident's needs and care for one of four sampled residents (Resident 1) in accordance with the resident's preferences, goals of care and professional standards of practice as indicated on facility's Policy and Procedure (P&P) when, 1)Resident 1 was admitted on [DATE] had Moisture-Associated Skin Damage (MASD- an inflammatory skin condition caused by prolonged exposure to moisture, such as sweat, urine, or wound exudate) in the groin area extended to the gluteal fold and there was no care plan (CP) to care for MASD. Resident 1 was discharged home on 4/21/2026 with MASD in the groin area extended to the gluteal fold. 2)Resident 1 who had history of stage 3 pressure injury (pressure ulcer [PU]- a localized damage to the skin and underlying tissues caused by prolonged, unrelieved pressure, friction or shear forces) and was moderate risk for PU and did not have a weekly skin assessment and updated CP from 3/20/26 to 4/20/2026. These deficient practices resulted in Resident 1 did not receive any assessments and care plan with measurable objectives and timeline to resolving the MASD, potential PU to reoccur, and was discharged with MASD still on the groin site. Findings: During a review of Resident 1's admission record indicated the resident was admitted on [DATE] with diagnoses that include but not limited to hemiplegia and hemiparesis (paralysis, half/partial weakness) affecting left dominant hand, cerebral infarction (the death of tissue caused by a lack of blood supply and oxygen to that area), diabetes (a chronic condition where body either cannot produce enough insulin or cannot effectively use the insulin it makes cause blood sugar too high and led to serious complications) and obesity (too much body fat that increases the risk of other serious health problems). During a review of Minimum Data Set (MDS, a resident assessment tool), dated 2/8/2026, indicated Resident 's cognitive skills (ability to make daily decisions) were intact. The MDS indicated, Resident 1 requires setup and clean-up assistance (helper sets up and cleans up; resident completes activity) with eating, and partial/moderate assistance (helper does less than half the effort) oral hygiene, and dependent (helper does all the effort) with toileting, bathing and dressing. During a review of Resident 1's Order Summary Report (OSR) dated 2/5/2026, the OSR indicated, Resident 1 had a treatment posterior groin extending to gluteal folds for MASD - clean with water and soap pat dry apply A&D ointment and zinc, report to MD if worsening. During a concurrent interview and record review on 6/1/2026 at 12:45 PM with DON (Director of Nursing), Resident 1's EHR-electronic health record dated 2/4/2026 (admission) to 4/21/2026 (discharge) was reviewed. Resident 1's EHR indicated: -Resident 1 was admitted on [DATE] and had a planned discharge on [DATE]. -Resident 1 did not have CP for MASD and updated PU CP. -Resident 1's last weekly skin assessment by skin doctor (SD) and Treatment Nurse (TN) 1 was on 3/20/2026. DON stated, he was not sure why there was no CP for MASD and updated PU care plan, and why there was no weekly skin assessment after 3/20/2026 it was part of our standard of practice. During an interview on 6/1/2026 at 2:25 PM with TN 1, TN 1 stated, he forgot to initiate a care plan for Resident 1's MASD and updated PU care plan. TN1 stated, after Resident 1's left rear thigh PU resolved on 3/17/2026, his last weekly skin assessment was 3/20/2026 and forgot to continue it. TN 1 stated, Resident 1's MASD was just stable but not resolved. During a concurrent interview on 6/1/2026 at 2:27 PM with TN 1, TN 1 stated, (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	Resident 1's care plan for MASD and PU was important so there's a goal for its resolution, and revision of treatment if needed. TN 1 stated, Medical Doctor (MD) was not aware Resident 1's MASD was not resolving. During a concurrent interview on 6/1/2026 at 2:29 PM with TN 1, TN 1 stated, as a standard of care he should have continued Resident 1's weekly skin assessment, and Resident 1 having a history of stage 3 PU, not having a weekly monitoring potentially could result in reoccurrence. During a review of Resident 1's Progress Notes (PN) dated 4/21/2026, the PN indicated, Resident 1 had MASD on groin site extended to gluteal fold upon discharge. During a concurrent interview and record review on 6/1/2026 at 4:40 PM with DON, Resident 1's Braden Scale-for Pressure Ulcer Risk Evaluation dated 2/4/2026 was reviewed. The Braden Scale indicated Resident 1' score was 15 (score of 12 or less indicates high risk / score of 19 or higher indicates low risk). DON stated Resident 1's score of 15 indicated moderate risk to acquire pressure ulcer. During a concurrent interview and record review on 6/1/2026 at 4:41 PM with the DON, Resident 1's Braden Scale-for Pressure Ulcer Risk Evaluation dated 4/17/2026 was reviewed. The Braden Scale indicated Resident 1' score was 14. DON stated Resident 1's score of 14 indicated moderate risk to acquire pressure ulcer. During an interview on 6/1/2026 at 4:42 PM with the DON, DON stated it is the facility's standard of practice and facility's policy, and procedure (P&P) also indicate, assessment, documentation, prevention and CP is required to prevent and heal PU and any skin breakdown. DON stated, Resident 1's MASD is a wound so it should have a care plan and weekly skin assessment to proper monitor if it is getting better or not and address it accordingly. DON stated, not having a care plan and a weekly skin assessment, resulted in Resident 1 not having a measurable objective and timetable in resolving the MASD, also potentially result in the reoccurrence of PU which can negatively affect Resident 1's quality of life. A review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, indicated; a) the comprehensive , person-centered care plan includes measurable objectives and time frames, resident's goals and outcomes, b) assessment of residents are ongoing and care plans are revised as information about the residents and the resident's condition changed. A review of the facility's P&P titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol, dated 4/2018, indicated, a)nursing staff and practitioners will assess and document an individual significant risk factors for developing pressure ulcers, such as immobility and history of pressure ulcer, b)during resident visits the physician will evaluate and document the progress of wound healing especially for those with complicated, extensive, or poorly healing wounds, and c)the physician will guide the care plan as appropriate, especially when wounds are not healing. A review of the facility's policy and procedure (P&P) titled, Prevention of Pressure Injuries, dated 4/2020, indicated; a) assess the resident for existing pressure injury risk factors and repeat the risk assessment weekly and upon any change of condition and b)evaluate, report and document potential changes in the skin.