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	05/28/2024

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** 47882 Based on observation, interview, and record review, the facility failed to ensure adequate supervision for one of three sampled residents (Resident 1) by not escalating the process of finding Resident 1 ' s whereabout by not informing the Medical Doctor (MD), Director of Nurses (DON)] or the Social Worker (SW) for guidance when Resident 1 went out on pass (OOP) (temporary permission of a patient to leave the hospital in a specified time) on 5/23/2024 at 8:30 AM, and did not return to the facility the same day at 12:00 PM (which was Resident 1 ' s estimated time of return). This incident delayed the notification of law enforcement and other appropriate agencies, who were notified more than 24 hours from the time of the incident. Resident 1 returned to the facility on [DATE] at 1:30 AM (more than 24 hours from the time resident went OOP), feeling tired, with untidy clothes and dirty hands and feet. Resident 1 also missed 2 days of due medications. This deficient practice had the potential for Resident 1 to sustain accidents and physical injury while out of the facility. Findings: A review of Resident 1 ' s Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily), schizoaffective disorder, bipolar type (Episodes of mania {extreme highs} and sometimes major depression {severe lows}, and hypertension (high blood pressure). A review of Resident 1 ' s History and Physical Examination, dated 2/27/2024, indicated Resident 1 had the capacity to understand and make decisions. A review of Minimum Data Set (MDS, a standardized assessment and care screening tool), date 3/4/2024, indicated Resident 1 ' s cognitive skills (ability to make daily decisions) was moderately impaired. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and or contact guard assistance as resident completes activity) with eating and partial/moderate assistance (helper does less than half the effort) with personal hygiene. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1 ' s physician order dated 3/9/24, indicated Resident 1 may go out on pass. A review of Resident 1 ' s care plan (CP) titled Out on Pass, dated 3/9/2024, the CP indicated concern Resident may sustain injury going out on pass. The CP intervention included; if Resident is due for medication during the time that he or she will be out on pass, the Resident will be given medications that are due for that time and written and or oral instructions on when and how to administer the medications that are to be issued. A review of Resident 1 ' s facility document titled Temporary Leave of Absence (TLA), dated 5/23/2024, indicated Resident 1 went OOP on 5/23/2024 at 8:30 AM with estimated time of return of 12:00 noon. A review of Resident 1 ' s facility document titled Departmental Notes (DN), dated 5/24/2024 timed at 2:27 PM, indicated Primary Medical Doctor (PMD), and the Police was notified regarding Resident 1 have not returned from going OOP from 5/23/2024 at 8:30 AM (more than 24 hours from Resident 1 estimated time of return). A review of Resident 1 ' s facility document titled Departmental Notes (DN), dated 5/25/2024 timed at 5:30 AM, indicated, Resident 1 returned to the facility around 1:30 AM clothes were untidy, hands and feet were dirty, overall appearance were disheveled (messy). During an interview on 5/28/2024 at 12:20 PM with the Director of Nurses (DON), the DON stated, Resident 1 went OOP on 5/23/2024 at 8:30 AM and did not return until 5/25/24 at 1:30 AM. The DON stated Resident 1 missed two days of scheduled medications. The scheduled medications included Fluoxetine 10 mg daily for depression, Senna 8.6 mg daily for constipation, metoprolol 50 mg tablet twice daily for hypertension, quietapine 100 mg twice daily for schizophrenia, gabapentin 300 mg three times daily for neuralgia/seizure, another quietapine 200 mg at bedtime. During a concurrent observation and interview on 5/28/2024 at 12:28 PM with Resident 1 in Resident 1 ' s room, Resident 1 stated, she usually goes OOP frequently. On 5/23/2024 Resident 1 stated, she went OOP to go to a pawnshop and get money to fix herself, manicure, and shopping. Resident 1 stated, she had trouble getting transportation to go back to the facility and her phone stopped working. Resident 1 stated, she stayed at a (Store 1) the whole time and random people and Store 1 owner did not let her use their phone to call the facility. Resident 1 stated she felt cold while outside the facility and her feet hurts. Resident 1 stated, on 5/25/2024 at around 1 AM, a good citizen (Citizen 1), called transportation for her to get back to the facility. During an interview on 5/28/2024 at 1 PM with the Social Worker (SW), the SW stated, Resident 1 was gone for more than 24 hours (Resident 1 went OOP 5/23/2024), and Resident 1 whereabouts should have been addressed immediately when Resident 1 did not return from her expected time of return on 5/23/2024 at 12 noon. The SW stated, she was not informed of Resident 1 not returning from OOP until the next day, 5/24/2024. The SW stated, she informed the police, the ombudsman, and the Department of Health 5/24/2024, and it should be documented. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/28/2024 at 1:15 PM with the DON, the DON stated, the OOP order was not complete, it should include the duration the resident is allowed to be OOP. The DON stated, she should have been notified when Resident 1 did return from OOP immediately, so she could have notified the Police earlier. The DON stated it is important to always know Resident 1 ' s whereabouts for her safety. During an interview on 5/28/2024 at 1:45 PM with Licensed Vocational Nurse (LVN) 1, stated, if a resident did not return from going OOP at the expected time of return, and unable to contact the resident, it should be escalated to upper management for guidance. LVN 1 stated, regarding Resident 1 ' s incident, the PMD, the DON, and SW should have been notified immediately to alert authorities. LVN 1 stated, the facility is responsible for Resident 1 ' s safety. During an interview on 5/28/2024 at 1:45 PM with Registered Nurse (RN) 1 (RN supervisor 7 to 3 shift 5/23/2024), stated, on 5/23/2024 when Resident 1 did not return from going OOP at 12 PM (estimated time of return), she should have escalated the concern and notify the MD, DON, and SW to alert the authorities. During a concurrent interview and record review, on 5/28/2024, at 2:15 PM, with the DON, Resident 1 ' s Medication Administration Record (MAR) for the month of May 2024 indicated, for 5/22/2024 and 5/23/2024 medications were initialed N. The DON stated, N indicated the medications were not given for 2 days which included medication for high blood pressure. The DON stated, Resident 1 not getting her blood pressure medication and other scheduled medications had the potential for harm. During an interview on 5/28/2024 at 3:25 PM with LVN 2 (worked on 5/23/2024 7 to 3 shift), stated, when Resident 1 did not return from going OOP she should have escalated the issue and notified the MD, DON, and SW for guidance. LVN 2 stated, it is important to know Resident 1 ' s whereabout because it is a safety issue and something bad might happen to her. During an interview on 5/28/2024 at 3:25 PM with LVN 3 (worked on 5/23/2024 3 to 11 shift), stated, it was endorsed to her by the previous shift, that Resident 1 went OOP and had not returned yet. LVN 3 stated, she should have escalated the concern and inform the resident ' s physician, the DON, and the SW for guidance and alert authorities. LVN 3 stated, knowing Resident 1 whereabouts is a patient safety issue. During an interview on 5/28/2024 at 4 PM with the DON, the DON stated, she expected the staff to inform her if a resident did not return at least within 4 hours from the time the resident is supposed to comeback from OOP so she can report it to the appropriate agencies as an unusual occurrence. A review of the facility ' s policy and procedure (P&P) titled Signing Resident Out, revised 8/2006. The P&P indicated; a) unless otherwise prohibited by law, medications that must be administered while the resident is out will be given to the resident /person signing the resident out, b) written and/or oral instruction on when and how to administer the medication will be provided to the resident or to the person signing the resident out, and only medications that must be administered while the resident is out will be issued.