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	12/12/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - 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 protect the resident's rights to be free from physical abuse for two of three sampled residents (Resident 2 and 3) by failing to protect Residents 2 and 3 from physical abuse. On 11/24/25, Resident 1 was observed by facility staff to be agitated, pacing back and forth in the room and swinging two metal wheelchair footrests in the air. Facility staff (Certified Nurse Assistant 1) failed to redirect and remove Resident 1 from the room leaving two other residents (Residents 2 and 3) in the room with Resident 1. As a result, Resident 1 hit Resident 2 several times in the head with the metal wheelchair footrests while Resident 2 was in bed. Resident 2 sustained severe, multiple lacerations (a jagged or irregular tear in the skin, often with edges that do not line up, caused by blunt force or tearing), bruising and severe pain to the face. Resident 3 verbalized fear and frightened for her life as she witnessed Resident 1 attempt to strike her with the metal footrests. The facility called 9-1-1 emergency services on 11/24/2025 at 12:08 AM, and Resident 2 was transferred to General Acute Care Hospital (GACH) 3. In GACH 3, Resident 2 was found to have sustained forehead soft tissue hematoma (collection of blood outside the blood vessel that forms a swollen area under the skin after an injury) as well as a right periorbital (around the eye socket) laceration. Resident 2's Computerized Tomography scan (CT scan - imaging using x-ray [a photographic or digital image of the internal composition of a part of the body] technique to create detailed images of the body) indicated there was partial mild irregularity of the right nasal (internal part of the nose) bone and a questionable right anterior (front) nasal bone fracture (broken bone). Resident 2 was readmitted back to the facility on [DATE] at 8:15 AM with derma bond (surgical glue) and steri-strips (sterile, adhesive, porous strips used to close small cuts, lacerations, and surgical incisions) applied to Resident 2's facial injuries. Findings: During a review of Resident 1's General Acute Care Hospital Records (GACH) 1 dated 5/21/2025, prior to admission to the facility, the GACH 1 record indicated Resident 1 was previously admitted to the GACH 1 Emergency Department (ED) due to an altercation with Family Member (FM) 1, threatening FM 1 with a knife. The GACH 1 ED record indicated Resident 1 was placed on a 5150 hold (involuntary psychiatric detention) at the GACH 1 for danger to others During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted the resident to the facility on 5/22/2025, with diagnoses including dementia (a general term for a decline in thinking, memory, and reasoning skills severe enough to interfere with daily life) with behavioral disturbance (loss of memory and thinking ability with agitation and physical aggression), psychosis (loses of touch with reality, experiencing symptoms like hallucinations (seeing/hearing things not there) and delusions (false beliefs), along with confused thinking and speech. During a review of Resident 1's care plan initiated on 5/23/2025 indicated Resident [1] has a behavioral symptom manifested by delusions as evidenced by resident saying the resident hears God's voices all the time, the care plan indicated the care plan goals for the resident's behavior is to not result in harm or injury to self or others. The care plan interventions included for facility staff to provide behavioral management or modification as needed, such as providing redirection when exhibiting inappropriate behavior. During a review of Resident 1's History and Physical (H&P) dated 5/24/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. The H&P indicated Resident 1 came from GACH 1 for altered mentation (confusion, not acting right, altered behavior), metabolic encephalopathy (brain dysfunction caused by illness) and dementia. During a review of a care plan developed for Resident 1 and initiated on 6/14/2025, the care plan indicated the resident has a behavioral problem of being physically aggressive related to pushing staff and throwing trash when entering her room. The care plan indicated that staff must intervene to protect the rights and safety of others, divert attention and remove Resident 1 from the situation and/or take to an alternate location. During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/26/2025, the MDS indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 1 was assessed requiring partial/moderate assistance for activities of daily living (basic self-care tasks). The MDS further indicated Resident 1 was assessed walking with partial/moderate staff assistance. The MDS further indicated Resident 1 manifested wandering behavior (a disturbance of motor activity that involves directionless, disoriented movement) and behavioral symptoms not directed towards (MDS examples indicated physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes or

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. (continued on next page)

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F 0745 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 provide medically related social services for one of three sampled residents (Resident 3) by not ensuring the resident attained or maintained his/her highest practicable physical, mental, or psychosocial well-being. Specifically, facility staff did not identify or address factors negatively affecting Resident 3's psychosocial functioning after the resident witnessed and was exposed to a violent incident (physical abuse) involving another resident (Residents 1 and 2). No nursing or facility staff checked or followed up on Resident 3 following the incident. This deficient practice had the potential to result in long-term psychosocial harm as resident 3 verbalized experiencing fear, anxiety, and emotional distress after witnessing and being threatened during a violent incident. These deficiencies may further lead to depression and/or post-traumatic stress disorder (PTSD) symptoms, thereby reducing Resident 3's sense of security and quality of life. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted the resident to the facility on 5/22/2025, with diagnoses including dementia (a general term for a decline in thinking, memory, and reasoning skills severe enough to interfere with daily life) with behavioral disturbance (loss of memory and thinking ability with agitation and physical aggression), psychosis (loses of touch with reality, experiencing symptoms like hallucinations (seeing/hearing things not there) and delusions (false beliefs), along with confused thinking and speech. During a review of Resident 1's History and Physical (H&P) dated 5/24/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. The H&P indicated Resident 1 came from GACH 1 for altered mentation, metabolic encephalopathy and dementia. During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/26/2025, the MDS indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). MDS indicated that Resident 1 was partial/moderate assistance for activities of daily living (basic self-care tasks). The MDS further indicated that Resident 1 was able to walk 50 feet with two turns with partial/moderate assistance. The MDS further indicated Resident 1 manifested wandering behavior and behavioral symptoms not directed towards (MDS examples indicated physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes or verbal/vocal symptoms like screaming, disruptive sounds). During a review of Resident 3's AR, the AR indicated the facility admitted the resident on 6/3/2024, with a diagnosis of type 2 diabetes (high blood sugar levels) and anxiety disorder (experiencing excessive worry and fear). During a review of Resident 3's H&P dated 11/27/2025, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3's MDS dated [DATE], the MDS indicated the Resident 3 cognition was moderately impaired. The MDS indicated that Resident 3 toileting hygiene required substantial/maximal assistance. The MDS indicated that Resident 3 was partial/moderate assistance for lying and sitting on the side of the bed, sit to stand and chair/bed to chair transfer. During a review of Resident 1's Progress Notes dated 11/24/2025 documented at 10:40 PM, the Note indicated an incident happened around 10:30 PM when the [CNA 1] informed [Registered Nurse (RN) 1] that Resident 1 was playing with a wheelchair's metal footrests. The Notes indicated [CNA 1] tried to calm [Resident 1] down and get the wheelchair footrests from [Resident 1], but the resident was swinging it [at] CNA 1. The Note indicated CNA 1 went to ask help from RN 1 but while walking back to Resident 1's room, a scream was heard from the roommate, [Resident 2]. The Note indicated that Resident 1's physician (MD 1) was notified and ordered to administer Haldol 5 mg and Benadryl 25 mg IM to [Resident 1]. The Note indicated that RN 1 entered [Resident 1's] room and the roommate, [Resident 2] was observed with multiple lacerations to her face. The Note indicated the Police Department was notified and a police report was filed with the local police department. During a review of Resident 1's physician's telephone order dated 11/25/2025 the order indicated to transfer Resident 1 to GACH 2 to rule out (r/t) agitation. During a review of Resident 1's Nursing Progress Note dated 11/25/2025 documented at 2:35 AM, the Note indicated that Resident 1 was taken to GACH 2 on 11/25/2025 at 12:52 AM for further behavioral evaluations related to agitation. During a review of Resident 1's Change of Condition (COC) dated 11/25/2025, the COC indicated that an incident occurred around 10:30 PM when [CNA 1] informed [RN 1] that Resident 1 was playing [with] the footrest of the wheelchair. She [CNA 1] tried to calm her (Resident 1) down but get the footrests from her, but she was swinging it [at] her. The Note indicated CNA 1 left the room and went to ask