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	05/20/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to report immediately and/or no later than two hours if the alleged allegation involves abuse, the verbal and physical altercation that happened with two of two sampled residents (Resident 1 and Resident 6) on 5/3/2025. Resident 6 reported that on 5/3/2025 around 9AM, Resident 1 stopped him in the hallway in his wheelchair, and yelled profanity (offensive or vulgar language, often considered impolite, rude, or disrespectful) at him and while in his wheelchair, he was pushed fast, spun around and grabbed his shirt prior to the staff separating them. As a result, Resident 6 verbalized feeling upset, sad and discouraged, which negatively affected his quality of life. Also, it had the potential for a recurrence resulting in harm to other residents and staff in the facility. On the same day, 5/3/2025, approximately four hours after the altercation with Resident 6, the facility failed to report an incident of Resident 1 choking Certified Nurse Assistant (CNA) 1 on 5/3/2025, while CNA 1 was inside another resident ' s room (Resident 5). Resident 1 was transferred to the General Acute Care Hospital (GACH 1) on 5/3/2025 via 5150 (temporary, involuntary psychiatric commitment of individuals who present a danger to themselves or others due to signs of mental illness). Findings: A review of Resident 1 ' s admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cognitive communication deficit (communication difficulties stemming from underlying cognitive impairments, rather than from speech or language deficits), schizoaffective disorder- bipolar type (a mental illness that combines symptoms of schizophrenia [like hallucinations and delusions) with those of bipolar disorder (like mania and depression)], and psychotic disorder (when you see reality very differently to people around you). A review of Resident 1 ' s History and Physical Examination (HPE), dated 4/18/2024, indicated Resident 1 was alert to time, person and situation. (continued on next page)

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
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1 ' s Minimum Data Set (MDS – a resident assessment screening tool), dated 4/18/2025, indicated the Resident 1 ' s cognitively status (ability to think, remember, and reason) moderately impaired impaired. The MDS indicated Resident 1 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, dressing, toileting and bathing. A review of Resident 6 ' s admission record indicated the resident was admitted to the facility on [DATE] with diagnoses that included osteoarthritis (a degenerative joint disease where the cartilage cushioning the bones in your joints wears away over time) of both shoulders and both knees, diabetes mellitus (disease of inadequate control of blood levels of glucose), and hypertension (high blood pressure). A review of Resident 6 ' s History and Physical Examination (HPE), dated 10/11/2024, indicated Resident 6 has the capacity to understand and make decisions. A review of Resident 6 ' s Minimum Data Set (MDS – a resident assessment screening tool), dated 4/18/2025, indicated the Resident 6 ' s cognitively status (ability to think, remember, and reason) was intact. The MDS indicated Resident 6 required Setup and clean-up assistance (helper sets up and cleans up; resident completes activity) with eating and oral hygiene, substantial/maximal assistance (helper does more than half the effort) with dressing and personal hygiene, and dependent (helper does all the effort) with bathing and toileting. A review of Resident 5 ' s admission record indicated the resident was admitted to the facility on [DATE] with diagnoses that included Alzheimer ' s disease (a progressive brain disorder that primarily affects memory and thinking skills, eventually leading to difficulty with everyday tasks and behavior changes), aortic aneurysm (a bulge that occurs in the wall of the body's main artery, called the aorta) and palliative care (focuses on improving the quality of life for people with serious illnesses by providing comfort and support, even when a cure isn't possible). A review of Resident 5 ' s History and Physical Examination (HPE), dated 5/1/2024, indicated Resident 5 does not have the capacity to understand and make decisions. A review of Resident 5 ' S Minimum Data Set (MDS – a resident assessment screening tool), dated 4/14/2025, indicated Resident 5 dependent with eating, oral hygiene, toileting, bathing, dressing and personal hygiene. A review of Resident 1 ' s facility document titled, Progress Notes (PN), dated 5/3/2025 timed at 1:45 PM, indicated Resident 1 was aggressive and hurt Certified Nurse Assistant (CNA) 1 by putting his hands around CNA ' s 1 neck, and the police came and took Resident 1 to GACH 1 for physical aggression via 5150 (California law code for the temporary, involuntary psychiatric commitment of individuals who present a danger to themselves or others due to signs of mental illness). (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/2025 at 3:30 PM with Family 2 (Family of Resident 5), Fam 2 stated, on 5/3/2025 around 1 PM, while inside Resident 5 ' s room (which was adjacent to Resident 1 ' s room), she was talking to CNA 1, when Resident 1 came to Resident 5 ' s room and without warning attacked and started choking CNA 1. Fam 2 stated she helped CNA 1 and had to remove Resident 1 ' s hand around CNA 1 ' s neck. Fam 2 stated, the police came and took Resident 1 away. Fam 2 stated, she was concerned for Resident 5 ' s safety since Resident 5 is cognitively impaired, and other residents who cannot protect themselves from Resident 1. Fam 2 stated, she informed the Director of Social Services (DSS) and the facility leadership about her concern that same day. During an interview on 5/7/2025 at 3:50 PM with CNA 1, CNA 1 stated, on 5/3/2025 around 1 PM she was talking to FAM 2 inside Resident 5 ' s room, when Resident 1 came inside Resident 5 ' s room and grabbed her neck and started choking her without warning. CNA 1 stated the staff came to help, and the police took Resident 1 away on 5/7/2025. During a concurrent observation and interview on 5/7/2025 at 4:30 PM with Resident 6, in Resident 6 ' s room, Resident 6 was sitting at the side of the bed, next to his wheelchair, face was flushed, eyebrows drawn together, clenched teeth with teary eyes and would look up and down while being interviewed. Resident 6 stated, the incident with Resident 1 started with him, on 5/3/2025 around 9AM, he was in the hallway going towards the smoking area, when Resident 1 blocked his way and started yelling profanity, grabbed his wheelchair and pushed him in the hallway so fast, even touching his back and he almost fell. Resident 6 stated, he struggled, then Resident 1 turned his wheelchair around and grabbed his jacket, that ' s when the facility staff separated them. Resident 6 stated he reported the incident to the charge nurse, and there were other nurses there, but he does not remember their names. Resident 6 stated, he felt discouraged and sad and what upsets him the most was no one talked to him about the incident, and he felt he was nobody and no one cares for him. During an interview on 5/8/2025 at 9:30 AM with Housekeeper (HSK) 1, HSK 1 stated., she worked on 5/3/2025, and around 9AM she saw Resident 6 wheeling himself in the hallway, when Resident 1 stopped him, and they yelled at each other. HSK 1 stated, Resident 1 then grabbed Resident 6 ' s wheelchair, pushed him hard and turned Resident 6 ' s wheelchair around. HSK 1 stated there were other people around and stopped the altercation, and she did not report it because she thought someone else would tell the administrator. During an interview on 5/8/2025 at 9:45 AM with CNA 1, CNA 1 stated, on 5/3/2025 around 9 AM Resident 1 and Resident 6 were yelling at each other, then Resident 1 grabbed Resident 6 ' s wheelchair and pushed Resident 6 ' s wheelchair and turned him around and grabbed Resident 6 ' s jacket. CNA 1 stated, she does not know why it was not reported, since there were other staff there. CNA 1 stated, the incident should have been reported, and maybe the incident with her would not have happened. During an interview on 5/8/2025 at 10:10 AM with CNA 4, CNA 4 stated, on 5/3/2025 around 9AM Resident 1 and Resident 6 were yelling at each other using profanity, Resident 1 yelled mother_____ to Resident 6. CNA 4 stated, he separated Resident 1 and resident 6 and escorted Resident 1 to his room while Resident 6 went to the nurse ' s station. CNA 4 stated, he did not see the physical abuse but saw the verbal abuse and it should have been reported to the abuse coordinator. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/2025 at 10:20 AM with LVN (license Vocational Nurse) 4, LVN 4 stated, on May 3 she heard to commotion around 9 am, the staff was already separating Resident 1 and Resident 6. LVN 4 stated, Resident 6 told her that Resident 1 pushed him in his wheelchair and yelled at him profanity, and Resident 6 was concerned that he might get hurt. LVN 4 stated that the incident should have been reported because of verbal abuse and possible physical abuse, for patient safety and prevent recurrence. LVN stated the incident was not in the progress notes or change of condition (COC) documentation. LVN 4 stated, she reported it to RN (Registered Nurse) 3. During an interview on 5/8/2025 at 10:35 AM with RN 3, RN 3 stated, no one told her about the incident between resident 1 and Resident 6. RN 3 stated, on 5/3/2025 in the morning, Resident 6 came to her very upset and told her Resident 1 yelled profanity at him and push his wheelchair while he was in it. RN 3 stated, she was unable to interview Resident 1 because he was still agitated. RN 3 stated, the incident should have been reported to the abuse coordinator, the ombudsman, police and California Department of Public Health (CDPH) as per policy. RN 3 stated that not reporting the incident had resulted in upsetting Resident 3 and had the potential for abuse to recur or escalate and could affect the safety of the other patients in the facility. During an interview on 5/8/2025 at 11:00 AM with DON (Director of Nurses), the DON stated, any suspicion of abuse should be reported within 2 hours as indicated in the facility policy. The DON stated, any type of verbal or physical altercation should be reported, and should be investigated thoroughly, so the incident would be addressed and prevent from potential recurrence or harm to other residents. DON stated, yelling profanity to another Resident is considered abuse, grabbing a resident or pushing someone on a wheelchair against his will, is considered abuse and should be reported to PD, Ombudsman and CDPH. DON stated, not reporting the incident between Resident 1 and Resident 6 had the potential for recurrence and escalation of the problem that could potentially affect the safety of the residents in the facility. A review of the facility ' s policy and procedure (P&P) titled, Abuse Prevention/ Prohibition, revised 11/2018, the P&P indicated; a) the facility does not condone any form of Resident abuse and/or mistreatment and develops a system in order to promote an environment free from abuse and mistreatment, b)Abuse is defined as a willful infliction of injury, involuntary seclusion, intimidation with resulting physical harm pain or mental anguish. A review of the facility ' s policy and procedure (P&P) titled, Abuse Investigation and Reporting, revised 7/2017, the P&P indicated; a) all reports of residents abuse, mistreatment shall be promptly reported to local , state and federal agencies and thoroughly investigated by facility management, b) under reporting, all alleged violations of abuse or mistreatment will be reported by the facility administrator or his/her designee to the state licensing /certification agency, ombudsman, and law enforcement, c) an alleged abuse or mistreatment will reported immediately, but no later than two hours if the alleged allegation involves abuse.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the facility have sufficient and competent nursing staff to address, and provide necessary services (behavior monitoring and management) and implement person centered care plans for the behavioral healthcare needs of one of three sampled residents (Resident 1) diagnosed with schizoaffective disorder- bipolar type (a mental illness that combines symptoms of schizophrenia [a serious mental health condition that affects how people think, feel and behave] with those of bipolar disorder (a mood disorder characterized by extreme mood swings)], and psychotic disorder (severe mental disorders that cause abnormal thinking and perceptions), in accordance with the facility ' s policy and procedures on Behavioral Assessment, Intervention and Monitoring and Care Planning – Interdisciplinary Team. The facility failed to: 1. Ensure Resident 1 ' s aggressive behavior was addressed, monitored and managed after an incident of choking Certified Nurse Assistant (CNA) 1 on 5/3/2025 while CNA 1 was inside another resident ' s room (Resident 5). Resident 1 transferred to the General Acute Care Hospital (GACH 1) on 5/3/2025 via 5150 (temporary, involuntary psychiatric commitment of individuals who present a danger to themselves or others due to signs of mental illness). Resident 1 was readmitted back to the facility on 5/8/2025. 2. Ensure Resident 1 ' s behavioral aggressiveness was thoroughly evaluated and licensed staff develop individualized comprehensive care plan interventions and approaches that were communicated with all facility staff upon readmission to the facility on 5/8/2025 due to the resident ' s history of aggressive and violent behaviors with a recent choking incident on 5/3/2025. As a result, Resident 1 displayed physically aggressive and violent behaviors when Resident 1 ran after the facility staff with a bread knife at the facility lobby while pointing the bread knife at the facility receptionist and made a gesture of slitting Registered Nurse (RN) 5 ' s neck with the same bread knife on 5/16/2025 at 3 AM, during the night shift (11 PM to 7 AM). Resident 1 was taken by the Police via another 5150-hold, 5/16/2025 and was taken to GACH 2 Psychiatric facility. These deficient practices had the potential to result in facility staff getting physically hurt and injured, including other vulnerable residents that included Resident 1 ' s roommate (Resident 12) who is cognitively impaired and assistance with activities of daily living, and Resident 5 who is also cognitively impaired and resides adjacent to Resident 1 ' s room. Findings: During a review of Resident 1 ' s admission Record (AR), the AR indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cognitive communication deficit (communication difficulties stemming from underlying cognitive impairments, rather than from speech or language deficits), schizoaffective disorder- bipolar type (a mental illness that combines symptoms of schizophrenia [like hallucinations and delusions) with those of bipolar disorder (like mania and depression)], and psychotic disorder (when you see reality very differently to people around you). (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 ' s History and Physical Examination (HPE), dated 4/18/2024, the HPE indicated Resident 1 was alert to time, person and situation. During a review of Resident 1 ' S Minimum Data Set (MDS – a resident assessment screening tool), dated 5/12/2025, the MDS indicated the Resident 1 ' s cognitively status (ability to think, remember, and reason) moderately impaired. The MDS indicated Resident 1 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, dressing, toileting and bathing. During a review of Resident 12 ' s AR, the AR indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cognitive communication deficit, schizophrenia, bipolar disorder, unsteadiness on feet and muscle weakness. During a review of Resident 12 ' s History and Physical Examination (HPE), dated 5/15/2025, the HPE indicated Resident 12 does not have the capacity to understand and make decisions. During a review of Resident 12 ' s MDS, dated [DATE], the MDS indicated the Resident 12 ' s cognitively status was severely impaired. The MDS indicated Resident 12 required Setup and clean-up assistance (helper sets up and cleans up; resident completes activity) with eating and oral hygiene, supervision or touching assistance with dressing, personal hygiene and walking, and partial/moderate assistance (helper does less than half the effort) with toileting and bathing. During a review of Resident 5 ' s AR, the AR indicated the resident was admitted to the facility on [DATE] with diagnoses that included Alzheimer ' s disease (a progressive brain disorder that primarily affects memory and thinking skills, eventually leading to difficulty with everyday tasks and behavior changes), aortic aneurysm (a bulge that occurs in the wall of the body's main artery, called the aorta) and palliative care (focuses on improving the quality of life for people with serious illnesses by providing comfort and support, even when a cure isn't possible). During a review of Resident 5 ' s HPE, dated 5/1/2024, the HPE indicated Resident 5 does not have the capacity to understand and make decisions. During a review of Resident 5 ' s MDS, dated [DATE], the MDS indicated Resident 5 dependent with eating, oral hygiene, toileting, bathing, dressing and personal hygiene. During a review of Resident 1 ' s facility document titled, Progress Notes (PN), dated 5/3/2025 timed at 1:45 PM, the PN indicated Resident 1 was aggressive and hurt Certified Nurse Assistant (CNA) 1 by putting his hands around CNA 1 ' s neck, and the police came and took Resident 1 to GACH 1 for physical aggression via 5150. During a review of Resident 1 ' s GACH 1 record titled Transfer of Summary dated 5/8/2025, the GACH 1 record indicated Resident 1 ' s Reason for admission or Evaluation was due to involuntary hold for DTO (danger to others) initiated on 5/3/2025 through 5/6/2025 . The record further indicated Resident 1 was at risk for danger to others. During a review of Resident 1 ' s facility document titled, Progress Notes (PN), dated 5/8/2025 at 9:06 PM, indicated Resident 1 was readmitted to the facility from GACH 1 at 3:40 PM. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 ' s GACH 1 document titled Transfer of Care Summary dated 5/8/2025, indicated diagnosis was at risk for danger to others. During a review of Resident 1 ' s IDT Conference Record dated 5/9/2025 (one day after facility readmission), the IDT Record attended by the Activity Assistant, Social Services Director (SSD), Dietary Services Director (DSS), Director of Rehabilitation (DOR), and RN MDS Coordinator, indicated the IDT met with Resident 1 ' s representative via telephone and discussed the resident ' s plan of care [NAME] included medical diagnosis, nursing care/services, medication management, health teachings, training therapy needs, dietary/activity preferences, discharge process, and code status. The IDT Record, including IDT interventions indicated in the IDT Record did not include recommendations for developing individualized comprehensive care plan interventions and approaches that were communicated with all facility staff upon Resident 1 ' s readmission to the facility on 5/8/2025 due to the resident ' s history of aggressive and violent behaviors and with a recent choking incident with CNA 1 on 5/3/2025 that resulted to a 5150 transfer to GACH 1. During a review of Resident 1 ' s facility document titled, Progress Notes (PN), dated 5/12/2025 at 12:00 AM, the PN indicated Resident 1 had a sudden outburst of anger towards a CNA, and refuse to take PRN medication, the PN indicated the resident ' s physician was made aware and monitored. The PN did not indicate any other individualized behavioral interventions developed or implemented to prevent physical aggression towards others and protect other staff and residents from Resident 1. During a review of Resident 1 ' s Progress Notes (PN), dated 5/12/2025 at 6:44 AM, the PN indicated Resident 1 noted with verbal and aggressive behavior towards staff and residents, yelling and screaming. The PN did not indicate any other individualized behavioral interventions developed or implemented to prevent physical aggression towards others and protect other staff and residents from Resident 1. During a review of Resident 1 ' s Progress Notes (PN), dated 5/16/2025 at 5:11 PM, the PN indicated at around 3:07 AM, Resident 1 went out of his room towards the lobby and turned to the RN (RN 5) sitting at the Nurse Station and showed a silver knife in his hand. The PN indicated He (Resident 1) moved it towards his neck, acted like slitting it. The PN indicated [Resident 1] run towards RN 5 and other nurses in Station 1 pointing the knife towards them acted as if he will stab one. RN hurriedly called 911 for police assistance. The PN further indicated [Resident 1] went to the front desk area and pointed the knife at the receptionist. [Resident 1] got a folded metal chair, went to Station 1 and tried to slam it to a nurse who is trying to calm him down. When he [Resident 1] wasn ' t able to, he went inside his room with the bread knife and foldable chair. He [Resident 1] closed the door and locked it most probably with another chair. 2 police officers came and went inside his room, a banged (sic) was heard inside the room like a heavy object hitting the floor, one office was able to open the door. [Resident 1] was inside by his bed, while his roommate was inside too (Resident 12) on his own bed and was not hurt at all . The PN further indicated Resident 1 was taken via 5150 hold and GACH 2 psychiatric facility was notified. During a review of a facility document (untitled) dated 5/17/2025 at 12 AM, the document indicated Resident [1] had a bread knife in his hand, and while in the [facility] lobby he moved the bread knife in his neck and acted like slitting it. He [Resident 1] also run after the nurses with a bread knife, he pointed a bread knife to the receptionist and almost hit a nurse with a folded metal chair. The document indicated law enforcement (police department) was notified and that there were no residents present in the facility hallway during that time. (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/7/2025 at 3:30 PM with Family 2 (Family of Resident 5), Fam 2 stated, on 5/3/2025 around 1 PM, while inside Resident 5 ' s room (which was adjacent to Resident 1 ' s room), she was talking to CNA 1, when Resident 1 came to Resident 5 ' s room and without warning attacked and started choking CNA 1. Fam 2 stated she helped CNA 1 and had to remove Resident 1 ' s hand around CNA 1 ' s neck. Fam 2 stated, the police came and took Resident 1 away. Fam 2 stated, she was concerned for Resident 5 ' s safety since Resident 5 is cognitively impaired, and other residents who cannot protect themselves from Resident 1. Fam 2 stated, she informed the Director of Social Services (DSS) and the facility leadership about her concern that same day. During an interview on 5/7/2025 at 3:50 PM with CNA 1, CNA 1 stated, on 5/3/2025 around 1 PM she was talking to FAM 2 inside Resident 5 ' s room, when Resident 1 came inside Resident 5 ' s room and grabbed her neck and started choking her without warning. CNA 1 stated the staff came to help, and the police took Resident 1 away on 5/7/2025. During an interview and record review on 5/20/2025 at 11:40 AM with the Medical Record Director (MRD) and the Director of Nurses (DON), Resident 1 ' s Electronic Health Records (EHR) dated 5/8/2025 (Resident 1 ' s admission date) until 5/20/2025 were reviewed. The EHR indicated the facility did not have an active care plan developed for Resident 1 ' s behavior or a behavior monitoring for Resident 1 ' s history of aggressive behavior/s, history of violence nor specific interventions for managing Resident 1 ' s behavior and protecting others against Resident 1 ' s aggressive/violent behaviors. During the concurrent record review, Resident 1 ' s IDT (Interdisciplinary Team - a group of professionals from different fields who work together to provide comprehensive care for a patient or resident) notes dated 5/9/2025 (day after readmission) did not indicate Resident 1 ' s aggressive behavior, history of violence nor specific plan for facility staff to manage/address Resident 1 ' s behavior was discussed during the IDT meeting. The MRD stated, Resident 1 should have a current/active care plan that addressed Resident 1 ' s behavior history with this current facility readmission. The MRD stated the previous care plans prior to the readmission cannot be used. The DON stated, Resident 1 ' s active care plans should include behavior monitoring and specific interventions regarding the resident ' s aggressive behavior and history of violence, The DON stated the IDT notes did not indicate Resident 1 ' s aggressive behavior nor history of violence was discussed and there was no specific interventions to address Resident 1 ' s behavior history. During an interview on 5/20/2025 at 1:40 PM with LVN (license Vocational Nurse) 6, LVN 6 stated she started her shift on 5/16/2025 around 3 AM and heard a commotion by the facility lobby. LVN 6 stated she saw Resident 1 yelling while at the facility lobby. LVN 6 stated Resident 1 was holding something but not sure what it was. LVN 6 stated, when she called for help from the other facility staff, Resident 1 started to chase the staff away and so the staff had to ran. LVN 6 stated, Resident 1 went back to his room while his roommate (Resident 12) was inside the same room, sleeping and closed the door. (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/20/2025 at 1:50 PM with RN (Registered Nurse) 5, RN 5 stated on 5/16/2025 around 3AM, she saw Resident 1 come out of his room, went to the facility lobby then looked at RN 5 while Resident 1 was holding a bread knife and made a gesture of slitting his neck. RN 5 stated she felt threatened and scared, and she does not know where Resident 1 got the bread knife. RN 1 stated, when she asked Resident 1 to put the knife down, Resident 1 pointed the knife at her while RN 1 remained about 15 feet away from Resident 1 ' s location. RN 1 stated, she ran away from Resident 1 and called the police, so as the sitter. RN 1 stated, Resident 1 ran back to his room, still holding on to the bread knife, closed the door of the room, while Resident 12 remained inside the same room, sleeping. RN 5 stated, she was not aware Resident 1 did not have a specific care plan for his aggressive behavior and history of violence. RN 5 was asked if the CNAs assigned to provide one to one monitoring to Resident 1 was provided with Resident 1 ' s behavior care plan or how to manage Resident 1 ' s specific behaviors and how to protect others against Resident 1. RN 5 stated, she just instructed the CNAs/sitter to ensure Resident 1 do not hurt himself or others. During an interview on 5/20/2025 at 3:00 PM with CNA 6, CNA 6 stated, she sometimes works as a sitter for Resident 1. CNA 6 stated the instruction from the licensed nurses and RN supervisors when she was assigned as a sitter for Resident 1 was just to keep Resident 1 safe and does not get into fight with others. CNA 6 there was specific reason and care plan provided to her when she was assigned to supervise Resident 1 one-on-one. During an interview on 5/20/2025 at 3:10 PM with CNA 7, CNA 7 stated, was assigned as a sitter for Resident 1 before and recalled the RN supervisor ' s instructions were to make sure if Resident 1 gets agitated to make sure he does not hurt himself or other residents. CNA 7 stated, he was not provided a specific plan of care of how to ensure Resident 1 does not hurt others. During an interview and record review on 5/20/2025 at 3:15 PM with the Director of Social Services (DSS), Resident 1 ' s IDT notes dated 5/9/2025 (day after admission) was reviewed. the DSS stated, she is part of the IDT and the IDT notes did not have documented evidence that Resident 1 ' s specific aggressive behavior and history of violence was discussed, and there was no specific care plan interventions indicated in the IDT notes to prevent potential for abuse or harm to residents or staff. During an interview on 5/20/2025 at 3:30 PM with CNA 8, CNA 8 stated on 5/16/2025 around 3AM, she saw Resident 1 in the lobby with a bread knife, he was screaming at RN 5, then he ran to his room with the bread knife and close the door, Resident 12 was in there sleeping. CNA 8 stated, everyone felt threatened and scared. During an interview on 5/20/2025 at 3:55 PM with DON, DON stated, Resident 1 did not have a specific care plan nor intervention for his aggressive behavior and history of violence. DON stated, the care plan Resident 1 had was general and not specific enough. DON stated the IDT notes on 5/9/2025 had no documentation regarding the plan of care for Resident 1 ' s history of violent behavior. DON stated, not having a specific care plan for Resident 1 ' s aggressive behavior and history of violence and not having documentation on the plan of care on the IDT notes upon admission for Resident 1 ' s aggressive behavior and history of violence, had potentially led to an escalation of Resident 1 ' s behavior that could have resulted in abuse to residents and staff. (continued on next page)

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	05/20/2025

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

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s policy and procedure (P&P) titled, Abuse Prevention/ Prohibition, revised 11/2018, the P&P indicated; a) the facility does not condone any form of Resident abuse and/or mistreatment and develops a system in order to promote an environment free from abuse and mistreatment, b)Abuse is defined as a willful infliction of injury, involuntary seclusion, intimidation with resulting physical harm pain or mental anguish. During a review of the facility ' s policy and procedure (P&P) titled, Care Planning – Interdisciplinary Team, revised 3/2022, the P&P indicated; a) the interdisciplinary team is responsible for the development of resident care plans, and b) comprehensive, person centered care plans are based of resident assessments and developed by an IDT. During a review of the facility ' s policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 3/2022, the P&P indicated; a) A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet resident's physical, psychosocial and functional needs is developed and implemented for each resident, b) The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment, and c) The comprehensive, person-centered care plan includes measurable objectives and timeframes and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. During a review of the facility ' s policy and procedure (P&P) titled, Behavioral Assessment, Intervention and Monitoring, revised 3/2019, the P&P indicated; a) The interdisciplinary team will thoroughly evaluate new or changing behavioral symptoms in order to identify underlying causes and address any modifiable factors that may have contributed to the resident's change in condition, including: worsening of or complications related to other conditions and emotional, psychiatric and/or psychological stressors. b) Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for their behavior. The care plan will include, as a minimum, a description of the behavioral symptoms, including frequency, intensity, duration, outcomes, and precipitating factors or situations.