STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056190	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Ridge Post Acute LLC	525 South Central Avenue Glendale, CA 91204

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 - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48219 Based on observations, interview, and record review, the facility failed to provide adequate supervision for one of five residents (Resident 1) based on the resident ' s individual and assessed needs. This lack of supervision has increased risk for falls and injuries due to resident ' s wandering (Going one location to another aimlessly, usually without a plan or definitive purpose). This deficient practice had the potential for Resident 1 to sustain injuries and increases the risk of altercations with other residents. Findings: A review of Resident 1 ' s Admission Record indicated the resident was admitted on [DATE], with diagnosis of, but not limited to, dementia (decline in mental ability server enough to interfere with daily function) and Alzheimer ' s disease (A progressive disease that destroys memory and other important mental functions). A review of Resident 1 ' s History and physical dated 11/2/2023, indicates Resident 1 does not have the capacity to understand and make decisions with chief complaint of wondering behavior and Dementia. A review of Resident 1 ' s Minimum Set Data (MDS - a standardized assessment and screening tool) dated 4/16/2024, indicated Resident 1 has severe cognitive impairment. The MDS also indicated the resident is dependent for all aspects of personal hygiene, dressing, bathing and indicated resident has presence of wandering behavior, occurring daily. A review of Residents 1 ' s Physicians orders dated 12/10/2023, indicated to Monitor whereabouts of Resident every hour. A review of Resident 1 ' s Medication Administration Record with a start date of 12/10/2023, indicated to monitor whereabouts of resident every hour. However, the MAR indicated documentation were completed every shift (8 hours - Day, Evening, Night). (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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(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 - Few	A review of Resident 1 ' s Care plan dated 10/30/2023, indicated a problem/need, that showed Resident 1 was at risk for injuries secondary to wandering behavior with a goal of Resident 1 will have no injuries and interventions. The interventions indicated to monitor the resident ' s location with visual check at least every 2 hours. A review of Resident 1 ' s records indicated Resident 1 was monitored hourly from 4/20/24 to 4/23/24 but no documentation found that Resident 1 was monitored every 2 hours after 4/24/24. A review of Resident 1 ' s Care plan dated 4/20/2024, indicated the resident will have 1:1 supervision as needed. A review of Resident 1 ' s records indicated that Resident 1 had no 1:1 supervision from 4/20/2024 up to present. Resident 1 ' s records indicated Resident 1 was monitored hourly from 4/20/24 to 4/23/24 only. A review of Resident 1 ' s record titled Renew SBAR dated 4/20/24 timed at 2:47 PM, indicated that an altercation happened between Resident 1 and Resident 2. Resident 2 physically assaulted Resident 1. Resident 2 punched Resident 1 on the left cheek because Resident 1 walked inside Resident 2 ' s room. The SBAR indicated, Resident 1 did not sustain injuries. During an interview on 5/6/2024 at 9:45 am with the DON, when asked how the facility staff monitor Resident 1 as indicated in the care plan and physician orders. The DON stated the CNA assigned to the area where Resident 1 was, would be responsible for monitoring the location of the resident and document in the MAR every shift. The DON noted during a concurrent review of the Physician Order indicated to monitor the resident every hour. During a concurrent record review and interview on 5/6/2024 at 10:40 am, with LVN 1, stated it was normal for Resident 1 to wander. LVN 1 stated Resident 1 does go into other resident ' s rooms occasionally. LVN 1 stated the facility staff make sure to make a visual check every 30 minutes and stated the physician order indicated Resident 1 should be monitored every hour, but the Medication Administration Record indicated to document every shift. This is the only documentation we do. During an observation on 5/6/24 at 11 am, inside Resident 1 ' s room, Resident 1 was lying in bed and unable to verbalize needs and unable to respond to basic questions. During an interview on 5/6/24 at 12:50 pm, the DON was asked how supervision was being provided to Resident 1. The DON stated that Resident 1 only had 72 hours monitoring after the altercation occurred on 4/20/24. The DON stated after that, Resident 1 had every shift monitoring. The DON stated Resident 1 had wandering behavior in the past but did not recall going inside other resident's rooms or displaying hostile behaviors. On 5/6/2024 at 1:30 pm, during an observation, inside Resident 1 ' s room, Resident 1 was found on the floor, next to the resident ' s bed. Resident 1 ' s body was lying with head facing the foot of the bed with abdomen almost prone position on the floor. No visible signs of bleeding or lacerations noted. Observed resident not moving, no vocalization of being in pain or calling for help. No audible sound alarming from the bed. During the observation, and [NAME] Resident 1 was on the floor, CNA2 was inside the room in the next bed, assisting Resident 1 ' s roommate. CNA 2 was asked if he knew Resident 1 was on the floor. CNA 1 stated oh he is just crawling. (continued on next page)

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(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 - Few	During the same concurrent observation and interview, on 5/6/24 at 1:35 pm, CNA 2 assisted Resident 1 back in bed. CNA 2 stated he did not see Resident 1 get out of bed, even if he is just in the next bed assisting the roommate. When asked if Resident 1 was able to walk independently, CNA 2 stated Resident 1 was able to walk when he wants to. When asked why Resident 1 was still in bed at 1:35 pm, CNA 2 had no answer. During the observation, Resident 1 was attempting to get out of bed with unsteady gait and requiring maximum assistance of CNA2 to walk. On 5/6/24 at 1:36 pm, the DON stated that Resident 1 ' s behavior is at his baseline and that the facility would have to place a bed alarm to alert staff. On 5/6/24 at 3:15 pm, the SSD stated that she interviewed Resident 2, after the altercation and Resident 2 informed him that Resident 1 came inside his room behaving agitated, that is why he hit Resident 1. The SSD stated that Resident 1 is a fall risk. A review of Facility ' s policies and procedures titled Wandering and Elopement dated 7/2018, Indicated purpose: to enhance the safety of Residents, to help identify Resident who are at risk and to minimize possible injury. A resident who are deemed to be high risk for elopement or wandering will have a photograph maintained in their medical record and IDT will develop a plan of care considering the individual risk factors of the Resident. Person- centered approach/ interventions to prevent elopement and /or divert wandering behavior will be included in the plan- of - Care.

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F 0744

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48219

Based on observation, interview and record review, the facility failed to comprehensively assess the root cause of behavioral symptoms and develop measurable goals and interventions to address care and treatment of a resident with dementia (a disorder of mental processes caused by brain disease or injury and marked by memory disorder, personality changes, and impaired reasoning) for one of five sampled residents (Resident 1) with diagnosis of dementia with behaviors.

This deficient practice had the potential to negatively affect the safety, wellbeing, and the delivery of services.

Findings:

A Review of admission record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 ' s diagnoses included but was not limited to Dementia (loss of memory, language, problem - solving and other thinking abilities) with behavioral disturbances, schizoaffective disorder (hallucinations or delusions, and symptoms of a mood disorder, such as depression), anxiety disorder(responds to situations with fear and dread), and Alzheimer ' s disease(loss of memory and thinking skills and, loss of ability to carry out simple tasks).

A review of Resident 1 ' s History and physical report completed on 11/2/2023, indicated resident 1 does not have the capacity to understand and make decisions with diagnosis of advanced Dementia (loss of memory, language, problem - solving and other thinking abilities).

A review of Resident 1 ' s Minimum Set Data (MDS - a standardized comprehensive assessment and care planning tool) dated 4/16/2024, indicated the resident displays wandering behavior daily with potential for hallucinations (Perceptual experiences in the absence of real external sensory stimuli).

A review of Resident 1 ' s Physician order dated 12/10/2023, indicated to monitor resident 1 ' s whereabouts every hour with diagnosis of Alzheimer ' s disease.

A review of Resident 1 ' s Medical Administration Records indicated resident 1 receives Donepezil 10mg tablet: every day at 9 pm for Dementia.

A review of Resident 1 ' s Care plan dated 10/30/2023, indicated a problem/need, that showed Resident 1 was at risk for injuries secondary to wandering behavior with a goal of Resident 1 will have no injuries and interventions. The interventions indicated to monitor the resident ' s location with visual check at least every 2 hours.

A review of Resident 1 ' s records indicated Resident 1 was monitored hourly from 4/20/24 to 4/23/24 but no documentation found that Resident 1 was monitored every 2 hours after 4/24/24.

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Printed: 08/28/2024
Form Approved OMB
No. 0938-0391

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1 ' s Care plan dated 4/20/2024, indicated the resident will have 1:1 supervision as needed. A review of Resident 1 ' s records indicated that Resident 1 had no 1:1 supervision from 4/20/2024 up to present. Resident 1 ' s records indicated Resident 1 was monitored hourly from 4/20/24 to 4/23/24 only. A review of Resident 1 ' s record titled Renew SBAR dated 4/20/24 timed at 2:47 PM, indicated that an altercation happened between Resident 1 and Resident 2. Resident 2 physically assaulted Resident 1. Resident 2 punched Resident 1 on the left cheek because Resident 1 walked inside Resident 2 ' s room. During a concurrent record review and interview on 5/6/2024 at 10:40 am, with LVN 1, stated it was normal for Resident 1 to wander. LVN 1 stated Resident 1 does go into other resident ' s rooms occasionally. During an observation on 5/6/24 at 11 am, inside Resident 1 ' s room, Resident 1 was lying in bed and unable to verbalize needs and unable to respond to basic questions. During an interview on 5/6/24 at 12:50 pm, the DON was asked how supervision was being provided to Resident 1. The DON stated that Resident 1 only had 72 hours monitoring after the altercation occurred on 4/20/24. The DON stated after that, Resident 1 had every shift monitoring. The DON stated Resident 1 had wandering behavior in the past but did not recall going inside other resident ' s rooms or displaying hostile behaviors. On 5/6/2024 at 1:30 pm, during an observation, inside Resident 1 ' s room, Resident 1 was found on the floor, next to the resident ' s bed. Resident 1 ' s body was lying with head facing the foot of the bed with abdomen almost prone position on the floor. No visible signs of bleeding or lacerations noted. Observed resident not moving, no vocalization of being in pain or calling for help. No audible sound alarming from the bed. During the observation, and [NAME] Resident 1 was on the floor, CNA2 was inside the room in the next bed, assisting Resident 1 ' s roommate. CNA 2 was asked if he knew Resident 1 was on the floor. CNA 1 stated oh he is just crawling. During the same concurrent observation and interview, on 5/6/24 at 1:35 pm, CNA 2 assisted Resident 1 back in bed. CNA 2 stated he did not see Resident 1 get out of bed, even if he is just in the next bed assisting the roommate. When asked if Resident 1 was able to walk independently, CNA 2 stated Resident 1 was able to walk when he wants to. When asked why Resident 1 was still in bed at 1:35 pm, CNA 2 had no answer. During the observation, Resident 1 was attempting to get out of bed with unsteady gait and requiring maximum assistance of CNA2 to walk. On 5/6/24 at 1:36 pm, the DON stated that Resident 1 ' s behavior is at his baseline and that the facility would have to place a bed alarm to alert staff. On 5/6/24 at 3:15 pm, the SSD stated that she interviewed Resident 2, after the altercation and Resident 2 informed him that Resident 1 came inside his room behaving agitated, that is why he hit Resident 1. The SSD stated that Resident 1 is a fall risk. During a concurrent record review and interview on 5/6/2024 at 4:00 pm with the DON, the DON stated Dementia care plan was not created or implemented for Resident 1. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview on 5/6/2024 at 4:00 the pm with DON, the DON stated there is no record of IDT meeting conducted for Resident 1 ' s dementia diagnosis and manifesting behaviors associated with dementia. A review of the Facility ' s Policy Revised December 2016 Titled Care Plans indicated a plan of care shall be developed to assure that that the resident ' s needs are met and maintained including but not limited to goals, and Therapy services and to updated as necessary.