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	05/19/2026

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 - 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 interview and record review the facility failed to provide a hazard free environment, supervision and assistive device to prevent accidents and injuries to one of three sampled resident (Resident 1) in accordance with the resident's care plan, physician order and the facility's policy and procedure titled Assessing Falls and Their Causes. The facility failed to ensure: Resident 1's call light was always within Resident 1's reach.Application of the bed alarm (a pressure sensitive pads with a pad alarm (a device that alarms when pressure is relieved from the pad (by the patient 'getting up' from the chair or bed) the alarm will sound and assistance can be provided) in good functioning condition as ordered by the physician.To complete the Fall Risk Assessment to assess and implement interventions based on the resident's risk factor for fall.Thoroughly investigate the root cause of fall on 11/11/2025 to determine the appropriate inventions to prevent recurrent fall on 1/21/2026.Assess if Resident 1 could be placed on bowel and bladder program or incontinence (no control with bowel movement and urination) program (a structured, individualized plan designed to help residents regain or maintain continence, prevent skin breakdown, and promote independence. It relies on scheduled toileting, fluid management, pelvic floor exercises, and restorative nursing strategies rather than relying on adult briefs). These deficient practices resulted in Resident 1's fall on 11/11/2025 and was hospitalized due to a laceration (a jagged tear or deep cut in the skin and underlying soft tissues usually caused by blunt trauma or friction) on the forehead requiring sutures (stitch or medical device use to hold the tissues together) and right anterior (in front) scalp hematoma (a collection of blood trapped under the skin on the front-right side of the head) on 11/11/2025. In addition, Resident 1 had a recurrent fall and experienced pain and discomfort after the fall. Findings: During a review of Resident 1's General Acute Care Hospital (GACH) 1 Discharge Note dated 9/10/2025, indicated the resident's discharge diagnosis included sacral wound (a skin injury over the sacrum, the triangular bone at the very base of the spine, just above the tailbone) infection and foley catheter (a thin, flexible tube inserted into the bladder to drain urine) for urinary retention (the inability to completely empty your bladder, or in some cases, to pass any urine at all). The GACH 1 Progress Note indicated Resident 1 to have a bowel regimen (a routine or plan designed to help have regular, healthy bowel movements and prevent constipation). 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 Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) with dyskinesia (a movement disorder defined by involuntary, erratic, and uncontrollable muscle movements), pressure ulcer of sacral region stage four (skin injury due to prolonged unrelieved pressure resulting in full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), and unsteadiness on feet (a lack of balance, causing a wobbly, uneven, or unstable feeling while standing or walking). During a review of Resident 1's History and Physical (H&P) dated 9/10/2025 at 8:53 PM, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 12/8/2025, the MDS indicated the resident had moderate cognitive (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	impairment (a person was experiencing noticeable and significant difficulties with thinking, learning, remembering, and other cognitive skills that impact their daily life), that required substantial/maximal assistance (helper did more than half the effort) for transfers and sitting to standing, toileting and (partial/moderate staff does less than half the effort) on sit to stand, chair/bed-to-chair transfer, and walking 10 (ten) feet. The MDS indicated Resident 1 was always incontinent of bowel and urinary and was not on a toileting program. The MDS indicated the resident had a fall since admission/entry or reentry or the prior assessment with one injury. During a review of Resident 1's Fall Risk Evaluation dated 9/11/2025 at 2:29 AM, the Fall Risk Evaluation indicated the resident was alert and oriented, bedbound (a person spending most or all of their time in bed because of illness, injury, weakness, or disability making them unsafe or too difficult to move around) and incontinent (the involuntary loss of bladder or bowel control) and recently hospitalized in the last 14 days. The Fall Risk Evaluation was incomplete and did not indicate the fall risk score (a score or number used by healthcare providers to predict how likely a person was to fall - a score of 10 or higher indicates the resident was at high risk of falls) and the interventions to prevent falls. In addition, the report was not signed and dated by the facility staff who initiated the report. During a review of Resident 1's At Risk for Fall Care Plan dated 9/13/2025, the Care Plan indicated to reduce the risk for Resident 1's falls in three months, the facility will keep the call light within reach and the staff to answer call light promptly, keep frequently used items within reach, and to keep the bed at a low position. During a review of Resident 1's Change in Condition (COC) Evaluation dated 11/11/2025 at 6:24 AM, the Evaluation indicated on 11/11/2025 at 3:57 AM, Certified Nursing Assistant (CNA) 1 found Resident 1 on the floor lying on her right side with a right forehead laceration. The laceration was cleansed with normal saline (a sterile mixture of salt and purified water), patted dry, and covered with sterile gauze (a clean woven cotton material used in first aid) with applied pressure to stop bleeding. The Evaluation indicated that the resident representative and physician were notified with orders to transfer Resident 1 to the GACH via 911 (an emergency number). A review of the Nursing Progress Notes dated 11/11/2025 at 9:34 AM, Resident 1 was transferred to GACH 2 for further assessment of the head injury on 11/11/2025 at 4:24 AM. During a review of Resident 1's GACH 2 indicated Resident 1 was admitted to the Emergency Department (ED) on 11/11/2025 due to complaint of head injury after rolling out of bed, arrived with laceration on the head. A review of the Diagnostic Report dated 11/11/2025 at 5:24 AM, the GACH 2 Report indicated Resident 1's Computed Tomography (CT, imaging test that combined a series of X-rays taken from various angles with a computer to create detailed cross-sectional slices of the bones, organs, and tissues) indicated Resident 1 has a right anterior (in front) scalp hematoma. During a review of Resident 1's Fall Risk Evaluation dated 11/11/2025 at 6:25 AM (completed after the fall on 11/11/2025 at 3:57 AM), the Fall Risk Evaluation indicated the resident did not have any falls in the past three months, was alert and orientated to name, place and time and was, chairbound (someone unable to walk on their own and depended on a wheelchair to get around)/incontinent. The Evaluation indicated the resident's fall risk score was seven (7) indicating the resident was not at high risk for fall. During a review of Resident 1's GACH 2 Emergency Department Physician's Notes dated 11/11/2025 at 6:27 AM, the Physician's Notes indicated Resident 1 received four 6-0 nylon sutures (ultra-fine, non-dissolvable surgical stitch) with close approximation of two centimeters stellate appearing laceration (a star-shaped or jagged, multi-pronged tear in the skin) to the right forehead. The Physician's Notes indicated suture removal approximately in seven days given the wound appearance. During a review of Resident 1's Post Fall Evaluation dated 11/11/2025 at 6:45 AM, the Post Fall Evaluation indicated Resident 1 had unwitnessed fall in the room attempting to self-toilet and sustained a right forehead laceration. The Post Fall Evaluation indicated contributing factors to fall included the resident was incontinent and using incontinent supplies (incontinent brief) at the time of the fall. Resident 1 complained of generalized moderate body pain after the fall and was given pain medications as needed. During a review of Resident 1's Interdisciplinary Team (IDT-a group of facility staff that meet to create a plan of care for residents) Conference Record - Fall Management (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Follow-Up dated 11/11/2025 at 2:59 PM, the Follow-Up indicated the resident was placed on neurological (brain function and mental status) checks, post fall monitoring, and post fall Rehabilitation (rehab) assessment was competed and interventions (completed an evaluation and provided direct, hands-on treatment) and provided re-education to the resident to use the call light when needing help, changing the call light to a tap call light (a bedside button resident's use to ask for help) for easier manipulation by the resident, continued treatment of the right forehead laceration until healed, and to continue monitoring the application of the resident's bed alarm. During a review of Resident 1's Actual Fall with Minor Injury Care Plan dated 11/11/2025, the Care Plan indicated the goal for the resident to resume usual activities without further incident and for the resident's right forehead laceration to resolve without complications. The Care Plan included intervention to apply bed alarm, continuing interventions from the At Risk for Falls Care Plan and checking vital signs in the first 24 hours. During a review of Resident 1's Comprehensive Medical Chart, the Medical Chart did not indicate the resident had a Rehabilitation Post Fall/Incident Assessment done on 11/11/2025. During a review of Resident 1's Actual Fall with Minor Injury Care Plan dated 1/21/2026, the Care Plan indicated a goal for the resident to resume usual activities without further incident. The Care Plan interventions included continuing interventions on the At Risk for Falls care plan, educate Resident 1 for use the call light for help, and to offer snacks and fluids during medication pass and activities of daily living care. During a record review of the Order Summary Report indicated the physician ordered on 11/12/2025 to place bed alarm for Resident 1. During a review of Resident 1's COC Evaluation dated 1/21/2026 at 4:25 AM, the COC Evaluation indicated the resident fell at night. The Care Plan did not include information such as the exact time of the fall, location, how the resident was found, who witnessed the fall, what happened before the fall, and immediate interventions provided. The Evaluation indicated Resident 1's representative, and the physicians were notified with no new orders. During a review of Resident 1's Comprehensive Medical Chart, the Medical Chart indicated Resident 1's Fall Risk Evaluation form was not completed after the fall on 1/21/2026. During a review of Resident 1's IDT Conference Record - Fall Management Follow-Up dated 1/21/2026 at 4 PM, the Follow-Up indicated the resident was placed on neuro checks, post fall monitoring, and a post fall Rehab Assessment was competed and innervations were provided. The Follow-Up was incomplete and interventions to prevent recurrent falls were not documented. The Fall Management Follow-Up did not include a facility staff member's signature or date of completion. During a review of Resident 1's Rehabilitation Post Fall/Incident assessment dated [DATE] at 2:14 PM, the Assessment indicated the resident was seen with no apparent distress, the resident stated she was reaching for something and fell from the left side of the bed, screamed for help and the staff found the resident on the floor. The Assessment indicated the resident did not demonstrate proper safety techniques during transferring or using the call light properly. During a concurrent interview and record review on 5/13/2023 at 4 PM with the MDS Nurse, Resident 1's Change in Condition Evaluation dated 1/21/2026 was reviewed. The MDS Nurse stated the Evaluation did not have information on what specifically happened regarding the fall on 1/21/2026. The MDS Nurse stated the COC Evaluation was not completed because pertinent information about what happened and what caused the fall was not included in the COC. The MDS Nurse explained without any information showing what was done for Resident 1 safety could mean there was no proof that the facility staff did anything to care for the resident. During a telephone interview on 5/13/2026 at 7:56 PM, Registered Nurse Supervisor (RNS) 1 stated, when she arrived in Resident 1's room on 11/11/2025, the resident was already back to bed, and she informed CNA 1 and Licensed Vocational Nurse (LVN) 1 to apply pressure to the resident's forehead laceration while RNS 1 called 911. RNS 1 stated after calling 911, she assessed Resident 1 and the resident's mental orientation was intact. RNS 1 stated Resident 1 informed her that the resident was trying to turn off the light and close the bathroom door. The RNS 1 stated Resident 1 did not call for help. During a telephone interview on 5/14/2026 at 11:56 AM, CNA 1 stated on 11/11/2025 at around 3 AM, while she was assisting another resident CNA 1 heard Resident (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1 yelling for help. CNA 1 stated she went to Resident 1's room she found the resident sitting on the floor leaning against the side of the bed and was actively bleeding on her forehead. CNA 1 stated she called for assistance and waited for the LVN 1 to assess the resident before moving the resident back into bed. CNA 1 stated Resident'1s bed was not in a low position and the resident did not have a floor mat. CNA 1 stated Resident 1 had a bed alarm that was under the resident's back which did not alarm when the resident was found on the floor. CNA 1 stated You would be able to hear the bed alarm if the bed alarm went off because the bed alarm was so loud, but there was no bed alarm sound coming from the resident's (Resident 1's) room at the time of the fall. During a telephone interview on 5/14/2026 at 12:16 PM, LVN 1 stated, on 11/11/2025 after the fall she found Resident 1 in her room with hands and feet were on the floor, sitting down and actively bleeding from her head. LVN 1 stated Resident 1 was alert and oriented during the assessment. LVN 1 explained the bed was not at a low position and he was not sure if a floor pad was on the floor. LVN 1 stated he did not hear the bed alarm go off on the morning Resident 1 fell on the floor. During a concurrent interview and record review on 5/14/2026 at 12:47 PM, the Physical Therapist (PT) stated when a resident had a fall, the Rehab Department conducted a Post Fall Assessment every time to assess if the resident broke any bones, investigate what caused the fall to try and prevent future falls, and implement a treatment plan. The PT stated there was no documented evidence that a Post Fall Assessment was completed for Resident 1 on 11/11/2025. During a telephone interview on 5/18/2026 at 11:31 AM, Resident 1 stated, on 11/11/2025 she was unsure how she fell off the bed, but she recalled that she was dizzy and her forehead was pounding. Resident 1 stated she was yelling for help for more than 30 minutes, but nobody came to assist her. Resident 1 stated she did not have a floor mat and was unsure if she had a bed alarm. Resident 1 stated she was unable to reach the call light to call for help, it was not near her. Resident 1 stated because of her Parkinson's Disease she has unsteady gait. During a continued telephone interview on 5/18/2026 at 11:31 AM, Resident 1 stated she does not remember how she fell on 1/21/2026. Resident 1 stated that she tried to yell for help after the fall since she could not reach her call light, because the call light was too far from her, but nobody came to help her. Resident 1 stated the staff takes away the call light away from her. Resident 1 reported she was in a lot of pain and she received pain medication. During a review of the Weight and Vitals Summary indicated Resident 1's pain level ranged from 11/11/2025 at 5:30 AM to 11/15/2026 was from 3-8 out of 10 (pain scale 0-no pain and 10-severe pain). The pain level from 1/15/2026 to 1/21/2026 ranged from 0-8 on the pain scale. During a concurrent interview and record review of Resident 1's Fall Risk Evaluation dated 9/11/2025 on 5/18/2026 at 12:18 PM, the Director of Nursing (DON) stated the Fall Risk Evaluation should be completed to identify the residents risk for fall and develop a person-centered care plan with interventions based on the risk factors to prevent recurrent falls and prevent injury . The DON stated there was a possibility that the residents' fall could have been prevented if the Fall Risk Assessment was completed because then the facility staff could have based our interventions from our assessment to make the plan resident specific. During a concurrent interview and record review of Resident 1's Change in Condition Evaluation dated 11/11/2025 on 5/18/2026 at 12:35 PM, the DON stated a genitourinary (GU, assessment of the urinary tract such as kidney, bladder, ureters and reproductive organs)/urine assessment was not completed because Resident 1 had no issues with urinary and bowel elimination during the fall. During a concurrent interview and record review of Resident 1's IDT Conference Record - Fall Management Follow-Up dated 11/11/2025 on 5/18/2026 at 12:38 PM, the DON stated the IDT's recommendation was not implemented because the resident did not have a Post Fall Assessment on 11/11/2025 from Rehab because that was best practice to reassess the resident after the resident returned from the GACH. The DON stated that because Resident 1 was not assessed by the Rehab Department the care plan related to mobility needs of the resident was not developed to prevent recurrent fall. During a concurrent interview and record on 5/18/2026 at 12:47 PM of Resident 1's Post Fall Evaluation dated 11/11/2025 with the DON, the DON stated the facility staff should have conducted a GU/urine (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	assessment in the Change of Condition Evaluation dated 11/11/2025 as the Post Fall Evaluation indicated contributing factors included incontinence. The DON stated the resident was not placed in a bowel/bladder program and the staff should have anticipated the needs of the resident by putting the residents personal items closer to the resident to prevent recurrent fall. During a concurrent interview and record review on 5/18/2026 at 12:53 PM of Resident 1's Actual Fall with Minor Injury Care Plan dated 11/11/2025, the DON stated there were no interventions that included the contributing factors for the fall in 11/11/2026. The DON stated the facility staff should have followed the interventions from the At Risk for Falls Care Plandated 9/13/2025 and had everything Resident 1 needed within reach to prevent the resident from reaching out to grab things and being unsafe. During a current interview and record review on 5/18/2026 at 1:12 PM with the DON Resident 1's Change in Condition Evaluation dated 1/21/2026, the DON stated the Evaluation was not completed to indicate what happened, how the resident fell and who was present during the fall. During a concurrent interview and record review of Resident 1's Post Fall Evaluation dated 1/21/2026 on 5/18/2026 at 1:18 PM, the DON stated there was no documented evidence that a Post Fall Evaluation was completed for Resident 1 on 1/21/2026 to ensure the resident was provided with the appropriate treatment. During a concurrent interview and record review of Resident 1's Fall Risk Evaluation on 5/18/2026 at 1:19 PM, the DON stated there was no documented evidence that a Fall Risk Evaluation was completed on 1/21/2026. During a concurrent interview and record review of Resident 1's clinical records on 5/18/2026 at 1:20 PM with the DON, the DON stated the facility did not conduct a complete internal investigation of Resident 1's falls on 11/11/2025 to identify the risk factors that contributed to falls. The DON stated a resident specific care plan was not developed to indicate interventions to prevent recurrent falls related to the risk factors identified, such as incontinence care, bladder and bowel program, after the fall on 11/11/2025. The DON explained there was no record to ensure the pad alarm was monitored to be in place and functioning, and no record to indicate that the residents' call light was always within reach for the resident to use when needed. The DON stated that without a completed internal investigation the facility staff would not be able to find out and identify the root cause of what happened and escalate interventions, so Resident 1 does not have recurrent falls. During a continued concurrent interview and record review of Resident 1's clinical records on 5/18/2026 at 1:20 PM with the DON, the DON stated the facility did not conduct an internal investigation of Resident 1's fall on 1/21/2026 to identify the risk factors that contributed to falls and a resident specific care plan was not developed to indicate interventions to prevent recurrent falls related to the risk factors identified, after the fall on 1/21/2026, there was no record to indicate the residents' call light was always within reach for the resident to use when needed. The DON stated that without an internal investigation the facility staff would not be able to find out and identify the root cause of what happened and escalate interventions, so Resident 1 did not have recurrent falls. 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 events 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 root 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 is ongoing, and care plans are revised as information about the residents and residents' condition change.