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	06/27/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review, the facility failed to provide a homelike environment for one of one sampled resident (Residents 11) by not ensuring Resident 11 was provided a functional wall clock in the room. This deficient practice had the potential to cause disorientation and Resident 11 verbalizing feelings of frustration. Findings: During a review of Resident 11's admission Record (AR), the AR indicated the facility admitted Resident 11 on 4/14/2025 with diagnoses that included dementia (progressive decline in cognitive function, memory, and thinking abilities that can impact daily life), osteoarthritis (a degenerative joint disease, in which the tissues in the joint break down over time), and muscle wasting. During a review of Resident 11's History and Physical Examination (H&P), dated 4/16/2025, the H&P indicated Resident 11 had the capacity to understand and make decisions. During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool), dated 4/18/2025, the MDS indicated Resident 11 required supervision or touching assistance (Helper provides verbal cues and or touching steadying) with eating, partial/moderate assistance (helper does less than half the effort) with personal hygiene, substantial/maximal assistance (helper does more than half the effort) with bathing and dressing, and dependent (helper does all the effort) with toileting. During a concurrent observation and interview on 6/24/2025 at 9:30 AM with Resident 11 and Certified Nurse Assistant (CNA) 2, in Resident 11's room, Resident 11 was observed staring at the wall clock that indicated the current time as 6:05 (shorthand pointed at #6 and long hand pointed at #1). Resident 11 stated, the time on the wall clock was wrong, and that Resident 11 was frustrated since she had to ask facility staff for the current time. CNA 2 stated the time on the wall clock was wrong and she would inform the maintenance right away to fix Resident 11's wall clock since it caused confusion and frustration to Resident 11. During an interview on 6/24/2025 at 9:37 AM with license Vocational Nurse (LVN)2 in Resident 11's room, LVN 2 stated, it was important to ensure residents' wall clocks indicated the accurate time to help with her orientation and to minimize frustration. LVN 2 stated having a functional clock that indicates the accurate time was part of providing a homelike environment to Resident 11. During an interview on 6/25/2025 at 10:59 AM with the Director of Nurses (DON), DON stated, to create a homelike environment for the residents would include having a wall clock that indicated the accurate time in every room. DON stated, not having an accurate time on Resident 11's wall clock had the potential for disorientation and resulted in frustration, and not a homelike environment. A review of the facility's policy and procedure (P&P) titled, , Homelike Environment, revised 5/2017 indicated: a) Residents are provided with a safe, clean , comfortable and homelike environment, b) staff shall provide person-centered care that emphasizes the residents comfort , independence and personal needs and preferences and, c) the facility staff and management shall maximize to the extent possible, the characteristics of the facility that reflects a personalized, homelike setting.

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
	055845	A. Building B. Wing	06/27/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

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	06/27/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a prompt response to address grievances for one of one sampled resident (Resident 5) Resident Representative (FAM 1), when FAM 1 reported missing clothing items belonging to Resident 5. This deficient practice delayed the process of investigating Resident 5's missing clothing items and violated the residents' right to have grievances addressed promptly. Findings: During a review of Resident 5's admission Record (AR), the AR indicated the facility originally admitted Resident 5 on 4/26/2023 and readmitted on [DATE] with diagnoses that included dementia (progressive decline in cognitive function, memory, and thinking abilities that can impact daily life), atherosclerotic heart disease (thickening or hardening of the arteries), and chronic kidney disease (a condition in which the kidneys are damaged and can't filter blood as well as they should). The AR indicated Resident 5 had a Representative for her care (FAM 1). During a review of Resident 5's History and Physical Examination (H&P), dated 6/12/2025, the H&P indicated Resident 5 does not have the capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool), dated 4/18/2025, the MDS indicated Resident 5 required supervision or touching assistance (Helper provides verbal cues and or touching steadying) with eating, partial/moderate assistance (helper does less than half the effort) with personal hygiene, substantial/maximal assistance (helper does more than half the effort) with bathing and dressing and dependent (helper does all the effort) with toileting. During an interview on 6/24/2025 at 1:45 PM with FAM 1, FAM 1 stated when Resident 5 was discharged home on 6/3/2025, FAM 1 informed Social Service Assistant (SSA) that Resident 5 was missing two pants and a blouse. FAM 1 stated the facility had not informed FAM 1 regarding the outcome of the missing clothing for Resident 5. FAM 1 stated, the facility was aware that she does the laundry, and FAM 1 was concerned that Resident 5's clothing would get lost again. During an interview on 6/24/2025 at 2:28 PM with SSA, SSA stated Resident 5 was discharged to home on 6/3/2025 and readmitted to the facility on [DATE]. SSA stated, she was aware that family did Resident 5's laundry, and prior to Resident 5's discharge from the facility on 6/3/2025, FAM 1 informed SSA that Resident 5 was missing some clothes. SSA stated she thought FAM 1 would come to the facility to find Resident 5's missing clothing. SSA stated, she did not initiate a grievance report nor did SSA follow up with FAM 1. SSA stated she should have initiated a grievance report when FAM 1 informed the SSA of Resident 5's missing clothes. SSA stated it was a violation of resident's rights that a grievance report was not initiated when the facility became aware of Resident 5's missing clothing items. During a concurrent interview and record review, on 6/24/2025 at 4:27 PM with SSA, the facility document titled Concern/Grievance Log, dated June/2025 was reviewed. The Log did not indicate any grievance initiated from Resident 5 and/or FAM 1. SSA stated, grievance from FAM 1 was not initiated, and that with any grievances filed the DON (Director of Nurses) and the Administrator should have been informed. During an interview on 6/25/2025 at 10:53 AM with DON, DON stated SSA should have reached out to FAM 1 regarding Resident 5's missing clothing, and that a grievance report should have been initiated. DON stated not promptly addressing Resident 5 and/or FAM 1 grievance violates resident rights. During an interview on 6/25/2025 at 2:20 PM, with the Administrator (ADM), ADM stated, she was not aware Resident 5's clothes were missing. The ADM stated a grievance report should have promptly been initiated in accordance with the facility's policy and procedure, and by not promptly conducting a grievance report violated residents rights. A review of the facility's policy and procedure (P&P) titled, Grievances/Complaints, Filing, revised 4/2017 indicated; a)Residents and their representative have the right to file grievances, either orally or in writing to the facility staff or to agency designated to hear grievances, b) the administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative, c) resident representative may file grievance or complaint regarding resident stay in the facility, and d) all grievances concerning resident care will be considered and actions on the issues will be responded to in writing, including rationale for the response. A review of the facility's policy and procedure (P&P) titled, Resident Rights, revised 12/2016 indicated: a) employees shall treat all residents with kindness, respect and dignity, b) resident rights include voice grievances to the facility and have the facility respond to his or her grievances.

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	06/27/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the Minimum Data Set (MDS, a federally mandated standardized assessment and care-screening tool) and Quarterly Risk Assessment was accurate for two (2) of 2 sampled residents (Resident 69 and 102) who had a diagnosis of dementia and was not evaluated for elopement risk. These deficient practices had the potential to result in Resident 69 and 102 not receiving appropriate treatment and/or services. Findings: 1. A review of Resident 69’s admission Record indicated Resident 69 was initially admitted to the facility on [DATE], with diagnoses that included metabolic encephalopathy (change in how the brain works due to an underlying condition), unspecified dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and Alzheimer’s disease (progressive disease that destroys memory and other important mental functions). During a review of Resident 69’s Admission/readmission Initial assessment dated [DATE] indicated resident walked frequently (walks outside room at least twice a day and inside room at least once every two hours during waking hours) with no limitation. The MDS assessment indicated an evaluation of resident elopement risk was not completed. The evaluation of resident elopement risk indicated resident was not independently mobile. During a review of Resident 69’s History and Physical (H&P) dated 3/27/2025 indicated Resident 69 did not have the capacity to understand and make decisions. During a review of Resident 69’s MDS dated [DATE], indicated Resident 69 was independent with indoor mobility (walking from room to room [with or without a device such as a cane, crutch, or walker]). During a review of Resident 69’s Quarterly Risk assessment dated [DATE] indicated resident walked frequently with no limitation. The assessment indicated an evaluation of resident elopement risk was not completed. The evaluation of resident elopement risk indicated resident was not independently mobile. During a review of Resident 69’S MDS dated [DATE] indicated Resident 69 required partial/moderate assistance to walk 10 feet and walk 50 feet with two turns. During a concurrent interview and record review of Resident 69’s Admission/readmission Initial assessment dated [DATE] on 6/26/2025 at 12:03 PM, Registered Nurse (RN) 2 stated she should have documented Resident 69 walked occasionally instead of frequently because resident was only walking inside the room. RN 2 stated the level of activity should have been documented accurately because the admission assessment is the baseline of the resident. During an interview on 6/26/2025 at 12:28 PM, Minimum Data Set Nurse (MDSN) 2 stated she has seen Resident 69 walk and exercise around the facility. MDSN 2 stated Resident 69 was able to walk around to activities room, facility patio, and resident rooms to speak with other residents. (continued on next page)

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	06/27/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 69’s Quarterly Risk Assessments dated 6/19/2025 on 6/26/2025 at 12:37 PM, MDSN 2 confirmed she did not complete the evaluation for elopement risk. MDSN 2 stated she used her own judgment that Resident 69 was not a “wanderer” (moving from one place to another aimlessly) and selected “no” for the first question “is the resident independently mobile.” MDSN 2 stated she misinterpreted the question and chose “no” because from her understanding, Resident 69 was not an elopement risk. MDSN 2 stated she knew Resident 69 was independently mobile and she was just focused on the elopement risk and decided Resident 69 was not an elopement risk. MDSN 2 stated it was important for documentation to be accurate so the whole facility knows that Resident 69 could have potential to wander or elope. During the same interview on 6/26/2025 at 12:43 PM, MDSN 2 stated when documenting the quarterly evaluation of Elopement Risk, she always thinks about elopement, “I didn’t really think dementia could be a risk for elopement and misinterpreted the questions.” MDSN 2 stated residents with dementia repeat themselves, are agitated and irritable, only remember certain things and are forgetful. MDSN 2 stated when she was doing the quarterly assessment, she would see the residents and assess them from head to toe, ask other staff like certified nursing assistants, charge nurses about the resident. MDSN 2 stated she should have been answering questions for the quarterly risk assessment as a cumulative of the resident’s current status. During an interview on 6/26/2025 at 1:18 PM, MDSN 1 stated she focuses on resident admission when they are admitted to facility and oversees MDSN 2 who focuses on quarterly assessments when residents are in long term care. MDSN 1 stated she has to review and sign off MDSN 2’s quarterly risk assessments. During a concurrent interview and record review of Resident 69’s Quarterly Risk Assessments dated 6/19/2025 on 6/26/2025 at 1:24 PM, MDSN 1 confirmed the evaluation for elopement risk should have been filled out correctly. MDSN 1 stated this was “so you have a proper idea of where the residents are, functionally.” MDSN 1 stated because of this, there was a discrepancy on the MDS, the MDS provides an overview of what kind of care the resident needs. MDSN 1 stated the assessment needs to be accurate so the facility knows who would need individualized care. During the same interview on 6/26/2025 at 1:30 PM, MDSN 1 stated MDSN 2 documents residents quarterly risk assessment and quarterly MDS. MDSN 1 stated she reviews MDSN 2’s documentation. MDSN 1 stated “I was not focusing on elopement because we know our patients here. MDSN 2 misinterpreted the question, I trust her, and I didn’t check.” MDSN 1 stated she reassessed all the residents of the facility yesterday. MDSN 1 stated she should be reviewing for accuracy so that it would be a correct reflection of the resident and to show that MDSN 2 was competent in assessing. MDSN 1 stated this showed MDSN 2’s failure to accurately assess residents. During an interview on 6/27/2025 at 1:38 PM, the Director of Nursing (DON) stated the elopement risk assessment should have been accurate and filled out completely in order to provide an accurate intervention for resident. The DON stated if a resident was high risk for elopement they need to have appropriate placement. The DON stated if there was a resident who tried to elope, the facility needs to provide intervention right away and look for placement because the facility was not an appropriate place for resident who was at high risk for elopement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2025
NAME OF PROVIDER OR SUPPLIER Leisure Glen Post Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of Resident 102’s admission Record indicated Resident 102 was initially admitted to the facility on [DATE], with diagnoses that included unspecified dementia, muscle wasting and atrophy and cognitive communication deficit. During a review of Resident 102’s History and Physical (H&P) dated 8/14/2024 indicated Resident 102 did not have the capacity to understand and make decisions. During a review of Resident 102’s MDS dated [DATE], indicated Resident 102 was independent with indoor mobility (walking from room to room [with or without a device such as a cane, crutch, or walker]). During a review of Resident 102’s Quarterly Risk assessment dated [DATE] indicated resident walked occasionally with no limitation. The assessment indicated an evaluation of resident elopement risk was not completed. The evaluation of resident elopement risk indicated resident was not independently mobile. During a review of Resident 102’s Quarterly Risk assessment dated [DATE] indicated resident walked occasionally with no limitation. The assessment indicated an evaluation of resident elopement risk was not completed. The evaluation of resident elopement risk indicated resident was not independently mobile. During a review of Resident 102’s Quarterly Risk assessment dated [DATE] indicated resident walked occasionally with no limitation. The assessment indicated an evaluation of resident elopement risk was not completed. The evaluation of resident elopement risk indicated resident was not independently mobile. During a review of Resident 102’s MDS dated [DATE] indicated Resident 102 required partial/moderate assistance to walk 10 feet and walk 50 feet with two turns. During a concurrent interview and record review of Resident 102’s Quarterly Risk assessment dated [DATE] on 6/26/2025 at 12:43 PM, MDSN 2 confirmed Resident 102’s elopement risk evaluation was not completed. MDSN 2 stated when documenting Resident 102’s elopement risk she “did not think dementia could be a risk for elopement and misinterpreted the question.” During a concurrent interview and record review of Resident 102’s Quarterly Risk assessment dated [DATE] on 6/26/2025 at 1:46 PM, MDSN 1 confirmed Resident 102’s elopement risk was incorrect and should have been filled out correctly. MDSN 1 stated need to make sure documentation was accurate to get a proper picture of the resident and what their activity levels and needs are. A review of the facility’s policy and procedure (P&P) titled “Resident Assessments” dated 12/2024 indicated risk assessments will be conducted on admission, quarterly, and as needed to include fall, elopement, pain, Braden scale, bowel and bladder and dehydration risk assessments. The P&P indicated all persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. The P&P indicated the results of the assessments are used to develop, review, and revise the resident’s comprehensive care plan. (continued on next page)

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	06/27/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility’s P&P titled “Charting and Documentation” dated 7/2017 indicated documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.

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	06/27/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the care plan was revised for two of two sampled residents (Resident 69 and 102) who had an active care plan for a diagnosis for dementia (a progressive brain disorder that results in a decline in memory and thought process).This deficient practice had the potential result in Resident 69 and 102 no receiving appropriate interventions and treatment and/or services. Cross Referenced to F641 and F744 Findings: 1. A review of Resident 69’s admission Record indicated Resident 69 was initially admitted to the facility on [DATE], with diagnoses that included metabolic encephalopathy (change in how the brain works due to an underlying condition), unspecified dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and Alzheimer’s disease (progressive disease that destroys memory and other important mental functions). During a review of Resident 69’s History and Physical (H&P) dated 3/27/2025 indicated Resident 69 did not have the capacity to understand and make decisions. During a review of Resident 69’s MDS dated [DATE], indicated Resident 69 was independent with indoor mobility (walking from room to room [with or without a device such as a cane, crutch, or walker]). During a review of Resident 69’s Dementia Care plan dated 3/17/2025 did not indicate resident specific behaviors to monitor. During an interview on 6/26/2025 at 11:53 AM, Registered Nurse (RN) 2 stated Resident 69 stated in the past 2 weeks resident has become more mobile. RN 2 stated if Resident 69 had a behavior of going into the wrong resident room she would tell the charge nurses and Certified Nursing Assistants (CNAs) to monitor for when Resident 69 goes into other resident rooms. RN 2 stated a care plan should be created for this to protect other residents' privacy. RN 2 stated the care plan is developed to ensure specific interventions for her tailored to her and her behaviors. RN 2 stated this should be added to Resident 69’s care plan. RN 2 stated licensed nurses can update or create care plan. During an interview on 6/26/2025 at 12:28 PM, Minimum Data Set Nurse (MDSN) 2 stated she has seen Resident 69 walk and exercise around the facility. MDSN 2 stated Resident 69 was able to walk around to activities room, facility patio, and resident rooms to speak with other residents. During an interview on 6/26/2025 at 1:35 PM, MDSN 1 stated for residents with dementia care plan would include medication, activities, and reorienting the resident if needed. MDSN 1 stated the care plan should be created on admission and updated quarterly or as needed if there was a change. MDSN 1 stated when staff notice behaviors, they should notify the charge nurse, and the care plan should be updated specific to Resident 69. MDSN 1 stated if Resident 69 walks into another resident’s room, there could be a “terrible altercation” if the other resident does not want Resident 69 in the room. (continued on next page)

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	06/27/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 69’s Dementia Care Plan on 6/27/2025 at 11:14 AM, MDSN 1 stated there was no actual behavior indicated to increase monitoring for Resident 69. MDSN 1 stated the care plan was not resident specific. 2. A review of Resident 102’s admission Record indicated Resident 102 was initially admitted to the facility on [DATE], with diagnoses that included unspecified dementia, muscle wasting and atrophy and cognitive communication deficit. During a review of Resident 102’s History and Physical (H&P) dated 8/14/2024 indicated Resident 102 did not have the capacity to understand and make decisions. During a review of Resident 102’s MDS dated [DATE] indicated Resident 102 required partial/moderate assistance to walk 10 feet and walk 50 feet with two turns. During a review of Resident 102’s Dementia Care plan dated 8/12/2024 did not indicate the specific resident’s behaviors to be monitor. During a concurrent interview and record review of Resident 102’s Dementia Care Plan on 6/27/2025 at 11:16 AM, MDSN 1 stated there was no actual resident behavior to monitor for Resident 102. MDSN 1 stated the care plan was not resident specific. During an interview on 6/27/2025 at 1:40 PM, the Director of Nursing (DON) stated the residents care plan should have specific behavior so that licensed nurses and staff could be aware of residents' specific behaviors and interventions for the behaviors to ensure everyone was aware of what was going on and what to do. The DON stated care plan should be revised to show patient specific behaviors to monitor. A review of the facility’s policy and procedure (P&P) titled “Care Plans, Comprehensive Person-Centered” dated 12/2016 indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident’s physical, psychosocial and functional needs was developed and implemented for each resident. The P&P indicated assessments of residents are ongoing and care plans are revised as information about the residents and the residents’ conditions change. The P&P indicated the interdisciplinary team must review and update the care plan at least quarterly, in conjunction with the required quarterly MDS assessment.

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	06/27/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on interview, observation and record review, the facility failed to set the Alternating Pressure Mattress (APM, mattress that provides pressure redistribution by filling and un-filling air cells within the mattress so that contact points with the body are reduced) according to the resident's weight as indicated in the manufacturer's recommendation and physicians orders for one of [three] residents (Resident 94). This deficient practice had the increased potential for Resident 94 to develop new pressure ulcer or injury (skin injury due to prolonged unrelieved pressure or skin friction) and/or delay the resident's wound to heal. Findings: During a review of Resident 94's admission Record (AR), the AR indicated the facility admitted Resident 1 on 2/22/2008 with diagnoses that included fracture of unspecified part of neck of right femur [the section of the thigh bone (femur) that connects the femoral head (the ball of the hip joint) to the femoral shaft (the main part of the thigh bone)], muscle wasting and atrophy (loss of muscle mass and strength), type 2 diabetes mellitus (DM2 – a condition that results in too much sugar circulating in the blood). During a review of Resident 94’s History and Physical (H&P), dated 2/24/2025, the H&P indicated the Resident 94 did not have the capacity to understand and make decisions. During a review of Resident 94’s Order Summary Report (OSR), the OSR indicated the physician ordered on 2/26/2025, without an end date, indicated that Resident 94 may have Low Air Loss mattress (LALM-a type of the APM) for skin management and to monitor for function and settings every shift. During a review of Resident 94’s “Pressure Ulcer Assessment,” dated 3/4/2025, the assessment indicated Resident 94 had a healed unstageable right sacrococcyx [a single bony structure formed by the fusion of the sacrum (a large, triangular bone at the base of the spine) and the coccyx (also known as the tailbone)] due to Deep Tissue Injury (DTI, damage to the tissues beneath the skin, often caused by sustained pressure and/or shear forces). The assessment indicated Resident 94 remained at risk for further skin breakdown due to recent hospitalization and the preventive measures included a LAL mattress. During a review of Resident 75's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 6/1/2025, the MDS indicated Resident 94’s cognition (ability to think, remember, and reason) was severely impaired. The MDS indicated Resident 94 needed set up/clean up assistance in eating and oral hygiene; and needed moderate assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) in toileting hygiene and shower. During a concurrent observation and interview on 6/24/2025 at 9:26 AM with Licensed Vocational Nurse (LVN 3) in Resident 94’s room, Resident 94 was lying in bed in supine position with the head of bed slightly elevated and the LAL mattress setting was set at 350 lbs. There was a yellow circle sticker with Resident 94’s room and bed number with 120-180 lbs. written on it. LVN 3 confirmed Resident 94’s mattress setting was at 350 lbs. LVN 3 stated, she did not know what the correct setting for Resident 94’s LALM was supposed to be as the Treatment Nurse (TN) was the one who is in charge of adjusting the LALM settings for the residents. (continued on next page)

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	06/27/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and observation on 6/24/2025 at 9:56 AM with TN 1 in Resident 94’s room, the TN 1 stated Resident 94’s LAL mattress should always be in the correct setting according to the resident’s weight range as indicated in the yellow sticker pasted on Resident 94’s LALM. TN 1 stated, Resident 94’s LALM setting should be between 120-180 pounds maximum to help Resident 94 prevent further pressure injury as Resident 94 was not mobile and had a previous sacrococcyx pressure injury in the past. TN 1 stated, she did not know why the LALM was set at 350 lbs., which was not the correct setting for the Resident 94. During a review of manufacture’s guidelines for Drive-Med Aire Melody control unit, indicated the following: - The Med Aire Melody Alternating Pressure and Low Air Loss Mattress is indicated for the prevention and treatment of any and all stage pressure ulcers when used in conjunction with a comprehensive pressure ulcer management program. - Operating instructions Step 6: Determine the patients' weight and set the control knob to that weight setting on the control unit.

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	06/27/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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	06/27/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide safe and hazard free environment and interventions for safety and supervision for four of four sampled residents (Residents 7,69,102, and 79) the facility failed to: 1.Ensure Resident 7's bed alarm was in the working condition. 2.Provide adequate supervision and safety measures to ensure safety to Residents 69 and 102 who are at risk for elopement (leaving the facility without permission) keeping the patio gate closed and not kept opened with a wire. 3a. Ensure Certified Nurse Assistants 3 and 4 maintain Resident 79, environment free from accidents/hazards, by using caution during transfers and bed mobility, to prevent striking the resident's arms, legs, and hands against any sharp or hard surface to prevent bruising/bleeding for Resident 79, who was assessed at risk for bleeding and bruising due to Lovenox (an anticoagulant) medication, in accordance with the resident's developed care plans. 3b. Ensure that LVN 6 notified Resident 79's representative (RP 1) of Resident 79's accident that resulted to an open ecchymosis and bleeding on the right dorsal forearm on 6/13/25, in accordance with the facility's policy and procedure (P&P) titled Safety and Supervision of Residents. 3c. Ensure Resident 79's information recorded in the resident's record titled Situation Background Report (SBAR) report was accurately documented to include that RP 1 was notified of Resident 79's open ecchymosis and bleeding to the right dorsal forearm on 6/13/25, in accordance with the facility's policy and procedure (P&P) titled Safety and Supervision of Residents. 3d. Ensure Resident 79's information recorded in the resident's record titled Situation Background Report (SBAR) report was accurately documented to include that Resident 79's open ecchymosis was bleeding on the right dorsal forearm on 6/13/25, as reported by Resident 79 and CNA 4, in accordance with the facility's policy and procedure (P&P) titled Safety and Supervision of Residents. LVN 6 verbalized on 6/27/25 at 11:22 AM during an interview that Resident 79's right forearm skin tear was bleeding on 6/13/25, but the SBAR documentation indicated No bleeding noted. LVN 6 verbalized on 6/27/25 at 11:22 AM during an interview that she did not notify RP 1 of Resident 79's skin tear to the right dorsal forearm, but the SBAR documentation indicated [RP 1] was made aware. These deficient practices had placed the residents: Resident 7 at risk for fall and injury. Resident 69 and 102 to be at risk for elopement and potential harm, which could lead to serious injury and decline in the resident's well-being. and for Resident 79 to be at risk for injury and harm. Findings: 1. During a review of Resident 7's admission Record (AR), the AR indicated the facility originally admitted Resident 7 on 7/22/2022 and readmitted on [DATE] with diagnoses that included dementia (a group of thinking and social symptoms that interferes with daily functioning) and repeated falls. During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool), dated 4/9/2025, the MDS indicated Resident 7 had severely impaired memory and cognition (ability to think and reasonably). The MDS indicated Resident 7 required partial/moderate assistance with eating and oral hygiene, and substantial/maximal assistance with personal hygiene, toileting hygiene, shower/bathe self and chair/bed-to-chair transfer. During a review of Resident 7's Order Summary Report, dated 6/24/2025, the Report indicated the physician ordered sensor bed alarm (a device placed on or under a bed that alerts caregivers when someone starts to get up or get out of bed) for safety every shift, starting on 1/9/2024. During a review of Resident 7's Care Plan, dated 1/9/2024, the Care Plan indicated interventions for a sensor pad in bed for safety was implemented to prevent falls. During a review of Resident 7's Quarterly Risk Assessment and Assessment Outcomes, dated 4/9/2025, the assessment indicated Resident 7 had a total score of 14 for fall risk, which represented high risk for fall. During a concurrent observation and interview on 6/24/2025 at 9:29 AM with Registered Nurse (RN) 1 in Resident 7's room, Resident 7's bed alarm monitor was observed on the floor next to Resident 7's bed, with the sensor pad plug disconnected from the sensor mat jack. RN 1 inserted the sensor pad plug into the sensor mat jack on the monitor and hung the sensor pad on the bed rail, but the sensor pad plug fell out the sensor mat jack. on the monitor. RN 1 stated, the sensor pad plug was loose, and since the sensor mat plug could be easily disconnected, the bed alarm monitor was not in good working condition. RN 1 stated, Resident 7 was at risk for falls and the resident could get out of bed without staff's knowledge, which could lead to fall and injury. During an interview on 6/24/25 at 11:04 AM with Certified Nursing Assistant (CNA) 1, CNA 1 stated she did not check Resident 7's bed alarms this morning (6/24/25) and did not know Resident 7's bed alarm monitor's sensor plug was loose. CNA 1 stated, if the bed alarm was not working, the bed alarm would not trigger to alert facility staff that Resident 7 attempted to get out of bed. CNA 1 stated the bed alarm monitor was used

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	06/27/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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	06/27/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility to failed to provide respiratory care to ensure four of 4 sampled residents (Resident 15, 99, 75, and 213) who were receiving oxygen therapy were provided care in accordance with the professional standard of practice and facility's policy and procedure by failing to: 1. Ensure Resident 99 was monitored to ensure the resident wears the nasal cannula (a tube inserted into the nostril used to deliver oxygen into the lungs) to received continuous oxygen as ordered by the physician ordered for oxygen administration. 2.Ensure Resident 15's oxygen tubing (flexible plastic tubing used to deliver oxygen through nostrils and the tubing is fitted over the patient's ears) was placed in designated plastic bag when not in use. 3. Facility failed to provide a working/ functioning BIPAP (a type of non-invasive ventilation that helps people breathe by providing two different levels of air pressure through a mask) machine for one of one sampled resident (Resident 213) with a diagnoses of sleep apnea upon admission and for 7 days after (7/17/2025-7/24/2025). 4.Ensure the nasal cannula (NC-a flexible tube used to deliver supplemental oxygen to people through the nostrils) was changed every seven (7) days for Resident 75 and to ensure to label the oxygen humidifier bottle (a device used to add moisture to oxygen gas, making it more comfortable and less drying for patients who require supplemental oxygen therapy) with the date it was opened and used for Resident 75. These deficient practices placed Residents 15, 99, 75, and 213 at risk for shortness of breath and/or hypoxia (low levels of oxygen in the body tissues), respiratory infection (a process when a microorganism, such as bacteria, fungi, or a virus, enters a person's body and causes harm) and a widespread infection in the facility which can lead into serious injury or death. Findings: 1. During a review of Resident 99's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses that included fusion of spine lumbar region (surgical procedure that joins two or more vertebrae in the lower back, aiming to stabilize the spine and reduce pain), acute respiratory failure, and muscle wasting and atrophy (partial or complete wasting away of a part of the body). During a review of Resident 99's History and Physical (H&P), dated 6/20/2025, indicated the resident had the capacity to understand and make decisions. During a review of Resident 99's Order Summary Report dated 6/13/2025, indicated a physician order to administer Oxygen at 2 to 3 LPM (liters per minute) via nasal cannula continuously for acute respiratory failure (ARF-failure of the lungs to meet the body's oxygen demand), may titrate up to 5 LPM via nasal cannula and if oxygen saturation still < 95% may titrate up to 6-10 LPM via non-rebreather mask (a mask used to deliver high flow and concentrated oxygen)to keep oxygen saturation > 95% with humidifier for 2 to 3 L per resident and responsible party request every shift. During an observation in Resident 99's room on 6/24/2025 at 8:56 AM, Resident 99's was talking on the phone and not wearing nasal cannula with the oxygen concentrator on. Resident 99 stated the nasal cannula was behind her head. During a concurrent observation and interview in Resident 99's room on 6/24/2025 at 9:09 AM, verified with RN 1 of Resident 99 was not wearing the nasal cannula. RN 1 reminded Resident 99 to wear oxygen via nasal cannula. During an interview with the DON on 6/27/2025 at 1:35 PM, the DON stated if resident does not wear oxygen nasal cannula as ordered it should be documented, and care plan should be revised. The DON stated the nurse should notify the physician. The DON stated if the resident does not wear oxygen, there could be a decrease in oxygen saturation. 2. During a review of Resident 15's admission record indicated the resident was readmitted on [DATE] with diagnoses that included acute respiratory failure with hypoxia (a state in which oxygen is not available in sufficient amounts at the tissue level to maintain adequate homeostasis), chronic obstructive pulmonary disease (COPD, lung disease causing restricted airflow and breathing problems) with (acute) exacerbation (worsening of a disease or an increase in its symptoms), and intervertebral disc degeneration lumbar region (breakdown of the discs between the vertebrae [back bones] in the lower back) with discogenic back pain (type of low back pain that originates from a damaged or degenerated intervertebral disc). During a review of Resident 15's History and Physical (H&P), dated 6/10/2025, indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 15's Order Summary Report dated 4/11/2025, indicated a physician order to administer Oxygen at 2 to 3 liters (L, unit of measure) per minute (PM) via nasal cannula continuous for COPD, may titrate up to 5 LPM via nasal cannula and if oxygen saturation still < 95 may titrate up to 6-10 LPM via non-rebreather mask to keep oxygen saturation > 95% every shift. During an observation in Resident 15's room on 6/24/2025 at 9:01 AM, Resident 15's oxygen tubing and nasal cannula was observed on resident's soiled bed and oxygen

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	06/27/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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	06/27/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of two licensed nurses (Minimum Data Set Nurse [MDSN] 1 and 2) were trained and with sufficient competency to conduct and coordinate the development and completion the residents MDS assessment by failing to: Ensure MDSN 1 and MDSN 2 conducted an accurate MDS assessment of Resident 69 and 102's elopement risk. Ensure MDSN 2 had an updated competency skills to conduct annual evaluation used for MDS assessment. This deficient practice placed residents at risk for not receiving appropriate services, treatments, and unsafe level and type of care necessary for the resident population. Cross Referenced to F641 Findings: 1. A review of Resident 69's admission Record indicated Resident 69 was initially admitted to the facility on [DATE], with diagnoses that included metabolic encephalopathy (change in how the brain works due to an underlying condition), unspecified dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and Alzheimer's disease (progressive disease that destroys memory and other important mental functions). During a review of Resident 69's Admission/readmission Initial assessment dated [DATE] indicated resident walked frequently (walks outside room at least twice a day and inside room at least once every two hours during waking hours) with no limitation. The assessment indicated an evaluation of resident elopement risk was not completed. The evaluation of resident elopement risk indicated resident was not independently mobile. During a review of Resident 69's History and Physical (H&P) dated 3/27/2025 indicated Resident 69 did not have the capacity to understand and make decisions. During a review of Resident 69's MDS dated [DATE], indicated Resident 69 was independent with indoor mobility (walking from room to room [with or without a device such as a cane, crutch, or walker]). During a review of Resident 69's Quarterly Risk assessment dated [DATE] indicated resident walked frequently with no limitation. The assessment indicated an evaluation of resident elopement risk was not completed. The evaluation of resident elopement risk indicated resident was not independently mobile. During a review of Resident 69'S MDS dated [DATE] indicated Resident 69 required partial/moderate assistance to walk 10 feet and walk 50 feet with two turns. During a concurrent interview and record review of Resident 69's Admission/readmission Initial assessment dated [DATE] on 6/26/2025 at 12:03 PM, Registered Nurse (RN) 2 stated she should have documented Resident 69 walked occasionally instead of frequently because resident was only walking inside the room. RN 2 stated the level of activity should have been documented accurately because the admission assessment is the baseline assessment of the resident. During an interview on 6/26/2025 at 12:28 PM, Minimum Data Set Nurse (MDSN) 2 stated she has seen Resident 69 walk and exercise around the facility. MDSN 2 stated Resident 69 was able to walk around to activities room, facility patio, and resident rooms to speak with other residents. During a concurrent interview and record review of Resident 69's Quarterly Risk Assessments dated 6/19/2025 on 6/26/2025 at 12:37 PM, MDSN 2 confirmed she did not complete the evaluation for elopement risk. MDSN 2 stated she used her own judgment that Resident 69 was not a wanderer (going to one place to another aimlessly) and selected no for the first question is the resident independently mobile. MDSN 2 stated she misinterpreted the question and chose no because from her understanding, Resident 69 was not an elopement risk. MDSN 2 stated she knew Resident 69 was independently mobile and she was just focusing on the elopement risk. MDSN 2 stated she decided Resident 69 was not an elopement risk. MDSN 2 stated it was important for documentation to be accurate so the whole facility knows that Resident 69 had the potential to wander or elope. During the same interview on 6/26/2025 at 12:43 PM, MDSN 2 stated when documenting the quarterly evaluation of Elopement Risk, she always thinks about elopement, I didn't really think dementia could be a risk factor for elopement and misinterpreted the questions. MDSN 2 stated residents with dementia repeat themselves, are agitated and irritable, only remember certain things and are forgetful. MDSN 2 stated when she was doing the quarterly assessment, she would see the residents and assess them from head to toe, ask other staff like certified nursing assistants, charge nurses about the resident. MDSN 2 stated she should be answering questions for the quarterly risk assessment as a cumulative of the resident's current status. During an interview on 6/26/2025 at 1:18 PM, MDSN 1 stated she focuses on resident admission when they are admitted to facility and oversees MDSN 2 who focuses on quarterly assessments when residents are in long term care. MDSN 1 stated she has to review and sign off MDSN 2's quarterly risk assessments. During a concurrent interview and record review of Resident 69's Quarterly Risk Assessments dated 6/19/2025 on

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	06/27/2025

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on interview and record review, the facility failed to post the nurse staffing information of the number of Registered Nurses (RN), License Vocational Nurse (LVN)/ License Practical Nurse (LPN) and Certified Nursing Assistant (CNA)/Nursing Assistant (NA) per shift in a prominent location in accordance with the facility's policy and procedure titled Posting Direct Care Daily Staffing Numbers. This deficient practice had the potential to not inform and cause misleading information to the residents and the visitors of the nursing care provided to the residents. Findings: During an observation on 6/24/2025 at 8:30 AM, one page of the Census and Direct Care Service Hours per Patient Day (DHPPD), dated 6/24/2025, was posted on the wall by the facility entrance near Nursing Station 2. There was no other nursing staff information posted. During an observation on 6/25/2025 at 2:40 PM, only the DHPPD, dated 6/25/2025 was posted on the wall by each nursing stations. there was no information posted indicating how many RN ' s, LVN ' s and CNA ' s were on shift for 6/25/25. During a concurrent observation and interview on 6/25/2025 at 2:44 PM with the Staffer, the Staffer removed the DHPPD from the wall sign holder and revealed a second page of paper behind the DHPPD. The Staffer stated the nursing staffing information of the number of RNs, LVNs, and CNAs was on the second page behind the DHPPD, which was not visible to the residents and visitors. The Staffer stated she had worked as the Staffer for three months and had always placed the posting that way. The Staffer stated the nursing staffing information should be posted in clear view and visible to all residents and the visitors. During an interview on 6/27/25 at 9:25 AM with the Director of Nursing (DON), the DON stated facility staff did not post the entire nursing staffing information for the RNs, LVNs, and CNAs per shift which could result in the residents and the visitor did not know the actual number of nursing staff working to provide care to the residents and cause misleading information of nursing care that the residents received. During a review of the facility ' s policy and procedure (P&P) titled, Posting Direct Care Daily Staffing Numbers, dated 8/2022, the P&P indicated; a)the facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to resident, b) within two hours of the beginning of each shift the number of licensed nurses (RNs, LPNs, and LVNs) directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in clear and readable format.

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	06/27/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to enforce the facility's policy and procedure to ensure a visitor was monitored and instructed not obtain the cups, spoons, juice and water pitchers from medication cart for 1 of 3 sampled resident (Resident 15). This deficiency has the potential to result in cross contamination (the process by which bacteria or other microorganism unintentionally transfer from one object to another with harmful effect) and spread of infection in the facility. Findings: During a medication pass observation on 6/25/2025 at 12:51 PM with Licensed Vocational Nurse (LVN 5), LVN 5 was preparing to dispense medication from medication cart - when a facility visitor (Visitor 1) grabbed multiple cups and pulled out a cup from the middle of the cup stack on top of the medication cart and then proceeded to pour juice and water in the presence of LVN 5. LVN 5 did not inform the visitor that she could not get cups, pour juice and water from the cart then take to the resident's room. During a concurrent medication pass observation on 6/25/2025 at 12:52 PM with LVN 5 facility Visitor 1 was observed exiting a Resident 15's room approach the medication cart again to grab spoons. During a review of Resident 15's admission Record (AR), the AR indicated the facility admitted Resident 15 on 4/11/2025 with that included acute respiratory failure (failure of the lungs to meet the body's oxygen demand) with hypoxia, type 2 diabetes mellitus (DM2 - a condition that results in too much sugar circulating in the blood). During an interview on 6/27/2025 at 7:39 AM with Infection Prevention Nurse (IPN), IPN stated the facility does not allow for visitors or residents to grab cups, spoons, juice or water from the medication carts because it can cause contamination as we do not know if they did hand hygiene. Standard Precautions, Enhanced Barrier Precautions and Transmission Based precautions indicated, purpose of the policy: to provide guidelines for infection control practices to reduce the potential for transmission of pathogens including Covid-19 and multi-drug-resistant organisms and viruses. Furthermore, the policy indicated J. Residents, visitor, volunteers shall be educated and instructed in hand hygiene protocols, PE use, and other infection control practices.