STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056190	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2024

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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779 Based on interview and record review, the facility failed to provide sufficient nursing staff who have the knowledge, training, and skills sets to address behavioral healthcare needs for one of four sampled residents (Resident 1), who was diagnosed with dementia and assessed at high risk for elopement, in accordance with the resident ' s care plan, the facility ' s policy and procedure on Behavioral Health Services, Dementia Care, and the Facility Assessment. The facility staff failed to intervene when Resident 1, who was visibly agitated and refused to come back inside the facility upon returning from an out-on-pass with the family [FM 1] on 11/27/2024. Registered Nurse [RN] 1 failed to implement Resident 1 ' s care plan on Behavioral Problem. RN 1 did not address Resident 1 ' s agitated behavior and allowed Resident 1 to wander out of the facility and instructed FM 1 to follow the resident and for FM 1 to call law enforcement. As a result of this deficient practice Resident 1 could not be found for two and half hours on 11/27/2024. On 11/27/2024, at around 8:10 PM, local law enforcement found Resident 1 and transferred to the general acute care hospital [GACH] and was placed on Welfare and Institutions Code 5150 hold (the code allows an adult who is experiencing a mental health crisis to be involuntarily detained for a 72- hour when evaluated to be a danger to others, or to himself or herself, or gravely disabled). Findings: During a review of Resident 1 ' s Admission Record indicated the facility admitted Resident 1 on 6/20/2024 with diagnoses that included encephalopathy (a general term for a group of brain disorders or diseases that cause brain dysfunction) and unsteadiness on feet. During a review of Resident 1 ' s Elopement Risk Assessment (ERA), dated 6/21/2024, indicated Resident 1 had elopement risk total score of 12 which indicated Resident 1 had a history of elopement and was at high risk for elopement. The ERA indicated Resident 1 had wander behavior and wander aimlessly. The potential interventions for elopement indicated frequent monitoring-check every two hours, identification bracelet, and staff aware of resident ' s wander risk. During a review of Resident 1 ' s Care Plan, dated 6/21/2024, the Care Plan indicated Resident 1 was at risk for elopement and the interventions were to assist in re-orientation to room/facility, monitor resident location with visual check, monitor behavior and mood patterns, anticipate resident needs based upon wandering behavior. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056190	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2024
NAME OF PROVIDER OR SUPPLIER Chestnut Ridge Post Acute LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s History and Physical Examination (H&P), dated 6/22/2024, indicated Resident 1 had a diagnosis of dementia (a term used to describe a group of symptoms affecting memory, thinking and social abilities) and Resident 1 does not have the capacity to understand and make decisions. During a review of Resident 1 ' s Psychiatric Examination, dated 6/27/2024, indicated Resident ' s chief complaint and psychiatric history was anxiety (a feeling of fear, dread, and uneasiness that can be a normal reaction to stress). During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 9/24/2024, indicated Resident 1 required supervision or touching assistance for eating, and partial/moderate assistance with oral hygiene, toileting hygiene, shower/bathe self, and personal hygiene, and chair/bed-to-chair transfer. During a review of Resident ' s Care Plan, dated 10/8/2024, the Care Plan indicated Resident 1 has a behavior problem and the intervention was to intervene as necessary by approach/speak in a calm manner, divert attention, and remove from situation and take to alternate location as needed. During a review of Resident 1 ' s Elopement Evaluation (EE), with effective date 11/26/2024 and timed at 12:18 PM, indicated Resident 1 had a history of elopement and was the risk for elopement and she had a pattern of wandering behavior. The EE indicated the intervention included notify staff of wandering and elopement risk and monitor location frequently. During a review of Resident 1 ' s Change in Condition Evaluation (COC), dated 11/26/24 at 5:09 PM, the COC evaluation indicated Resident 1 attempted to leave the facility on 11/26/2024 [prior to the resident ' s out on pass with the family member on the same day]. During a review of Resident 1 ' s Progress Notes (PN), dated 11/27/2024, was reviewed. The PN indicated the Family Member (FM) took Resident 1 home out on pass on 11/26/2024 at 6 PM [an hour prior to Resident 1 ' s attempt to elope the facility on 11/26/2024 timed at 5:09 PM] and planned to bring Resident 1 back to the facility after the holiday celebration, but Resident 1 was showing aggressive behavior at home. Then, on 11/27/2024 at 6:30 PM, the FM came inside the facility and asked for help because she brought Resident 1 to the outside of the facility but Resident 1 refused to come inside and walked away. The PN indicated FM 1 did not want to force Resident 1 getting inside the facility. The facility staff followed up with the FM over the phone twice and asked about Resident 1 ' s whereabouts, then, the FM stated she did not know where Resident 1 was. The facility staff advised the FM to report to local police. On 11/27/2024 around 9:30 PM, Resident 1 was found by police. During a review of the Police Report (PR), dated 11/27/2024, the PR indicated that on 11/27/2024, at approximately 8:10 PM assisted with a missing person report. The PR indicated Resident 1 walked away from the facility after she was dropped off by the FM. The PR indicated Resident 1 was located sitting on a bus bench, subsequently. The PR indicated that based on Resident 1 ' s conflicting statements and wanting to wander the streets of another city, Resident 1 was transported to the GACH and was placed on Welfare and Institutions Code 5150 hold by the GACH. The PR indicated Resident 1 was gravely disabled and a danger to herself. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056190	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2024
NAME OF PROVIDER OR SUPPLIER Chestnut Ridge Post Acute LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Order Summary Report, for December 2024, the Order Summary Report indicated physician order dated 6/21/2024, to monitor the resident ' s whereabouts every two hours, visual check due to high risk for elopement. The Order Summary Report also indicated another physician order dated 11/26/204, that Resident 1 may go out on pass with the FM for 48 hours. During an interview on 12/3/2024 at 10:53 AM, with Certified Nursing Assistant (CNA) 1, CNA 1 stated she was assigned to take care of Resident 1 regularly in the morning shift and she was familiar with Resident 1 ' s care. CNA 1 stated Resident 1 was confused, and she would get mad sometimes by yelling and screaming at the staff. CNA 1 stated she was not aware that Resident 1 was on the watch for elopement risk before the incident on 11/27/2024. During an interview on 12/3/2024 at 11:15 AM, with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 was delusional sometimes and she could be aggressive sometimes by yelling and screaming at the staff. LVN 1 stated the facility identified Resident 1 was at risk for elopement before [could not recall date]. LVN 1 stated Resident 1 tried to go out the facility without the staff ' s supervision two times before [unable to recall dates], but the facility staff caught the resident before she could go out the facility. During an interview on 12/3/2024 at 11:30 AM, with the Director of Nursing (DON), the DON stated the receptionist reported to her that Resident 1 was holding a bag and had the tendency of going out the facility on 11/26/2024 [prior to leaving out on pass with the FM], so the facility notified Resident 1 ' s physician and obtained an order to put a wander guard on the resident, and completed the COC. The DON stated Resident 1 was often out on pass with the family members and returns to the facility on the same day without any issue in the past. The DON stated Resident 1 did not have any history of an actual elopement from the facility, so the FM ' s request to take Resident 1 home for 48 hours for the holiday was approved even though it was the first time for Resident 1 to be out of the facility overnight. The DON stated the FM took Resident 1 home out on pass for 48 hours on 11/26/24 at 6 PM, but the FM decided to bring Resident 1 back to the facility on [DATE], because Resident 1 was showing aggressive behavior, and she could not control the resident at home. The DON stated the FM informed the staff that Resident 1 did not want to come inside the facility and Registered Nurse (RN) 1 offered that the staff could grab Resident 1 and bring the resident inside, but the FM did not want to forcefully bring Resident 1 back to the facility. The DON stated since the FM refused the staff ' s help at that time [on 11/27/24] and allowed Resident 1 kept walking away, the facility had to respect the FM ' s choice and followed up with the FM by phone to check the whereabouts of Resident 1. The DON stated the facility did not send a staff to follow Resident 1 because the staff could not follow Resident 1 wherever she was going to walk to. The DON stated when RN 1 knew about Resident 1 was missing, the facility did not report to the police, instead, RN 1 advised the FM to report to the police to find Resident 1. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056190	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2024

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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 12/3/2024 at 12:52 PM, with RN 1, RN 1 stated on 11/27/2024 at 6:30 PM, the FM came inside the facility and said she brought Resident 1 back to the facility. The FM stated Resident 1 was still outside the facility, because the resident refused to come back inside the facility and walking away. RN 1 stated the FM said Resident 1 was acting out at home and yelling at the FM, and she could not control Resident 1 at home. RN 1 stated she did not see Resident 1 outside the facility lobby at that time. RN 1 stated she asked the FM if it was ok for the staff to grab Resident 1 and bring her in, but the FM did not want to force Resident 1 to go inside and wanted Resident 1 to be willing to go back to the facility. RN 1 stated she offered help, but the FM refused at that time. RN 1 stated she did not send any facility staff outside to check on Resident 1 because if Resident 1 would not listen to the FM, then, she would not listen to a facility staff who the resident was not familiar with. RN 1 stated she told the FM to follow Resident 1 and kept a visual on her, then, she called twice to follow up with the FM regarding the whereabouts of Resident 1. RN 1 stated 20 minutes later, she saw the FM was sitting in the car outside of the facility, and the FM said she did not know where Resident 1 was. RN 1 stated she advised the FM to report to the police. RN 1 stated Resident 1 was found around 9:30 PM. RN 1 stated Resident 1 was out on pass, the FM was responsible for the resident. RN 1 stated the facility would be responsible for Resident 1 until she was checked in back to the facility. RN 1 stated she was not sure or aware if Resident 1 was at risk for elopement. During a telephone interview on 12/3/2024 at 2:36 PM, with the FM, the FM stated on 11/27/2024 morning, Resident 1 was getting more difficult and agitated as the day progressed and she could not control Resident 1 at home anymore, so she decided to bring Resident 1 back to the facility. The FM stated Resident 1 had dementia and was showing the symptoms of early stage of dementia, but the aggressive behavior at home was new to her and she did not know how to handle Resident 1 safety at home. The FM stated she drove Resident 1 to the facility, but when Resident 1 was 10 feet away from the facility ' s lobby door, Resident refused to go inside and started to walk away. The FM stated she tried to convinced Resident 1 but Resident 1 just kept walking further away. The FM stated she did not know what to do and went inside the facility to ask for help. The FM stated she could not get help from the facility staff at the front lobby until RN 1 came out and talked to her. The FM stated RN 1 asked if she agreed to have the staff to grab Resident 1, and she replied she did not want to force Resident 1 back to the facility and she did not know what to do. The FM stated RN 1 told her to follow Resident 1 and keep an eye on the resident. The FM stated she tried to follow Resident 1, but when Resident 1 saw her, Resident 1 turned around and walked away from her, so she decided to wait in the car, in hoping that Resident 1 would return on her own if Resident 1 did not see her following, but she did not see Resident 1 walked back to the facility. The FM stated when she told RN 1 that she did not know where Resident 1 was, RN 1 told her that she had to call the police herself. The FM stated she went inside the facility to ask for help because she did not know what to do when Resident 1 refused to go inside the facility and walked away. The FM stated she thought the facility staff would send someone outside to talk to Resident 1 and bring her in the facility calmly, but the facility did not send anyone outside to check on Resident 1. The FM stated she felt helpless at that time because she did not have the professional knowledge of dealing with a situation like this and she expected the facility staff to provide professional assistance to address Resident 1 ' s behavior and ensure the resident safety. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056190	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2024
NAME OF PROVIDER OR SUPPLIER Chestnut Ridge Post Acute LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/3/2024 at 3:55 PM, with the DON, the DON stated the facility had the responsibility for Resident 1 ' s safety when the resident was outside the facility. The DON stated Resident 1 had a diagnosis of dementia and was showing signs and symptoms of distress when the FM tried to bring Resident 1 back to the facility. The DON stated the staff should addressed Resident 1 ' s distress and provide professional assistance to check on Resident 1 right away, bring her back to the facility, and call the police as needed to ensure the resident ' s safety. During an interview on 12/10/2024, at 3 PM, the DON stated as this time, the staff would receive dementia care training upon hire and regular dementia care in-service during facility huddle and daily rounding. The DON stated the facility did not have a competency checklist for each staff about dementia care. The DON stated dementia care was not included in the staff annual competency evaluation. The DON stated there were 14 residents residing at the facility assessed at risk for elopement. During a review of the facility ' s Policy and Procedures (P&P), Behavioral Health Services, dated 2/2019, indicated Residents who exhibit signs of emotional/psychosocial distress receive services and support that address their individual needs and goals for care. The P&P indicated Staff must promote dignity, autonomy . and safety as appropriate for each resident and are trained in ways to support residents in distress. During a review of the facility ' s Hand in Hand Dementia Training Acknowledgement, dated 4/23/2024, indicated Registered Nurse (RN) 1 certified that she was able to effectively listen and speak with a person with dementia and understand the actions and reactions of persons with dementia as forms of communication. During a review of the facility ' s Facility Assessment (FA), dated 7/1/2024 to 9/1/2024, The FA indicated the facility would address the diagnosis and condition of dementia and would provide training in non-pharmacological interventions, dementia care, change of condition, baseline and care plan content and resident rights. The FA also indicated the facility would provide dementia training twice per year.