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	07/02/2026

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 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 ensure a resident received treatment, care and services for 2 of 3 sampled residents (Resident 8 and 58) in accordance with professional standards of practice, resident's care plan, physician's order and facility' s policy and procedures. 1. For Resident 8, who has MASD (Moisture-Associated Skin Damage, a broad term for skin inflammation, irritation, or sores caused by prolonged exposure to moisture [such as urine, sweat, wound fluids, or saliva]), and receiving lactulose (a prescription medication to treat constipation and certain liver diseases) with frequent loose stool, by failing to: a. Ensure TXN 1 developed an individualized repositioning schedule for Resident 8 in accordance with the care plan. b. Ensure TXN 1 contacted the resident's wound consultant as ordered so the resident could receive a physical assessment and appropriate wound care. c. Ensure IDT (Interdisciplinary Team- a coordinated group of medical professionals for plans of care and coordinating medical care) assessed Resident 8 and contacted the resident's responsible party (RP) to determine the cause and create individualized interventions to address the resident's noncompliance of reposition and incontinent care. These deficient practices resulted in Resident 8's wound delayed healing or worsened MASD and Resident 8 was sent to a general acute care hospital (GACH 1) on 6/28/2026 for further evaluation of worsening MASD and nonpitting edema (swelling caused by fluid buildup). These deficient practices placed the resident at risk for complications such as infection (the invasion and growth of germs in the body), bacterial overgrowth, pressure injuries (or pressure sores, localized damage to the skin and underlying tissue caused by prolonged or intense pressure-or pressure combined with rubbing [shear]). 2. For Resident 58 who was diagnosed with type 2 diabetes mellitus (DM - body does not produce enough insulin to control blood glucose [or blood sugar, the main sugar found in the bloodstream] levels) and receiving daily insulin therapy the facility failed to ensure the licensed nurses did not clarified with the physician the physician order for weekly blood sugar checks to appropriately monitoring the resident's blood sugar level. This deficient practice resulted in Resident 58 not receiving appropriate daily blood sugar monitoring needed to safely manage her DM. The deficient practice placed Resident 58 at risk for undetected hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar), delayed intervention for abnormal blood sugar levels, inappropriate insulin management, and preventable diabetic complications. Findings: 1. During a review of Resident 8's admission Record (AR), the AR indicated that Resident 8 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hepatic encephalopathy (brain dysfunction due to liver dysfunction), alcoholic cirrhosis of liver (a stage of alcohol-related liver disease where severe scarring of the liver impacts its ability to function), and obstructive and reflux uropathy (a blockage in the body that makes it difficult or impossible to urinate [pee] and condition of kidney damaged by the backward flow of urine into the (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	kidney). During a review of Resident 8's Care Plan (CP) titled, Resident at risk for skin break/ulcer formation, dated 3/28/2026, the CP indicated Resident 8 was at risk for skin break/ulcer formation related to impaired mobility, incontinence, non-compliant with treatment/positioning, frequent loose stool, and episode of refusal of perineal care. The CP indicated the interventions that included: to assess, document & monitor for treatment effectiveness; assist and encourage resident to turn and reposition with turning schedule to redistribute weight and reduce the risk of skin break down; monitor/assess skin condition during care and notify MD (medical doctor); provide skin care frequently; turn and reposition every 2 hours & PRN (as needed). During a review of Resident 8's Order Summary Report (OSR), dated 4/27/2026, the OSR indicated that Resident 8 may have wound consultation for evaluation and treatment as needed. During a review of Resident 8's History and Physical (H&P), dated 4/29/2026, the H&P indicated Resident 8 does not have the capacity to understand and make decisions. During a review of Resident 8's Braden Scale for Predicting Pressure Sore Risk (BSPPSR), dated 5/18/2026, the BSPPSR indicated, Resident 8's skin was often moist, confined to bed with very limited mobility, and friction and shear are identified problems. The BSPPSR indicated that Resident 8 was at high risk for pressure sore. During a review of Resident 8's BSPPSR dated 6/10/2026, the BSPPSR indicated Resident 8's skin was kept moist almost constantly by perspiration, urine, etc. dampness was detected every time the resident is moved or turned; the resident was confined to bed, completely immobile with friction and shear problems identified. The BSPPSR indicated that Resident 8 was at high risk for pressure sore. During a review of Resident 8's CP titled, Skin: Recurred MASD on sacrococcyx area (the region at the very base of the spine) extending to bilateral buttocks (both sides of the bottom), related to: resident non-compliant with turning and repositioning, and preference of lay down on her back for prolonged times, dated 6/10/2026, the CP indicated the goal was for Resident 8 to be free from further skin breakdown, and the interventions included to identify potential causative factors; inform staff of causative factors and measures to prevent skin tears; keep skin clean and dry; monitor and document locations with size and treatment of skin tear; report abnormalities, failure to heal, maceration, etc. to MD. During a review of Resident 8's Minimal Data Set (MDS- a resident assessment tool) dated 6/25/2026, the MDS indicated that Resident 8 had severely impaired cognition (never/rarely made decision). The MDS indicated that Resident 8 required substantial/maximal assistance (helper does more than half the effort) on personal hygiene and rolling left and right. The MDS also indicated that Resident 8 was dependent (helper does all the effort) on toileting hygiene. During a review of Resident 8's physician order, dated 6/28/2026 at 2:28 PM, Resident 8 had a physician order to transfer to GACH 1 for further evaluation. During a review of Resident 8's Transfer Form (TF), dated 6/28/2026, the TF indicated Resident 8 was transferred to GACH 1 for worsening MASD in the sacrococcyx area extending to bilateral buttocks and nonpitting edema. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and an interview on 7/2/2026 at 9:50 AM with the Treatment Nurse (TXN 1), Resident 8's clinical records since admission on [DATE], were reviewed. TXN 1 stated that he assessed Resident 8's skin on 6/10/2026 but did not notify Resident 8's physician or responsible party (RP) the resident's high risk for pressure sore. TXN 1 stated he developed the CP on 6/10/2026 to address Resident 8's noncompliance with turning and repositioning but did not assess the resident or contact the RP to determine the cause of the noncompliance or identify specific interventions to protect the resident's irritated skin. TXN 1 stated that he did not create an individualized repositioning schedule for Resident 8 and that the resident did not receive a wound consultation when her MASD presented on her sacrococcyx. TXN 1 further stated that he relied on certified nurse assistants (CNAs) to ensure Resident 8's skin was kept clean and dry after each incontinent care. During a concurrent interview and record review on 7/2/2026 at 11:50 AM with the Director of Nursing (DON), Resident 8's CP dated 6/10/2026, IDT dated 6/26/2026, were reviewed. The DON stated that TXN 1 should have developed an individualized repositioning schedule for Resident 8 in accordance with the CP. The DON stated that IDT should have assessed Resident 8 and contacted the resident's RP sooner to determine the cause and create individualized interventions to address the resident's noncompliance of reposition and incontinent care. The DON also stated Resident 8's skin issue should have been evaluated by a wound consultant for the resident's benefit and healing. During a review of the facility's policy and procedures (P&P) titled Prevention of Pressure Injuries revised in 4/2020, the P&P indicated the following: Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. During the skin assessment, inspect: presence of erythema; temperature of skin and soft tissue; and edema. Skin care included to keep the skin clean and hydrated; clean promptly after episodes of incontinence; use incontinence products with high absorbency; use facility approved protective dressings for at risk individuals; Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team; Evaluate, report, and document potential changes in the skin; Review the interventions and strategies for effectiveness on an ongoing basis; 2. During a review of Resident 58's admission Record (AR), the AR indicated Resident 58 was readmitted to the facility on [DATE] with a diagnosis of type 2 diabetes mellitus (DM - body does not produce enough insulin to control blood sugar levels) and dementia (impaired thinking). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 58's History and Physical (H&P)ˆsigned andˆdatedˆ5/13/2026, the H&P indicated that Resident 58 did not have capacity to understand and make decisions. The H&P further indicated that Resident 58 had a history of type 2 DM. During a review of Resident 58's MDS, dated [DATE], the MDS indicated that Resident 58 hadˆa severely impaired cognition (thinking). During a review of Resident 58's Order Summary Report (OSR), dated 7/1/2026, the OSR indicated the following physician orders for Resident 58: - Started on 12/4/2024: Linagliptin (a medication used to lower blood sugar) 5 milligrams (mg – unit of measure) tablet administered orally (by mouth) once a day for DM. - Started on 9/30/2025: Lantus (a medication used to lower blood sugar) administered subcutaneously (under the skin) via a pen-injector at a concentration of 100 units per milliliter (unit of measure), with instructions to inject 15 units subcutaneously at bedtime for DM. - Started on 5/16/2026: finger-stick blood sugar test (a method of measuring blood sugar in the blood) every Saturday before breakfast. During a concurrent interview and record review on 7/1/2026 at 10:30 AM with RN 1, Resident 58's OSR, dated 7/1/2026, was reviewed. RN 1 stated that Resident 58 had an order for weekly blood sugar monitoring, Resident 58 was prescribed 15 units of Lantus subcutaneously at bedtime daily and received a bedtime snack. RN 1 stated that, based on the resident's daily insulin regimen, blood sugar monitoring should have been performed daily rather than weekly to monitor the resident's response to insulin therapy and identify potential hypo- or hyperglycemia. RN 1 stated that by not monitoring Resident 58's blood sugar on a daily basis it would be difficult to evaluate insulin effectiveness. RN 1 stated that daily blood sugar monitoring helps determine whether the prescribed insulin dose is appropriate and would preventˆdelayed identification of changes in condition: illness, weight changes, medications, or decreased oral intake can significantly affect blood sugar levels. During a concurrent interview and record review on 7/1/2026 at 11:00 AM with the Director of Nursing (DON), Resident 58's physician summary order report on 7/1/2026 was reviewed. The DON stated that Resident 58's physician orders included weekly blood glucose monitoring, a daily order for 15 units of Lantus administered subcutaneously at bedtime, and a bedtime snack. The DON stated that Resident 58's blood glucose should have been monitored daily rather than weekly because the resident was receiving 15 unit of Lantus insulin daily. The DON stated that without daily monitoring, hypo or hyper glycemia occurrences may not be recognized promptly. The DON stated that by not monitoring Resident 58's blood glucose daily, the resident had an increased risk of diabetic complications that would affect the kidneys, eyes, nerves, and cardiovascular system. ˆDuring a review of the facility P&P titledˆDiabetes – Clinical Protocol revised 11/2020, indicated that for the resident receiving insulin who is well controlled: monitor blood glucose levels twice a day if on insulin (for example, before breakfast and lunch_ and as necessary); monitor 3 to 4 times a day if on intensive insulin therapy or sliding-scale insulin; monitor as indicated if the individual is fasting before a medical procedure, has returned to the facility after a significant absence, or has an acute infection or illness.