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	01/09/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide care and services to ensure one of three sample residents (Resident 1) with blisters (a painful skin condition filled with fluid fills a space between layers of skin) due to shingles (an infection caused painful rash) was assessed, monitored and documented weekly for two weeks the skin condition in accordance with the facility's policy and procedures (P&P) titled, Wound Care. This deficient practice had the potential for Resident 1's to receive delayed care or no care when the resident's skin condition with blisters due to shingles to worsen, become infected, and could also spread to other vulnerable residents in the facility. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility originally admitted Resident 1 on 5/20/2025 and readmitted on [DATE] with diagnoses that included anxiety disorder (a normal feeling of worry or fear in response to stress) and hypertension (high blood pressure). During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning screening tool), dated 12/24/2025, the MDS indicated Resident 1 had moderately impaired cognitive (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 1 required partial/moderate assistance with eating, oral hygiene, personal hygiene and chair/bed-to-chair transfer, and substantial/maximal assistance with toileting hygiene and shower/bathe self. During a review Resident 1's Physician Order, dated 12/24/2025, the order indicated the physician ordered to cleanse the shingles rash on bilateral buttocks in the morning with normal saline, pat dry, and cover with foam dressing daily for 14 days. During an interview on 1/8/2026 at 1:02 PM with Certified Nursing Assistant (CNA) 1, CNA 1 stated she assisted the Treatment Nurse (TXN) to assess Resident 1's skin when the resident was admitted to the facility on [DATE]. CNA 1 stated she saw Resident 1 had some red closed dots on her low back area and Resident 1 complained it was painful in that area. During a concurrent interview and record review on 1/8/2026 at 2:55 PM with the TXN, Resident 1's medical record was reviewed. The TXN stated Resident 1 had shingles and she saw red blisters on Resident'1 lower back area when she assessed Resident 1 on 12/19/2025. The TXN stated the Registered Nurse (RN) supervisor was responsible with documenting Resident 1's skin condition related to blisters, but the RN supervisor did not document the condition of the blisters in the resident's clinical record. The TXN stated the there was no documentation in Residen1's clinical record that indicated the resident's blisters was assessed, documented and monitored for two weeks since 12/19/2025 The TXN stated she was off for the past two weeks and the covering nurses did not assess and complete the Weekly Skin Check for Resident 1 from 12/26/2025 and 1/2/2026. The TXN stated it was important to assess the skin and document the assessment on the admission and weekly afterwards, so they could monitor the healing progress of the shingles and evaluate the effectiveness of the current treatment. The TXN stated if Resident 1's blisters condition worsens compared to the previous assessment; they could intervene immediately to prevent the wound and the infection from getting worse. During a concurrent interview (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and record review on 1/8/2026 at 3:15 PM with the Infection Preventionist (IP), Resident 1's medical record was reviewed. The IP stated she was aware Resident 1 had shingles and blisters upon admission on [DATE]. The IP stated there was no documentation indicated Resident 1's skin condition due to shingles were assessed, documented and monitored since her admission on [DATE]. The IP stated the nurses should assess and document Resident 1's skin condition due to shingles upon admission and weekly afterwards, so she could monitor the healing status of Resident 1's shingles and prevent potential spread of shingles virus to other vulnerable residents in the facility. During an interview on 1/8/2026 at 3:33 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she was covering for the TXN to provide wound care to Resident 1 for past two weeks, but she did not know and was not endorsed to assess and complete the Weekly Skin Check for Resident 1 for the past two weeks. During a concurrent interview and record review on 1/9/2026 at 3:00 PM with the Director of Nursing (DON), the facility's policy and procedures (P&P) titled, Wound Care, dated 10/ 2010, and admission Assessment and Follow Up: Role of the Nurse, dated 9/2012, were reviewed. The DON stated the RN supervisor did not assess and document Resident 1's shingles blisters condition on Skin Check upon admission on [DATE] and the nurses did not assess and document the Weekly Skin Check for Resident 1's blisters on 12/26/2025 and 1/2/2026. The DON stated it was important to assess and document Resident 1's shingles blisters upon admission, so they would know the baseline condition. The DON stated the facility's P&P did not indicate the frequency of follow up skin assessment, but as the facility's practice, the nurses should reassess and document the shingles blisters condition weekly so they could monitor the healing process of the blisters and determine when and how to intervene timely to promote wound healing and prevent the spread of shingles to other residents. During a review of the facility's P&P titled, Wound Care, dated 10/2010, the P&P indicated the nurse should record all assessment data obtained when inspecting the wound and any change in the resident's condition in the resident's medical record. During a review of the facility's P&P titled, admission Assessment and Follow Up: Role of the Nurse, dated 9/2012, the P&P indicated the nurse should conduct physical assessments, including skin assessment, and record all relevant assessment data obtained during the admission assessment in the resident's medical record.