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	03/31/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1), who had a stage 4 (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), pressure injury (PI localized damage to the skin and/or underlying tissue usually over a bony prominence) was provided care and services to prevent wound deterioration in accordance with the facility's policy and procedures titled Prevention of Pressure Injuries. This deficient practice placed Resident 1 at risk for delayed wound healing, infection, and negative outcome of Resident 1's prognosis.Findings: During a review of Resident 1's admission Record (AR) the AR indicated that Resident 1 was originally admitted to the facility on [DATE] and discharged on 2/11/2026 with diagnoses including PI of sacral region (shield-shaped bony structure at the base of spine) Stage 4 (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), and hypertension (high blood pressure). During a review of Resident 1's Minimal Data Set (MDS- a federally mandated resident assessment tool) dated 12/8/2025, the MDS indicated that Resident 1 was moderately cognitively impaired (decisions poor, supervision required). The MDS also indicated that Resident 1 required substantial/maximal assistance (helper does more than half the effort) on toileting hygiene, rolling left and right, and chair/bed-to-chair transfer. During a review of Resident 1's Braden Scale for Predicting Pressure Injury Risk dated 9/11/2025, indicated the total score was 16 (scale range 15 to 18 at risk for pressure injury). During a review of Resident 1's Skilled Evaluation Nurse Note (SEN) dated 9/11/2025, the SEN indicated pressure-reducing device for bed was checked off. The SEN did not indicate a checkmark to indicate that Resident 1 was turned and repositioned every two (2) hours. During a review of Resident 1's Care Plan Resident has sacrococcyx pressure injury Stage 4 dated 9/13/2025, the Care Plan indicated interventions included to cleanse with normal saline, pat dry, apply Santyl ointment (a topical medicine used to debride (remove) dead, necrotic tissue from chronic skin ulcers and severe burns to promote healing), cover with dry dressing then foam dressing daily. The Care Plan indicated to provide pressure relief and low air loss mattress (LAL-a mattress designed to prevent and treat pressure wounds), and to support good body alignment and position. The Care Plan did not indicate an individualized repositioning schedule, educate and remind residents of the importance of repositioning. During a review of Resident 1's Documentation Survey Report (DSR) dated from 11/1/2025 to 11/30/2025, the DSR indicated that Resident 1 was assisted to roll left and right every shift. The DSR did not indicate that Resident 1 was turned and repositioned every two (2) hours while in bed. The DSR did not indicate the frequency Resident 1's incontinence brief was checked and changed after each episode. During a review of Resident 1's Nursing Progress Notes (NPN) dated from 11/25/2025 to 11/27/2025, the NPN indicated that despite explaining to Resident 1 the purpose of a foley catheter (thin, flexible, indwelling tube inserted through the urethra into the bladder to drain urine into a collection bag) for a Stage four (4) Sacral PI wound healing, Resident 1 refused reinsertion of foley catheter. During a review of Resident 1's IDT (Interdisciplinary Team- a collaborative group of health professionals working together to manage patient care) Conference (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
	056190	A. Building B. Wing	03/31/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record (IDTCR)- Wound Management dated 12/5/2025, the IDTCR indicated the following interventions utilized: Treatment per Physician's OrderMedication/Mineral/Vitamin SupplementsVitamin CLAL MattressPressure Reducing MattressLAL Mattress. There was no documentation in the IDTCR indicating that IDT identified incontinence (involuntary loss of bladder control, causing leakage) as one risk factor that could inhibit the healing process for Resident 1's stage 4 PI. There was no documentation in the IDTCR that indicated any new recommendations after Resident 1 refused reinsertion of foley catheter since 11/25/2025. During a review of Resident 1's Care Plan Resident has potential for injury, worsening in condition related to non-compliance as evidence by refusing to reinsert foley catheter dated 12/9/2025, the Care Plan did not include any wound protective measures or moisture preventive interventions. During a concurrent interview and a record review on 3/27/2026 at 3 PM with the Treatment Nurse (TXN), Resident 1's clinical records were reviewed. TXN stated since 11/25/2025 Resident 1 refused reinsertion of foley catheter the resident did not have a foley catheter prior to discharge. TXN stated she was not sure how often Resident 1 was turned/repositioned by staff. TXN stated she was not sure how frequent staff checked or changed Resident 1's incontinence brief. TXN stated that the facility did not develop or indicate on the Care Plan to ensure that Resident 1 was turned or repositioned at least every two hours. TXN also stated that the Care Plan regarding Resident 1 refusal of a foley catheter did not have effective measures to protect Resident 1's sacrococcyx PI. During an interview on 3/27/25 at 4PM with the Director of Nursing (DON), the DON stated that the staff were supposed to ensure that Resident 1 was turned at least every two hours and that Resident 1's wound dressing was protected from soiling by incontinence. The DON stated preventative measures like repositioning and moisture reduction were very important for Resident 1 to lower the risks for PI wound infection and deterioration, however IDT did not address this risk, therefore the Care Plan was not revised. During a review of the facility's Policy and Procedures (P&P) Prevention of Pressure Injuries reviewed in 6/2025, the P&P indicated the following: Keep the skin clean and hydrated,Clean promptly after episodes of incontinence,Use a barrier product to protect skin from moisture,Reposition all residents with or at risk of pressure injuries on an individualized schedule, Teach residents who can change positions independently the importance of repositioning. Provide support devices and assistance as needed. Remind and encourage residents to change positions.Review the interventions and strategies for effectiveness on an ongoing basis.

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	03/31/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify interventions related to one (1) of three sampled residents (Resident 1's) specific risks and causes to try to prevent the resident from falling by failing to: Ensure that Resident 1 was frequently monitored and checked for safety and not to leave frequently used items unreachable for Resident 1;Ensure that IDT (Interdisciplinary Team- a collaborative group of health professionals working together to manage patient care) identified and evaluated specific factors and causes after Resident 1 fell on [DATE] and 1/21/2026;Ensure that staff obtained physician's order for floor mat and applied as recommended by IDT and as in the Care Plan. As a result, Resident 1 sustained a four (4)-centimeter laceration on the right forehead on 11/11/2025 requiring suture, and a second fall on 1/21/2026 during similar timeframe. These deficient practices also had potential risks to place other residents at risk for falls. Findings: During a review of Resident 1's admission Record (AR) the AR indicated that Resident 1 was originally admitted to the facility on [DATE] and discharged on 2/11/2026 with diagnoses including Pressure Ulcer (localized damage to the skin and/or underlying tissue usually over a bony prominence) of Sacral Region(shield-shaped bony structure at the base of spine), Stage 4 (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), and hypertension (high blood pressure). During a review of Resident 1's Minimal Data Set (MDS- a federally mandated resident assessment tool) dated 12/8/2025, the MDS indicated that Resident 1 was moderately cognitively impaired (decisions poor, supervision required). The MDS also indicated that Resident 1 required substantial/maximal assistance (helper does more than half the effort) on toileting hygiene, and partial/moderate assistance (helper does less than half the effort) on sit to stand, chair/bed-to-chair transfer, and walking 10 (ten) feet. During a review of Resident 1's Nursing Progress Notes (NPN) dated 11/11/2025, the NPN indicated Resident 1 was found on his right side on the floor at 4:05 AM and noted to have right forehead laceration (a tear or ragged cut in skin or flesh). The NPN also indicated that 911 was called at 4:11 AM, and Resident 1 was transferred to the general acute care hospital (GACH) 1 via 911 paramedics at 4:30 AM. During a review of Resident 1's GACH 1 Emergency Department (ED) Discharge Instruction Document dated 11/11/2025, the Discharge Instructions indicated that Resident 1 had a laceration to the forehead and would require suture removal. During a review of Resident 1's IDT Conference Record - Fall Management Follow-Up (IDTCR) dated 11/11/2025, the record indicated interventions that included Medication Regimen Review (MMR a comprehensive evaluation of a patient's medication list), bed in lowest position, landing floor mat, and applying bed alarm (a safety device to detect when a person attempts to leave their bed). There was no documented evidence that indicated the cause of Resident 1's fall. During a review of Resident 1's NPN dated 1/21/2026, the NPN indicated Resident 1 was found on the floor next to the left side of the bed at 4:10 AM. Resident 1 was lying on the floor and had a snack bag in her hand. The NPN indicated that Resident 1 was alert but forgetful and stated that she was trying to reach the snack bag from the bedside table and slide down from bed. The NPN indicated Resident 1 was observed with skin redness on left side of the forehead and that Resident 1 stated she hit bedside table. During a review of Resident 1's IDT Conference Record - Fall Management Follow-Up (IDTCR) dated 1/21/2026, the IDTCR was incomplete since there were no checkmarks by the IDT that indicated suggestive appropriate interventions. During a review of Resident 1's Physician's Orders dated from 9/10/2025 to 1/29/2026, the Physician Orders did not indicate an order for floor mats. During a review of Resident 1's Care Plan Resident presents with deficits in strength, safety awareness. dated 12/19/2025, the Care Plan did not indicate to provide supervision for safety when Resident 1 had poor safety awareness and not remembering to use call light. During a review of (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	03/31/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1's Care Plan Resident had an actual fall with minor injury dated 11/11/2025 and 1/21/2026, the Care Plan did not indicate to ensure bed alarm was functioning. During a concurrent interview and record review on 3/31/2025 at 10:30 AM with the MDS Nurse (MDSN 1), Resident 1's clinical records were reviewed. MDSN 1 stated Resident 1 fell on [DATE] and 1/21/2026 around the same time between 4 AM and 4:30 AM. MDSN stated Resident 1's IDTCR should have been completed and thorough, and should indicate the cause of Resident 1's fall. MDSN stated Resident 1's Care Plan interventions for fall precautions should have included frequent monitoring even though there was a bed alarm to alert the staff about resident's movement in bed. MDSN stated that finding the causes of a resident's fall was important because it was the first step to develop a resident-centered care plan and apply appropriate interventions tailored to Resident 1's specific needs. During an interview on 3/31/2026 at 2:45 PM with the Director of Nursing (DON), the DON stated that Resident 1 had Parkinson's Disease and was cognitively impaired. The DON stated Resident 1 did not have a care plan for supervision after Resident 1 sustained her first fall on 11/11/2025. The DON stated she was not sure why floor mat was recommended by the IDT but never ordered or applied to Resident 1. The DON also stated the staff failed to try to identify and document specific factors and causes of resident's fall and failed to implement a resident-centered Care Plan interventions. The DON stated since the cause of the fall was not identified and specific needs were not implemented for Resident 1, the DON stated Resident 1 could likely sustain another fall. During a review of the facility's policy and procedures (P&P) Assessing Falls and Their Causes reviewed in 6/2025, the P&P indicated the following: Within 24 hours of a fall, try to identify possible or likely causes of the incident, Evaluate chains of event or circumstance preceding a recent fall, Continue to collect and evaluate information until the cause of falling is identified or it is determined that the cause cannot be found,Consult with the attending physician or medical director to confirm specific causes from among multiple possibilities. During a review of the facility's policy and procedures (P&P) Care Plans, Comprehensive Person-Centered reviewed in 6/2025, the P&P indicated that care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. The P&P also indicated that assessment of residents are ongoing and care plans are revised as information about the residents and residents' condition change.