STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055845	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leisure Glen Post Acute Care Center	330 Mission Road Glendale, CA 91205

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review the facility failed to treat one of two sampled resident (Resident 1) in a manner that promoted respect and dignity, when the Certified Nurse Assistant (CNA) 1 was rough and loud to Resident 1 who spoke and understand a foreign language during care. CNA1 yelled and pushed Resident 1 to turn to the side when changing the resident's wet clothing and asked the resident why she was wearing a long gown that was hard to remove. This deficient practice resulted in Resident 1 to experienced fear and anxiety (fear of the unknown) towards CNA 1 during interactions. Resident 1 to immediately contacted Family Member 1 (FM 1) while crying to inform her about what had occurred. Resident 1 began to frequently calling FM 1 to contact facility staff to assist such as when turning and repositioning. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 4/23/2026 with diagnoses that included Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), muscle weakness, arthritis (swelling, pain, and stiffness in your joints, dementia(a progressive state of decline in mental abilities). During a review of Resident 1's care planˆtitled, Communication ProblemˆdueˆtoˆLanguage Barrier dated 4/24/2026,ˆindicatedˆresident had concern with communication due to language barrier. The intervention included providing translator as necessary to communicate with the residentˆwho spoke aˆforeign language,ˆask resident to repeat what has been said to confirm that the resident understood message, use low tone ofˆvoiceˆand speak slowly to the residentˆand present one thought, idea,ˆquestionˆor command at a time.ˆˆ ˆ During a review ofˆResident 1's Minimum Data Set (MDSˆ- aˆresident assessment tool), datedˆ4/27/2026, the MDS indicatedˆResident'sˆ1ˆcognitionˆ(the ability to process thoughts)ˆwas severely impaired.ˆThe MDS alsoˆindicatedˆthat Resident 1 wasˆdependentˆon staffˆto roll left and right (theˆability to roll from lying on the back to the left and right side),ˆdressing, shower/bathe self, toileting/hygiene,ˆsubstantial/maximalˆassistanceˆin personal hygiene, oral hygiene, andˆpartial/moderateˆassistanceˆin eating.ˆˆ During an interview on 5/9/2026 atˆ12:42 PM with Resident 1, Resident 1ˆstatedˆlast week (5/4/2026) a nurseˆ(Certified Nurse Assistant 1 [CNA 1])ˆwhoˆwas taking care of herˆraised her tone of voiceˆtowards herˆandˆpushing her to turn to herˆsidesˆto changeˆher wet andˆsoiled clothes.ˆResidentˆ1 ˆstatedˆ CNA 1ˆknew that she could not turn to herˆside,ˆbut CNA 1 was yelling at her toˆturn on her side.ˆˆResidentˆ1ˆstatedˆshe called FM 1 ˆimmediatelyˆabout the incident.ˆResident 1ˆstatedˆ her roommateˆ(Resident 2)ˆwhoˆwitnessedˆhow CNA 1 treatedˆherˆalso calledˆFM 1 ˆonˆ5/4/2026 approximately 4:30 AMˆandˆmade her aware of whatˆ CNA 1 did to her. Resident 1 statedˆFM 1ˆ immediatelyˆcalledˆthe facilityˆand talked to the staffˆ(unknown).ˆˆˆ Resident 1 stated, the incident make her feel anxious towards CNA 1. During an interview on 5/9/2026 at 12:53 PM withˆFM 1,ˆFM 1ˆstatedˆthat she received a call from Resident 1ˆonˆ5/4/2026ˆat aroundˆ4:30ˆAM, whoˆwas cryingˆon the phoneˆand told her that CNA 1 wasˆ screaming and pushingˆher in bed.ˆ FM 1ˆstatedˆshe asked Resident 1 ˆwhy ˆCNA 1 was screaming and pushingˆher?ˆˆResident 1ˆ replied that CNA 1 was complaining that her clothes were wet and tightˆwhich was difficult to remove.ˆFMˆ1ˆ statedˆ (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
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sheˆimmediatelyˆcalled the facility and spoke toˆLVNˆ1 who informed her that she wasˆgoing toˆlook intoˆthis matter and that sheˆwillˆreportˆthe incidentˆtoˆRegistered Nurse (RN)ˆ1.ˆFM 1ˆ stated ˆthatˆ Residentˆ2 called herˆon theˆphoneˆto inform her thatˆCNA 1ˆscreamedˆat Residentˆ1ˆ whileˆchangingˆherˆwet clothingˆand askingˆResidentˆ1 to turn to her sideˆknowing that Resident 1 could not ˆturn without ˆassistance.ˆˆFM 1 stated that following the incident with CNA 1, Resident 1 had been frequently calling her to request that FM 1 contact staff to assist to assist her in turning and repositioning. FM 1 stated that she is not sure if staff is not turning her or if Resident 1 is afraid to ask staff for assistance. FM 1 stated she was concern of Resident 1's ongoing apprehension about requesting assistance directly from staff, indicating a persistent sense of fear and anxiety. During an interview on 5/9/2026 at 1:09 PM with Resident 2,ˆResident 2ˆstatedˆsheˆwasˆawakenedˆwhen she heardˆResident 1ˆ(her roommate)ˆ calling for helpˆand crying.ˆˆWhenˆsheˆopened the curtain between her and Resident 1, she sawˆCNA 1ˆ yellingˆat Resident 1, questioningˆwhy she wasˆnotˆwearing aˆhospital gown.ˆˆResident 2 stated CNA 1 asked Resident 1 toˆturnˆbecauseˆCNA 1ˆwas havingˆa hard timeˆremoving Resident 1'sˆwetˆclothing.ˆResident 2ˆstatedˆshe toldˆCNA 1ˆ The ladyˆcan'tˆturn on her own, she needs help.ˆCNA 1 continued toˆchangeˆResident 1'sˆclothing while Resident 1ˆcontinued toˆcryˆand CNA 1 left Resident 1 crying.ˆˆResident 2ˆstatedˆshe heardˆCNA 1 tellˆResident 1, You are going to give me a stroke. Afterward, Resident 2ˆadvised Resident 1 toˆcall louder for help next time.ˆˆResident 2ˆstatedˆshe calledˆResident 1's familyˆimmediatelyˆonˆ5/4/2026ˆatˆ5AMˆto make her aware that CNA 1 was screaming at Resident 1. Resident 2ˆstatedˆshe felt the situation wasˆvery badˆandˆinjustice.ˆˆResident 2ˆstated, twoˆfacility staffsˆlater came into the room to question Resident 1.ˆResident 2ˆexplained sheˆdid not report the incident to facility staff out of fear of retaliation.ˆ During a review of the facility's P&P titled, Dignity dated 2/2021, the Policy & Procedure (P&P) indicated it is the policy of the facility to support resident's in exercising their rights such as encouraging the resident to dress in clothing that they prefer. Staff are expected to always speak to residents respectfully. the P&P also indicated that residents may exercise their rights without interference, coercion, discrimination or reprisal from any person or entity associated with the facility.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on observation, interview and record review, the facility failed implement to implement the facility's policies and procedure titled Abuse Investigation and Reporting for one of two sampled resident (Resident 1) by facility to: 1. Investigate the allegation of abuse when Family (FAM 1) reported to Licensed Vocational Nurse (LVN) 1 that Certified Nurse Assistant (CNA) 1 was loud and rough to Resident 1 when changing the resident's wet clothing. CNA 1 was yelling at Resident 1 pushing the resident while turning to the side and complained that resident should not be wearing a long gown that was hard to remove. 2. Report the allegation of abuse to the state agency, police department and the ombudsman when FAM 1 reported to LVN 1 that CNA 1 was rough and yelling at Resident during care. 3. Protect Resident 1 from the alleged abuser (CNA1) continued to work at the facility 5/4/26 when FAM 1 reported the allegation of abuse to LVN 1. 4. Identify the alleged abuse as verbal and emotional abuse when LVN 1 informed the DSD and DON that FAM 1 reported to her that CNA 1 was yelling and rough with Resident 1 while being changed due to wet clothing. These deficient practices resulted in Residents 1 feeling anxious (fear of the unknown) towards CNA 1 during interactions, and frequently called FM 1 to ask staff to assist her except for CNA 1. In addition, this could lead to emotional decline and decreased quality of life of Resident 1 and other vulnerable residents. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 4/23/2026 with diagnoses that included Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), muscle weakness, arthritis (swelling, pain, and stiffness in your joints, dementia(a progressive state of decline in mental abilities). During a review of Resident 1's care plan titled, Related Risk Factors/DX Arthritis, Parkinson's, Dementia . dated 4/24/2026, indicated to assist Resident 1 to turn and reposition every two hours using a draw sheet or a lifting device to move the resident. During a review of Resident 1's care plan titled, Communication Problem due to Language Barrier dated 4/24/2026, indicated resident had concern with communication due to language barrier. The intervention included to provide translators as necessary to communicate with the resident who spoke a foreign language, use low tone of voice and speak slowly to the resident and present one thought, idea, question or command at a time. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/27/2026, the MDS indicated Resident's 1 cognition (the ability to process thoughts) was severely impaired. The MDS also indicated that Resident 1 was dependent on staff to roll left and right (the ability to roll from lying on the back to the left and right side), dressing, shower/bathe self, toileting hygiene, substantial/maximal assistance in personal hygiene, oral hygiene, and partial/moderate assistance in eating. During an interview on 5/9/2026 at 12:06 PM with the facility Administrator (ADM 1), ADM 1 stated there was no allegation abuse reported to her by the facility staff or any resident representatives. During an interview on 5/9/2026 atˆ12:42 PM with Resident 1, Resident 1ˆstatedˆlast week (5/4/2026) a nurseˆ(Certified Nurse Assistant 1 [CNA 1])ˆwhoˆwas taking care of herˆraised her tone of voiceˆtowards herˆandˆpushed her to turn to herˆsidesˆto changeˆher wet andˆsoiled clothes.ˆResidentˆ1 ˆstatedˆ CNA 1 ˆknew that she could not turn to herˆside,ˆbut CNA 1 was yelling at her toˆturn on her side.ˆˆResidentˆ1ˆstatedˆshe called FM 1 ˆimmediatelyˆabout the incident.ˆResident 1ˆstatedˆ her roommateˆ(Resident 2)ˆwhoˆwitnessedˆhow CNA 1 treatedˆherˆalso calledˆFM 1 ˆonˆ5/4/2026 approximately 4:30 AMˆandˆmade her aware of whatˆ CNA 1 did to her. Resident 1 statedˆFM 1ˆ immediatelyˆcalledˆthe facilityˆand talked to the staffˆ(unknown).ˆˆˆ Resident 1 stated, the incident make her feel anxious towards CNA 1. During an interview on 5/9/2026 at 12:53 PM withˆFM 1,ˆFM 1ˆstatedˆthat she received a call from Resident 1ˆonˆ5/4/2026ˆat aroundˆ4:30ˆAM, whoˆwas cryingˆon the phoneˆand told her that CNA 1 wasˆ screaming and pushingˆher in bed.ˆ FM 1ˆstatedˆshe asked Resident 1 ˆwhy ˆCNA 1 was screaming and pushingˆher?ˆˆResident 1ˆ replied that CNA 1 was complaining that her clothes were wet and tightˆwhich was difficult to (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	remove.ˆFMˆ1ˆ statedˆ sheˆimmediatelyˆcalled the facility and spoke toˆLVNˆ1 who informed her that she wasˆgoing toˆlook intoˆthis matter and that sheˆwillˆreportˆthe incidentˆtoˆRegistered Nurse (RN)ˆ1.ˆFM 1ˆ stated ˆthatˆ Residentˆ2 called herˆon theˆphoneˆto inform her thatˆCNA 1ˆ screamedˆat Residentˆ1ˆ whileˆchangingˆherˆwet clothingˆand askingˆResidentˆ1 to turn to her sideˆknowing that Resident 1 could not ˆturn without ˆassistance.ˆˆFM 1 stated that following the incident with CNA 1, Resident 1 had been frequently calling her to request that FM 1 contact staff to assist to assist her in turning and repositioning. FM 1 stated that she is not sure if staff is not turning her or if Resident 1 is afraid to ask staff for assistance. FM 1 stated she was concern of Resident 1's ongoing apprehension about requesting assistance directly from staff, indicating a persistent sense of fear and anxiety. During an interview on 5/9/2026 at 1:09 PM with Resident 2, Resident 2 stated on 5/4/2026 at around 4:30 AM., she was awakened when she heard Resident 1 (her roommate) calling for help and crying. When she opened the curtain between her and Resident 1, she saw CNA 1 yelling at Resident 1, questioning why she was not wearing a hospital gown. Resident 2 stated CNA 1 asked Resident 1 to turn because CNA 1 was having a hard time removing Resident 1's wet clothing. Resident 2 stated she told CNA 1 The lady can't turn on her own, she needs help. CNA 1 continued to change Resident 1's clothing while Resident 1 continued to cry and CNA 1 left Resident 1 crying. Afterward, Resident 2 advised Resident 1 to call louder for help next time. Resident 2 stated she called Resident 1's family immediately on 5/4/2026 at 5AM to make her aware the CNA 1 was screaming Resident 1. Resident 2 stated, two facility staffs later came into the room to question Resident 1. Resident 2 explained she did not report the incident to facility staff out of fear of retaliation. During an interview on 5/9/2026 at 3:46 PM with RN 1, RN 1 stated he was the nursing supervisor assigned on 5/4/2026 at night shift, RN 1 denied that LVN 1 and other staff reported any allegation of abuse to him or that FAM 1 reported any allegation of abuse during his working hours on 5/4/2026. During an interview on 5/11/2026 at 6:18 AM with CNA 2, CNA 2 stated RN 2 informed her that CNA 1 could not take care of Resident 1 because Resident 1 was complaining about CNA 1, but RN 2 did not explain why. During an interview on 5/11/2026 at 6:54 AM with LVN 2, LVN 2 stated, through a translator, Resident 1 informed him that the room assignment was changed due to Resident 1 not wanting CNA 1 to provide care because CNA 1 was not nice to her. LVN 2 stated he did not ask to why CNA 1 was not nice to her, so he did not ask the resident further question. LVN 2 did not report Resident 1's complaint about CNA 1 to the DON or ADM. LVN 2 stated when he came back to work after being off and the assignment was changed and thought the issues were already addressed. During an interview on 5/11/2026 at 8:31AM with LVN 1, LVN 1 stated FM 1 called her on 5/4/2026 around 5AM and informed her FM 1 told her that Resident 1 was told that she could not bring a sweater. LVN 1 did not explain why there was an issue with the sweater. LVN 1 stated that she did not know why CNA 1's assignment was changed and not assigned to Resident 1. LVN 1 denied that FM 1 reported to her that CNA 1 was yelling and rough to Resident 1. LVN 1 stated Resident 1 and Resident 2 did not report anything suspicious to her regarding CNA 1 and that Resident 1 did not report anything to her as well. During an interview on 5/11/2026 at 8:42 AM with DSD 1, DSD 1 stated that LVN 1 communicated to him on 5/4/2026 in the morning that LVN 1 had received a call from FM 1 regarding Resident 1's clothing and that LVN 1 thought CNA 1 had a miscommunication issue with Resident 1. DSD 1 stated that FM 1 thought the CNA 1 was upset regarding the clothing that got wet and was too tight on the resident. DSD 1 stated that based on that conversation he took it upon himself to remove CNA 1 from Resident 1's assignment. DSD 1 stated any type of grievance is written up and the administrator gets informed with the investigation and resolution. DSD 1 stated that he did not identify the situation as abuse, therefore he did not report the situation to the ADM and stated that he thought it was just a miscommunication issue. During an interview on 5/11/2026 at 9:04 AM with CNA 1, CNA 1 stated that around on 5/4/2026 at 4:30 AM she woke up Resident 1 to change her incontinent brief, she took the blanket off and saw that the resident's entire gown and sweater were all wet. CNA 1 stated that she had no choice but to sit Resident 1 at the edge of the bed because it (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was very difficult to remove the clothing while lying in bed. CNA 1 stated that she opened the door to see if there were any staff that could help change Resident 1 but couldn't find anyone to assist her. CNA 1 stated that she suggested Resident 1 to tell her family to bring a gown that had buttons or zipper. CNA 1 stated that the roommate Resident 2 was awake and was helping her in translating the information to Resident 1. CNA 1 stated that on 5/4/2026 at about 6AM, RN 1 walked toward her and told CNA 1 that the family had complaint about her being rough and loud with Resident 1. CNA 1 stated that the next day her assignment was change but was never given a reason and that based on the complaint she thought that maybe the family of Resident 1 did not want her to take care of Resident 1. CNA 1 stated on 5/9/2026 at the beginning of her shift around 4PM CNA 1 stated she was called to the office by the ADM 1 and DON and was told that the Health Department was at the facility and were investigating the complaint and that CNA 1 was suspended pending investigation. During a concurrent record review of CNA 1's Payroll Pay Period 5/1/2026 - 5/15/2026 with DSD 1, CNA 1 worked at the facility after alleged complaint on 5/4/2026 10:54 PM - 7:01 AM; 5/5/2026 10:58 PM - 7:00 AM; 5/6/2026 10:57 AM - 6:58 AM, 5/8/2026 2:57 PM -11:00 PM; 5/9/2026 3:04 PM-5:12 PM.DSD stated that the CNA was suspended the day the Health Department visited the facility. DSD stated that the process is that immediately when there is an allege abuse the CNA is suspended until their investigation is completed and that the CNA should have been suspended until the allege abuse investigation was completed. During an interview on 5/11/2026 at 10:42 AM with the Director of Nurses (DON), DON stated that any type of family grievance staff should complete a grievance report that is forwarded to the administrator (ADM). DON stated that there was no grievance report from the staff or investigation conducted for Resident 1's allegation of abuse. CNA 1 was not suspended after the allegation of abuse from FM1 and Resident 1 because the incident was not reported by LVN 1, LVN 2, DSD and RN 1 and other facility staffs to the DON or ADM. DON stated that when the staff Charge Nurse/Registered Nurse were made aware of the grievance the report should have been completed and forwarded to the administrator. During a review of facility's policy and procedure (P&P) titled, Resident Rights Guidelines for All Nursing Procedures dated 10/2010, the P&P indicated it is the policy of the facility that prior to having direct care responsibilities for residents, staff must have appropriate in-service training on resident rights such as preventing, recognizing and reporting resident abuse. During a review of facility's P&P titled, Abuse Investigation and Reporting dated 7/2017 indicated all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. The Administrator will keep the resident and his/her representative informed of the progress of the investigation. The Administrator will suspend immediately any employee who has been accused of resident abuse pending the outcome of the investigation. The Administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented.