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	06/05/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure that Treatment Nurse (TXN) 1 observed the facility's Enhanced Barrier Precautions (EBP, an infection control strategy used in nursing homes to prevent the spread of multi-drug resistant organisms [MRDO, hard to treat, drug resistant germs]) policy and procedure and the facility's Infection Control policy and procedure when TXN 1 failed to wear a personal protective equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) while providing wound care for one of three sample residents (Resident 3). This deficient practice resulted in the failure to follow the facility's Infection Control policy to ensure the facility maintained a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections and had the potential to result in the spread of bacteria such as MDROs and viruses among the residents, staff, and visitors within the facility. Findings: During a review of Resident 3's admission Record (AR), the AR indicated that the facility admitted Resident 3 on 6/1/2026 with diagnoses that included sepsis (a life-threatening blood infection), Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs). During a review of Resident 3's Order Summary Report, the order, dated 6/2/2026, indicated that Resident 3 had a sacrum (lower back area above the buttocks) pressure injury (localized damage to the skin and/or underlying tissue usually over a bony prominence), left gluteus (the buttocks muscle) pressure injury and a left gluteal fold (the crease where the buttocks muscle and upper thigh meet) pressure injury with a wound care treatment to clean with normal saline, pat dry, apply medihoney gel (antibacterial honey ointment) and calcium alginate (type of wound care dressing), and cover with dry dressing every day for 30 days. During a review of Resident 3's Order Summary Report, the order, dated 6/2/2026, indicated that Resident 3 had a left above the knee amputation (AKA, surgical removal of the portion of the leg above the knee) with wound care treatments to clean with normal saline, pat dry, apply a wet to dry dressing (wound care technique) with Vashe solution (wound care solution), wrap with kerlix (gauze bandage roll) dressing, and tape every day for 21 days. During a review of Resident 3's care plans, dated 6/3/2026, the care plans indicated that Resident 3 had a left above the knee amputation, a stage 3 (full-thickness loss of skin. Dead and black tissue may be visible) left gluteus pressure injury, a stage 3 left gluteal fold pressure injury, and a stage 3 sacrum pressure injury. The care plans interventions included providing wound care daily and notifying the physician for signs and symptoms of infection such as redness, drainage, pain, and warmth at the site. During an observation on 6/5/2026 at 1:43 PM by Resident 3's room, an EBP sign was posted outside Resident 3's room. The EBP sign indicated that residents who had a blue dot next to their name plate indicated that those residents had EBP during high contact activities. During an observation on 6/5/2026 at 1:45 PM by Resident 3's room, TXN 1 was observed preparing his wound care treatments and supplies for Resident 3. After TXN 1 prepared his wound care treatments and supplies, TXN 1 was observed entering Resident 3's room without wearing a gown. For about 45 minutes, TXN 1 was observed performing Resident 3's wound care treatments to the left gluteal fold site, left gluteus site, sacrum, and left above the knee amputation wound without wearing a gown. During an interview on (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/5/2026 at 2:38 PM with TXN 1 after Resident 3's wound care treatment, TXN 1 stated that he did not wear a gown while performing Resident 3's wound care treatments because the wounds did not have any discharge or secretions. During the same interview and record review on 6/5/2026 at 2:40 PM with TXN 1, the EBP sign posted by Resident 3's room, was reviewed. TXN 1 stated that the EBP sign and blue dot by Resident 3's name indicated that Resident 3 had EBP precautions. TXN 1 stated that the EBP sign indicated that providing wound care was one of the high contact resident activities and staff were supposed to wear gowns and gloves prior to providing direct patient care. During an interview on 6/5/2026 at 3:10 PM with the Director of Nursing (DON), the DON stated that EBP were used to protect the spread of MDROs between residents and staff. The DON stated that any residents with open wounds and in-body medical devices were automatically placed on EBP. The DON stated any staff member providing wound care treatments to residents with EBP were supposed to wear gowns and gloves. During a review of the facility's policies and procedures (P&P) titled Infection Control, dated 10/2018, the P&P indicated that the facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of disease and infection, and the P&P applied to all personnel within the facility including residents, employees, contractors, and visitors. During a review of the facility's policies and procedures (P&P) titled Enhanced Barrier Precautions, dated 8/2022, the P&P indicated that Enhanced Barrier Precautions were used to as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents. The P&P indicated that EBP included the use of gown and gloves during high contract resident care such as but not limited to wound care (any skin opening requiring a dressing).