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	01/02/2026

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a physician's order for a resident's code status preference that included the resident's Provider Orders for Life-sustaining Treatment (POLST-a set of portable medical orders that communicate a patient's wishes for end-of-life intervention to health care facilities and providers) was readily retrievable and placed in the residents' current medical chart for 11 out of 100 sampled residents (Resident 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11), in case of an emergency and in accordance to the facility's Policy and Procedure (P&P) titled, Advance Directive. This deficient practice had the potential to delay life sustaining measures during a medical emergency. Findings: During a review of Resident 1's admission Record, (AR) the AR indicated the resident was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD, [a progressive lung condition making breathing difficult), chronic bronchitis (inflamed airways), emphysema (damaged air sacs), and respiratory failure (condition where the lungs can't adequately oxygenate the blood or remove carbon dioxide). During a review of Resident 1's History and Physical (H&P), dated [DATE], the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (a resident assessment tool), dated [DATE], the MDS indicated that Resident 1 has severely impaired cognition (the ability to process thoughts and emotions). The MDS also indicated that the resident did not have a life expectancy of less than 6 months at the time of assessment. The MDS further indicated that the resident did not have a POLST in the resident's medical chart. During a review of Resident 2's admission Record indicated the resident was admitted on [DATE] with diagnoses that included metabolic encephalopathy (when the brain has trouble working because of a chemical, or metabolic, problem in the body), hypertension (high blood pressure), and hyperlipidemia (high cholesterol level). During a review of Resident 2's History and Physical (H&P), dated [DATE], indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 2's MDS dated [DATE], the MDS indicated that the resident has severely impaired cognition. The MDS also indicated that the resident had a POLST in the resident's medical chart. During a review of Resident 3's admission Record indicated the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included chronic kidney disease (CKD, a disease characterized by progressive damage and loss of function in the kidneys), cardiomegaly (an enlarged heart), and dementia (progressive loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). During a review of Resident 3's History and Physical (H&P), dated [DATE], indicated that the resident has fluctuating capacity to understand and make decisions. During a review of Resident 3's MDS, dated [DATE], the MDS indicated the resident has severely impaired cognition. The MDS also indicated that the resident did not have a POLST in the resident's medical chart. During a review of Resident 4's admission Record indicated the resident was admitted on [DATE] with diagnoses that included pneumonia (a lung infection), muscle weakness, and dysphagia (difficulty swallowing). During a review of Resident 4's H&P, dated [DATE], the H&P indicated that the resident does not have the capacity to understand and make decisions. During a review of Resident 4's MDS, dated [DATE] the MDS, indicated that the resident has moderately impaired cognition. The MDS also indicated that the resident had a POLST in the resident's medical chart. During a review of Resident 5's admission Record indicated the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included COPD, muscle weakness, and hypertension. During a review of Resident 5's H&P, dated [DATE], indicated that the resident does have the capacity to understand and make decisions. During a review of Resident 5's MDS, dated [DATE], the MDS, indicated that the resident has moderately impaired cognition. The MDS also indicated that the resident had a POLST in the resident's medical chart. During a review of Resident 6's admission Record indicated the resident was admitted on [DATE] with diagnoses that included osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and CKD. During a review of Resident 6's H&P, dated [DATE], the H&P indicated that the resident has fluctuating capacity to understand and make decisions. During a review of Resident 6's MDS, dated [DATE], the MDS indicated that the resident has moderately impaired cognition. The MDS also indicated that the resident had a POLST in the resident's medical chart. During a review of Resident 7's admission Record indicated the resident was admitted on [DATE] with diagnoses that included quadriplegia (paralysis affecting all four limbs

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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 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care by qualified persons according to each resident's written plan of care. (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 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that direct care staff were qualified to respond and perform cardiopulmonary resuscitation (CPR) for one out of 66 identified full code (a resident who wants all possible life-saving measures used if their heart stops or they stop breathing, including CPR residents) (Resident 1). After further investigation, it was determined the facility failed to ensure that: 1.On [DATE], CNA 1, Registered Nurse (RN) 1, LVN 1, LVN 2, and LVN 5 did not call a code blue immediately when Resident 1 was found unresponsive on [DATE] between 3:05 PM to 3:10 PM. 2. On [DATE], LVN 1 and CNA 2 did not place Resident 1 on a firm, flat surface while performing CPR. LVN 1 and CNA 2 did not use the backboard (a rigid board inserted under a patient's back to create a firm surface, preventing soft surfaces [like mattresses] from absorbing compression force, thereby improving the depth and effectiveness of chest compressions) that was available at the facility. 3. On [DATE], LVN 1 and CNA 2 did not perform rescue breaths on Resident 1 while performing CPR on [DATE], in accordance with professional standard of practice and the 2025 American Heart Association (AHA) Guidelines for CPR. 4.On [DATE], LVN 1 and CNA 2 did not perform continuous and appropriate chest compressions with the required depth on Resident 1, in accordance with professional standard of practice and the 2025 AHA Guidelines for CPR. As a result, Resident 1 was pronounced deceased (dead) on [DATE] at 3:48 PM by EMS crew after 20 minutes of CPR. As a result of these deficiencies, the facility placed 66 full code (a patient wants all possible life-saving measures if their heart or breathing stops, including CPR) residents at risk to not receive adequate and proper life-saving measures during a code blue, potentially leading to greater harm and/or death to other residents residing in the facility. Cross referenced to F678 Findings: During a review of Resident 1's admission Record, (AR) the AR indicated the resident was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD, [a progressive lung condition making breathing difficult), chronic bronchitis (inflamed airways), emphysema (damaged air sacs), and respiratory failure (condition where the lungs can't adequately oxygenate the blood or remove carbon dioxide). During a review of Resident 1's POLST (Physician Orders for Life-Sustaining Treatment, a portable medical order form that helps seriously ill or frail individuals specify their end-of-life care wishes, such as CPR), dated [DATE], and signed by Resident 1, the POLST instructed staff to attempt CPR if Resident 1 has no pulse and is not breathing. During a review of Resident 1's History and Physical (H&P), dated [DATE], the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (a resident assessment tool), dated [DATE], the MDS indicated that Resident 1 has severely impaired cognition (the ability to process thoughts and emotions). The MDS also indicated that the resident did not have a life expectancy of less than 6 months at the time of assessment. The MDS further indicated that the resident did not have a POLST (---) in the resident's chart. During a review of Resident 1's Interdisciplinary Team (IDT) Conference Record Notes, dated [DATE], the IDT indicated that Resident 1's code status was Full code and that staff should attempt CPR when necessary. During a review of Resident 1's Physician Progress Notes, dated [DATE], the Notes indicated that Resident 1 had a code status of Full Code- Attempt CPR. During a review of Resident 1's Progress Notes for the month of [DATE], the Progress Notes indicated the following information: 1. On [DATE], timed at 4:10 PM, and signed by RN 1, the note indicated that at 3:15 PM, the charge nurse reported to [RN 1] that she saw [Resident 1] unresponsive during rounds (scheduled nurse visits to patient's bedside to assess, monitor and address patient needs). The note further indicated that RN 1 went to the resident's room to assess Resident 1 and could not obtain the resident's blood pressure. The note also indicated that RN 1 instructed one of the team members to start CPR right away. The note indicated that CPR was continued until the Emergency Medical Services crew from the local Fire Department (FD) arrived at 3:29 PM. The note further indicated that the resident was pronounced deceased at 3:48 PM. 2. On [DATE], timed at 4:47 PM, and signed by LVN 1, the note indicated that at 3:05 PM, the CNA [CNA1] reported [to LVN 1 that resident was unresponsive. The note indicated that Resident 1 did not have a pulse or blood pressure. The note also indicated chest compressions were performed until the EMS crew came and took over. The note further indicated that Resident 1's time of death was on [[DATE]] at 3:48 PM. During a review of a Statement of Declaration (SOD) titled, Declaration, signed

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure proper and effective Basic Life Support (BLS-the level of care provided to victims of life-threatening illnesses or injuries until full medical care is available, including recognition of cardiac arrest and activation of the emergency response system), that included cardiopulmonary resuscitation (CPR, an emergency procedure combining chest compressions and rescue breaths to circulate blood and oxygen when the heart stops or breathing ceases). The facility did not continuously perform BLS for one of 66 identified full code (a resident who wants all possible life-saving measures used if their heart stops or they stop breathing, including CPR residents) (Resident 1) during a code blue (a life-threatening medical emergency requiring an immediate trained response for CPR) when Resident 1 was found unresponsive, pulseless, and not breathing by failing to ensure: 1. Certified Nursing Assistant (CNA) 1, Registered Nurse Supervisor (RN) 1, Licensed Vocational Nurse (LVN) 1, LVN 2, and LVN 5 immediately called a code blue when Resident 1 was found unresponsive on [DATE] between 3:05 PM to 3:10 PM, so that CPR could be initiated without delay. 2. CNA 1, RN 1, LVN 1, LVN 2, and LVN 5 were aware of Resident 1's code status (a medical order indicating the type of emergency treatment a person would or would not receive if their heart or breathing stopped) and were able to locate this information in the resident's medical record. LVN 1 stated that CPR was initiated by a licensed nurse on the resident's bed at 3:22 PM on [DATE], approximately 12 minutes after the resident was found unresponsive. 3. LVN 1 and CNA 2 placed Resident 1 on a firm, flat surface while performing CPR on the resident's bed and utilized a backboard available at the facility, designed to provide a rigid surface under the resident's back to prevent mattress compression and improve the depth and effectiveness of chest compressions during CPR. 4. LVN 1 and CNA 2 performed continuous and uninterrupted CPR on the resident's bed until emergency medical services (EMS- ambulance services or emergency services that provide treatment and stabilization for the patient) assumed care. As a result, Resident 1 was pronounced deceased (dead) on [DATE] at 3:48 PM by EMS crew after 20 minutes of CPR were performed on the floor. These failures placed the facility's identified 66 full code residents at risk to not receive adequate and proper life-saving measures during a code blue, potentially leading to greater harm and/or death to other residents residing in the facility. On [DATE] at 2:34 PM, an Immediate Jeopardy (IJ: a situation in which the facility's' noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified in the presence of the facility's Administrator (ADM) and the Director of Nursing (DON) regarding the facility's failure to ensure Resident 1 adequately and continuously received BLS, including CPR, resulting in Resident 1's death on [DATE]. On [DATE] at 4:13 PM, the Administrator (ADM) provided an acceptable IJ Removal Plan (a detailed plan to address the IJ findings). On [DATE] at 6:13 PM, while onsite and after the surveyor verified/confirmed the facility's full implementation of the IJ Removal Plan through observation, interview, record review, and determined that the IJ situation was no longer present, the IJ was removed onsite on [DATE] at 6:13 PM, in the presence of the ADM and the Director of Nursing (DON). After the IJ was removed, the surveyor verified that the facility's non-compliance remained at a lower scope of isolated (when one or a very limited number of residents are affected and/or one or a very limited number of staff are involved) and lower severity of Level 2 (noncompliance with the requirements for participation that results in the potential for no more than minimal physical, mental, and/or psychosocial harm to the resident, but has the potential to result in more than minimal harm that is not immediate jeopardy). On [DATE] at 6:13 PM, the IJ was removed, in the presence of the ADM and the DON after the facility submitted an acceptable IJ Removal Plan. The surveyor verified and confirmed the implementation of the IJ Removal Plan while onsite through observation, interview, and record review. The acceptable IJ Removal Plan included the following: On [DATE], Quality Assurance Nurse (QA) and the RN on duty initiated a review of the current residents' care profile in the facility's electronic health record (EHR) system, Code Status. The QA and the RN verified the residents' Code Status via Physician Orders for Life-Sustaining Treatment (POLST -a portable medical order form that helps seriously ill or frail individuals specify their end-of-life care wishes, such as CPR) forms and/or physician's orders for Code Status and input the data accordingly in the residents' care profile under Code Status so that the information is readily available for facility staff, including such events as a Code Blue to ensure all residents who have a full code status receive effective BLS, including CPR. Out of 100 current residents, 66 residents have Full Code status. On [DATE], a copy of the

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the necessary respiratory care and interventions in accordance with the resident's respiratory care needs, care plan, facility policy and professional standards of practice, the physician's order and facility's policy and procedure for one of two sampled residents (Resident 1) diagnosed of respiratory failure (a condition where the lungs cannot supply enough oxygen or remove carbon dioxide from the blood) with hypoxia (a life-threatening condition where the lungs fail to deliver enough oxygen to the blood, leading to dangerously low oxygen levels in the body), chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty breathing), emphysema (a lung disease where the air sacs [alveoli] in the lungs are damaged, making breathing difficult) and recurrent pneumonia (an infection/inflammation in the lungs) by failing to: 1. Administer respiratory medications consistently as ordered for Resident 1 for COPD, chest congestion and shortness of breath. The Medication Administration Record (MAR) indicated the following missed respiratory treatments: -Acetylcysteine Inhalation Solution 20% (a medication used to thin mucus in the lungs) 25 (twenty-five) scheduled times between [DATE] to [DATE]. -Budenoside Inhalation Suspension (a medication inhaled to reduce swelling in the airways) 31 (thirty-one) scheduled times between [DATE] to [DATE]. -Ipratropium-albuterol Inhalation Solution (a medication used in a nebulizer that combines two drugs to relax and open the airways) 60 (sixty) scheduled times between [DATE] to [DATE]. 2. Monitor Resident 1 for respiratory distress (life-threatening condition that causes severe difficulty breathing. It occurs when the lungs become inflamed and damaged, making it difficult for oxygen to reach the bloodstream) and change in respiratory condition, in accordance with the resident's care plan for COPD and emphysema when Nurse Practitioner (NP) 1 identified Resident 1 on [DATE] as having cough, congestion, abnormal lung sounds and respiratory distress with oxygen saturation of 93% at 3 liter of oxygen and Registered Nurse (RN) 5 received abnormal laboratory (lab) and chest Xray (CXR - (a type of imaging that uses electromagnetic radiation to view internal structures of the body) results on [DATE]. 3. Revise and implement Resident 1's care plan to assess or monitor Resident 1's respiratory status that included assessment of lung sounds and monitoring Resident 1's worsening cough and congestion to initiate nursing interventions, after receiving Resident 1's abnormal laboratory (lab) and CXR results on [DATE]. 4. Notify Medical Doctor (MD) 1 of Resident 1's elevated white blood cell (WBC - a blood cell that helps attack infection or injury in the body) count and abnormal chest x-ray results indicating mild patchy opacity (an area that appears white or dense on an x-ray) in the left lower lung which represented a potential indicator of lung infection. This deficient practice had the potential to result to medical and respiratory complications which included severe respiratory distress/failure, collapsed lungs, septicemia that may lead to hospitalization and/or death. Furthermore, these deficient practices delayed necessary medical evaluation and treatment of Resident 1's respiratory condition from [DATE] to [DATE]. On [DATE], Resident 1 was found unresponsive and pulseless at 3:05 PM. Cardiopulmonary Resuscitation (CPR) was performed and Resident 1 was later pronounced dead on [DATE] at 3:48 PM by Emergency Medical Services (EMS). Cross referenced to F678Findings: During a review of Resident 1's admission Record, the record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including COPD, emphysema, respiratory failure (a condition where the lungs cannot supply enough oxygen or remove carbon dioxide from the blood) with hypoxia (a condition in which body tissues do not receive enough oxygen to function properly), recurrent pneumonia (an infection/inflammation in the lungs) and vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain). During a review of Residents 1's Minimum Data Sheet (MDS- a resident assessment tool) dated [DATE], the MDS indicated Resident 1 had significantly impaired cognition (the ability to process thoughts) and was dependent on staff for all cares such as eating, bathing, and rolling left and right in bed. During a review of Resident 1's Medication Administration Record (MAR) for the months of [DATE], [DATE], and [DATE], the MAR indicated the following orders: 1. Acetylcysteine Inhalation Solution 20% three mL (milliliter- a unit measure of volume) inhale orally two times a day for COPD, start date [DATE]. 2. Budenoside Inhalation Suspension 0.25 milligram (mg- a unit of measurement)/2 mL, inhale two mL orally every morning and at bedtime for COPD, start date [DATE]. 3. Ipratropium-Albuterol Inhalation Solution 0.5-2.5 mg (3 mg)/3 mL, inhale three mL orally four times a day for congestion/breathing treatment, start date [DATE]. During a continued review of resident 1's MAR for the months of [DATE], [DATE], and [DATE] indicated no documentation on the following days

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for one of two sampled residents (Resident 1). Licensed nurses did not administer prescribed respiratory medications to Resident 1, who had chronic obstructive pulmonary disease (COPD-a chronic lung disease causing breathing difficulty) and was oxygen-dependent. Missed doses included: Acetylcysteine Inhalation Solution 20% (used to thin mucus in the lungs): 25 scheduled doses between September and November 2025 Budesonide Inhalation Suspension (reduces airway inflammation): 31 scheduled doses between September and November 2025 Ipratropium-Albuterol Inhalation Solution (relaxes and opens airways): 60 scheduled doses between September and November 2025 This failure placed Resident 1 at risk for respiratory compromise and deterioration related to COPD exacerbation, potentially resulting in further complications and hospitalization. Cross referenced to F678 Findings: During a review of Resident 1's admission Record, the record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including COPD, emphysema, respiratory failure (a condition where the lungs cannot supply enough oxygen or remove carbon dioxide from the blood) with hypoxia (a condition in which body tissues do not receive enough oxygen to function properly), recurrent pneumonia (an infection/inflammation in the lungs) and vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain). During a review of Residents 1's Minimum Data Sheet (MDS- a resident assessment tool) dated 10/6/2025, the MDS indicated Resident 1 had significantly impaired cognition (the ability to process thoughts) and was dependent on staff for all cares such as eating, bathing, and rolling left and right in bed. During a review of Resident 1's Care Plan (CP) initiated on 4/11/2025 at revised 11/18/2025, the CP indicated Resident 1 had impaired gas exchange related to ineffective airway clearance, dyspnea (difficulty breathing)/ shortness of breath (SOB), COPD, and emphysema. The CP further indicated interventions to administer medications as ordered. During a review of Resident 1's Medication Administration Record (MAR) for the months of September, October, and November 2025, the MAR indicated the following orders: 1. Acetylcysteine Inhalation Solution 20% three mL (milliliter- a unit measure of volume) inhale orally two times a day for COPD, start date 9/30/2025. 2. Budenoside Inhalation Suspension 0.25 milligram (mg- a unit of measurement)/2 mL, inhale two mL orally every morning and at bedtime for COPD, start date 3/3/2025. 3. Ipratropium-Albuterol Inhalation Solution 0.5-2.5 mg (3 mg)/3 mL, inhale three mL orally four times a day for congestion/breathing treatment, start date 6/16/2025. During a continued review of resident 1's MAR for the months of September, October, and November 2025 indicated no documentation on the following days and times for Resident 1's Acetylcysteine Inhalation Solution: 9/30/2025 at 6 PM, 10/1/2025 at 6 PM, 10/2/2025 at 6 PM, 10/3/2025 at 6 PM, 10/4/2025 at 6 PM, 10/5/2025 at 6 PM, 10/6/2025 at 6 PM, 10/7/2025 at 9AM and 6 PM, 10/8/2025 at 6 PM, 10/9/2025 at 6 PM, 10/11/2025 at 6 PM,10/12/2025 at 6 PM, 10/17/2025 at 6 PM, 10/18/2025 at 6 PM, 10/20/2025 at 6 PM, 10/23/2025 at 6 PM, 10/24/2025 at 6 PM, 10/25/2025 at 6 PM, 10/28/2025 at 9AM and 6 PM, 10/31/2025 at 6 PM, 11/1/2025 at 6 PM, 11/15/2025 at 6 PM, and 11/22/2025 at 9 AM. The MAR for September, October, and November 2025 indicated a total of 25 undocumented administrations for Acetylcysteine between September and November 2025. During a continued review of Resident 1's MAR for the months of September to November 2025 indicated no documentation on the following days and time for Resident 1's Budenoside Inhalation Suspension: 9/5/2025 at 9 PM, 9/30/2025 at 9 PM, 10/1/2025 at 9 PM, 10/2/2025 at 9 PM, 10/3/2025 at 9 PM, 10/4/2025 at 9 PM, 10/5/2025 at 9 PM, 10/6/20258 at 9 PM, 10/7/2025 at 9AM and 9 PM, 10/8/2025 at 9 PM, 10/9/2025 at 9 PM, 10/11/2025 at 9 PM, 10/12/2025 at 9 PM, 10/15/2025 at 9 PM, 10/17/2025 at 9 PM, 10/18/2025 at 9 PM, 10/20/2025 at 9 PM, 10/22/2025 at 9 PM, 10/23/2025 at 9 PM, 10/24/2025 at 9 PM, 10/25/2025 at 9 PM, 10/28/2025 at 9AM and 9 PM, 10/31/2025 at 9 PM, 11/1/2025 at 9 PM, 11/6/2025 at 9 PM, 11/13/2025 at 9 PM, 11/14/2025 at 9 PM, 11/15/2025 at 9 PM, and 11/22/2025 at 9 AM. The MAR for September to November 2025 indicated a total of 31 undocumented administrations for Budenoside between September and November 2025. During a continued review of Resident 1's MAR for the months of September to November 2025 indicated no documentation on the following days and time for Resident 1's Ipratropium-Albuterol Inhalation Solution: 9/5/2025 at 5 PM and 9 PM, 9/30/2025 at 5 PM and 9 PM, 10/1/2025 at 5 PM and 9 PM, 10/2/2025 at 5 PM and 9 PM, 10/3/2025 at 5 PM and 9 PM, 10/4/2025 at 5 PM and 9 PM, 10/5/2025 at 5 PM and 9 PM, 10/6/2025 at 5 PM and 9 PM; 10/7/2025 at 9 AM, 12 PM, 5 PM and 9 PM; 10/8/2025 at 5 PM and 9 PM;

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	01/02/2026

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 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. (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 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to verify received or follow up with the attending physician (Medical Doctor [MD] 1) and/or the Nurse Practitioner (NP) 1 of the abnormal laboratory and diagnostic results for one of two sampled residents (Resident 1) with abnormal laboratory and diagnostic results. Resident 1 had an elevated white blood cell (WBC - a blood cell that helps attack infection or injury in the body) count of 16.85 x10*3/ul (thousands of cells per microliter- a unit of measurement [Normal range 4.0-11.0 x10*3/ul]) and abnormal chest x-ray (a type of imaging that uses electromagnetic radiation to view internal structures of the body) results indicating mild patchy opacity (an area that appears white or dense on an x-ray) in the left lower lung which represented a potential indicator of lung infection. This failure resulted in Resident 1 not to receive necessary medical intervention such as prescribing antibiotics (medication used to treat infection) which placed Resident 1 at risk for worsening infection, respiratory distress, sepsis (a life-threatening blood infection), hospitalization, and death. Cross referenced to F695 and F678 Findings: During a review of Resident 1's admission Record, the record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty breathing), emphysema (a lung disease where the air sacs [alveoli] in the lungs are damaged, making breathing difficult), respiratory failure (a condition where the lungs cannot supply enough oxygen or remove carbon dioxide from the blood) with hypoxia (a condition in which body tissues do not receive enough oxygen to function properly), recurrent pneumonia (an infection/inflammation in the lungs) and aneurysm of specified arteries (localized bulge on the wall of the blood vessels which pose a risk for rupture). During a review of Residents 1's Minimum Data Sheet (MDS- a resident assessment tool) dated [DATE], the MDS indicated Resident 1 had significantly impaired cognition (the ability to process thoughts) and was dependent on staff for all cares such as eating, bathing, and rolling left and right in bed. During a review of Resident 21's Care Plan, initiated on [DATE] and revised [DATE], indicated Resident 1 had impaired gas exchange. The intervention included to monitor and report any respiratory distress to the MD. During a review of Resident 1's MD Progress Notes (PN) dated [DATE], the notes indicated Resident 1 was assessed by Nurse Practitioner (NP) 1. The PN indicated Resident 1's lung exam exhibited rales (abnormal crackling sounds in the lungs when breathing) with respiratory distress, coughing and with oxygen saturation of 93% (normal range 90-100%) while receiving 3 L/min (liters per minute- a unit measuring the flow rate of oxygen through a delivery device). The PN indicated to continue regular breathing treatments as scheduled, physical therapy, chest percussion therapy (CPT- a technique that uses rhythmic clapping on the chest and back to loosen and clear mucus from the lungs) two times a day with administration of Mucomyst (acetylcysteine- a medication used to thin or loosen up mucus in the lungs), wean off of oxygen, obtain chest x-ray, and labs that included CBC (complete blood count) and CMP (comprehensive metabolic panel) to rule out possible cause of infection. During a review of Resident 1's Orders Report (a physician's order by MD 1) dated [DATE] indicated to obtain CBC and CMP, and Chest X-ray due to congestion and cough. During a review of Resident 1's lab results collected on [DATE] at 8:10 AM and resulted on[DATE] at 12:59 PM, faxed to the facility on [DATE] at 1:10 PM, indicated an (elevated) WBC 16.85 x10*3/ul (Normal range 4.0-11.0 x10*3/ul). During a review of Resident 1's Final chest X-ray report dated [DATE], the report indicated mild patchy opacity in left lower lung represent infectious process and a suggestion for radiographic follow-up examination to look for resolution, faxed to the facility on [DATE] at 11:13 PM. During a review of RN 5's text thread to NP 1 on (RN 5) [DATE] from the facility's RN Supervisor (RN5) phone, the text thread indicated pictures of Resident 1's faxed lab results for the CBC and CMP drawn on [DATE] and the faxed chest x-ray results from [DATE]. The text thread did not indicate a confirmation of delivery or a response from NP 1. During a review of Resident 1's Progress Notes for the month of [DATE], the Progress Notes indicated the following information: -On [DATE] timed at 10:36 PM, NP 1 came to see Resident 1 and ordered chest x-ray for congestion and cough, CBC and CMP for congestion and cough, and CPT two times a day with Acetylcysteine Inhalation Solution 20% in 3mL inhale orally two times a day -On [DATE], timed at 4:10 PM, and signed by RN 1, the note indicated that at 3:15 PM, the Charge Nurse reported to [RN 1] that she saw the resident during rounds unresponsive, RN 1 assessed the resident and could not obtain the resident's blood pressure, RN 1 instructed one of the team members to start CPR right away which was continued until the Emergency Medical Services (EMS - a system that provides emergency

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	056190	A. Building B. Wing	01/02/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Findings: During a review of Resident 1's admission Record, the record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), emphysema (a lung disease where the air sacs [alveoli] in the lungs are damaged, making breathing difficult), respiratory failure (a condition where the lungs cannot supply enough oxygen or remove carbon dioxide from the blood) with hypoxia (a condition in which body tissues do not receive enough oxygen to function properly), and recurrent pneumonia (an infection/inflammation in the lungs). During a review of Residents 1's Minimum Data Sheet (MDS- a resident assessment tool) dated 10/6/2025, the MDS indicated Resident 1 had significantly impaired cognition (the ability to process thoughts) and was dependent on staff for all cares such as eating, bathing, and rolling left and right in bed. During a review of Resident 1's care plan (CP) initiated on 4/11/2025 at revised on 11/18/2025, the CP indicated Resident 1 had an impaired gas exchange related to ineffective airway clearance, dyspnea (difficulty breathing), shortness of breath (SOB), COPD, and emphysema. The CP indicated goal for appropriate interventions that will improve airway function, maintain a patent airway, optimal oxygenation/ventilation, oxygen saturation (O2 sat- the percentage of oxygen in the blood) maintained greater than 92% (normal range for COPD: 88% - 92%), and mobilize secretions. The CP indicated interventions to administer medications as ordered. During a review of Resident 1's Medication Administration Record (MAR) for December 2025, the MAR indicated the following orders: 1. Order start dated 9/30/2025, the order indicated to administer Acetylcysteine (a medication used to thin mucus in the lungs) Inhalation Solution 20% three mL (milliliter- a unit measure of volume) inhale orally two times a day for COPD, 2. Order start dated 3/3/2025, the order indicated to administer Budenoside (a medication inhaled to reduce swelling in the airways) Inhalation Suspension 0.25 milligram (mg- a unit of measurement)/2 mL, inhale two mL orally every morning and at bedtime for COPD. 3. Order start dated 6/16/2025, the order indicated to administer Ipratropium-Albuterol (a medication used in a nebulizer that combines two drugs to relax and open the airways) Inhalation Solution 0.5-2.5 mg (3 mg)/3 mL, inhale three mL orally four times a day for congestion/breathing treatment. During a review of Resident 1's Medication Admin Audit Report dated December 2025, the report indicated the following: 1. Administration of Acetylcysteine Inhalation Solution 20% for COPD a. Schedule date: 12/5/2025 at 6 PM. Administration time: 12/5/2025 at 3:29 PM. Documented time in Resident 1's electronic records: 1/1/2026 at 3:30 PM by LVN 9. b. Schedule date: 12/6/2025 at 6 PM. Administration time: 12/6/2025 at 3:36 PM. Documented time in Resident 1's electronic records: 1/1/2026 at 3:37 PM by LVN 9. c. Schedule date: 12/11/2025 at 6 PM. Administration time: 12/10/2025 at 4:05 PM. Documented time in Resident 1's electronic records: 1/1/2026 at 4:06 PM by LVN 3 d. Schedule date: 12/12/2025 at 6 PM. Administration time: 12/12/2025 at 5:25 PM. Documented time in Resident 1's electronic records: 12/30/2025 at 5:26 PM by LVN 9 e. Schedule date: 12/13/2025 at 6 PM. Administration time: 12/13/2025 at 4 PM. Documented time in Resident 1's electronic records: 1/1/2026 at 4:07 PM by LVN 3 f. Schedule date: 12/19/2025 at 6 PM. Administration time: 12/19/2025 at 4:09 PM. Documented time in Resident 1's electronic records: 1/1/2026 at 4:09 PM by LVN 3 g. Schedule date: 12/23/2025 at 6 PM. Administration time: 12/23/2025 at 4:11 PM. Documented time in Resident 1's electronic records: 1/1/2026 at 4:12 PM by LVN 3 2. Administration of Budenoside Inhalation Suspension for COPD a. Schedule date: 12/4/2025 at 9 PM. Administration time: 12/4/2025 at 5:27 PM. Documented time in Resident 1's electronic records: 1/1/2026 at 3:27 PM by LVN 9 b. Schedule date: 12/5/2025 at 9 PM. Administration time: 12/5/2025 at 5:33 PM. Documented time in Resident 1's electronic records: 1/1/2026 at 3:34 PM by LVN 9 c. Schedule date: 12/6/2025 at 9 PM. Administration time: 12/6/2025 at 5:36 PM. Documented time in Resident 1's electronic records: 1/1/2026 at 3:37 PM by LVN 9 d. Schedule date: 12/10/2025 at 9 PM. Administration time: 12/10/2025 at 4 PM. Documented time in Resident 1's electronic records: 1/1/2026 at 4:05 PM by LVN 3 e. Schedule date: 12/11/2025 at 9 PM. Administration time: 12/11/2025 at 4 PM. Documented time in Resident 1's electronic records: 1/1/2026 at 4:06 PM by LVN 3 f. Schedule date: 12/12/2025 at 9 PM. Administration time: 12/10/2025 at 5:26 PM. Documented time in Resident 1's electronic records: 12/30/2025 at 5:26 PM by LVN 9 g. Schedule date: 12/13/2025 at 9 PM. Administration time: 12/13/2025 at 4 PM. Documented time in Resident 1's electronic records: 1/1/2026 at 4:07 PM by LVN 3 h. Schedule date: 12/18/2025 at 9 PM. Administration time: 12/18/2025 at 4:08 PM