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	05/20/2026

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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and device to prevent falls in accordance with the facility's policy and procedure (P&P) titled Falls and Fall Risk, Managing, and Smoking Policy or five of five sampled resident (Resident 2, 5, 6, 7, and 8) by failing to: 1. Supervise and implement intervention for Resident 2 who used a wheelchair instead of a Front Wheeled [NAME] (FWW-a mobility aid featuring two wheels on its front legs and rubber, non-slip tips on the back legs) plan for safety while ambulating. 2. Monitor, supervise compliance with Smoking Policy and implement intervention to promote safety for Resident 5 who smokes and found sharing cigarettes and carrying a lighter. 3. Complete Resident 6's Smoking and Safety Assessment (an assessment and evaluation form used by the facility to determine the resident's ability to smoke safely). 4. Complete Resident 7's Smoking and Safety Assessment, monitor, supervise compliance with Smoking Policy' and implement intervention to promote safety for Resident 7 who smoked cigarette and found carrying two lighters. 5. Complete Resident 8's Smoking and Safety Assessment, monitor, supervise compliance with Smoking Policy and conduct an interdisciplinary team (IDT) meeting and develop a care plan for Resident 8 who was found with marijuana (dry shredded mix of leaves, flowers, stems from the Cannabis plant that contained chemicals that interact with your body and brain altering your mood, senses) in the resident's belongings. These deficient practices had the potential to result for Resident 2 to have increased risk for fall and repeated falls that could result in major injuries. In addition, the deficient practice could result in Residents 5,6,7 and 8 to be at risk for smoking-related accidents, burns, and fire hazards that could affect the safety of the other residents, personnel and visitors in the facility. Findings: 1. During a review of Resident 2's admission Record, the admission Record indicated Resident 5 was admitted on [DATE] with diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) with psychotic symptoms (a severe mental condition that indicate a loss of contact with reality), unsteadiness (lack of physical stability or balance) on feet, lack of coordination (inability to make smooth, precise physical movements), and dementia (a progressive state of decline in mental abilities). During a review of Resident 2's History and Physical (H&P) dated 5/12/2026, the H&P indicated Resident 2 does not have the mental capacity to make medical decisions. During a review of Resident 2's Minimum Data Set (MDS-a comprehensive assessment and screening tool) dated 5/5/2026, the MDS indicated Resident 2 needs a helper to do less than half the effort for (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sit to stand, chair/bed-to-chair transfer, toilet transfer, walk 10 feet and walk 50 feet with two turns. During a review of Resident 2's Fall Risk Evaluation dated 4/18/2026, the Fall Risk Evaluation indicated Resident 2 was chairbound (being permanently or temporarily confined to a wheelchair due to illness or physical condition) and could not walk. During a review of Resident 2's Fall Risk Evaluation dated 4/20/2026, the Fall Risk Evaluation indicated Resident 2 had a balance problem while standing or walking. No goals or interventions were indicated. During a review of Resident 2's Interdisciplinary Team (IDT-a group of healthcare professionals with different specialties who collaborate to evaluate, plan and deliver resident centered care) Conference – Post Fall, dated 4/21/2026, the IDT Conference indicated on 4/19/2026, Resident 2 lost balance while walking to the restroom and was found sitting on the floor. The IDT conference indicated Resident 2 will have hands-on-assistance with transfer and ambulation. During a review of Resident 2's Physical Therapy (PT) Notes dated 5/15/2026, the PT notes indicated instructions were given to the resident and caregiver for use of FWW with ambulation. During a review of Resident 2's PT Progress Report dated 5/15/2026, the PT Progress Report indicated patient (resident) will safely perform functional transfers with stand by assistance for correct use of assistive device. During an interview on 5/18/2026 at 3 PM with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 2 usually walks around the facility pushing a wheelchair like a FWW. During an interview on 5/19/2026 at 9:30 AM with CNA 2, CNA2 stated Resident 2 was on fall precautions so needs supervision when walking or getting up out of bed. CNA 2 stated she walks with Resident 2 when walking around the facility and pushing the wheelchair as if it was a FWW. During an interview on 5/19/2026 at 10:45 AM with Physical Therapy Assistant (PTA), PTA stated Resident 2 was very confused and impulsive. The recommendation from physical therapy was to supervise Resident 2 while walking at all times. The PTA also stated, the wheelchair being on four wheels can easily keep rolling causing the resident to fall. During a concurrent interview and record review on 5/19/2026 at 2:38 PM with the Director of Nursing (DON), the Care Plan for impaired mobility, initiated 5/1/2026, was reviewed. The Care plan indicated, Resident to be supervised with bed mobility, transfers, gait with FWW. The DON stated she will follow up with the physical therapist is needed to ensure safe usage of a wheelchair versus the FWW. The DON stated it is important to provide appropriate supervision and care to achieve resident's goal and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provide safety from falls. During a review of the facility's Policy and Procedures (P&P) titled, Falls and Fall Risk, Managing, reviewed June 2025, the P&P indicated: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 2. During a review of Resident 5's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), and atherosclerotic heart disease (the narrowing or blockage of the artery that supplied blood to the heart). During a review of Resident 5's Smoking and Safety (a form used to evaluate the resident's safety while smoking) dated 1/30/2026 timed at 5:30 AM indicated that the resident used tobacco and followed the facility's designated smoking locations and times. The care plan goal was for the resident to comply with the facility's smoking policies, the interventions included conducting smoking safety evaluations as needed and providing education on smoking schedules and procedures. During a review of Resident 5's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 3/24/2026, the MDS indicated the resident's cognition was intact (sufficient judgement and self-control to manage the normal demands of the environment). The MDS did not indicate if Resident 5 was currently using tobacco products. During a review of Resident 5's clinical record indicated a comprehensive care plan was not developed a Smoking Care Plan for Resident 5 regarding interventions and safety measures to implement when the resident was smoking. During an interview on 5/19/2026 at 11:27 AM, Resident 5 stated he smoked cigarettes and did not smoke marijuana. Resident 5 stated other residents who live at the facility tried to give Resident 5 marijuana, but he refused. Resident 5 stated he would not give the names of the residents who tried to offer him marijuana. During a concurrent observation and interview in Resident 5's room on 5/19/2026 at 12:09 PM, Resident 5 handed Resident 6 two cigarettes, in return Resident 6 handed Resident 5 a one-dollar bill. Resident 5 stated he did not sell his cigarettes but gave them to my friends and if the other residents wanted to give Resident 5 one dollar I won't refuse. Resident 5 also stated he keeps a lighter in his possession and the resident a lighter out of his pocket to show the surveyor. 3. During a review of Resident 6's AR, the AR indicated the resident was admitted to the facility on (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] and re-admitted on [DATE], with diagnoses that included COPD, lack of coordination, and nicotine dependence - cigarettes. During a review of Resident 6's History and Physical (H&P) dated 9/12/2024 at 5:20 PM, the H&P indicated the resident had the capacity to understand and make decisions. A review of Resident 6's Chronic Smoker Care Plan, revised on 2/10/2026, identified goals for Resident 6 to avoid injury from unsafe smoking practices and to not smoke without supervision. The Care Plan included interventions to educate the resident on smoking risks and hazards, review the facility's smoking policies regarding approved locations, times, and safety procedures, and ensure staff supervision while the resident smokes. During a review of Resident 6's Smoking and Safety dated 3/20/2026 timed at 2:05 PM, the Smoking and Safety indicated the resident used tobacco products. The Smoking and Safety record did not include ca care plan or measures to implement and ensure safety. During a review of Resident 6's MDS dated [DATE], the MDS indicated the resident's cognition was intact. The MDS did not indicate if Resident 6 was currently using tobacco products. 4. During a review of Resident 7's AR, the AR indicated the resident was admitted to facility on 3/13/2026, with diagnoses that included COPD, unsteadiness on feet, and generalized muscle weakness. During a review of Resident 7's Smoking and Safety dated 3/13/2026, the Smoking and Safety indicated the resident used tobacco products and had balance problems while sitting or standing. The Smoking and Safety record did not include ca care plan or measures to implement and ensure safety. During a review of Resident 7's H&P dated 3/14/2026, the H&P indicated the resident had the capacity to understand and make decisions. The review of Resident 7's Smoking Care Plan, dated 3/16/2026 indicated a goal for the Resident 7 not to smoke without supervision. Interventions included educating Resident 7 about smoking risks and cessation, reviewing the facility's smoking policies regarding locations, times, and safety, and providing staff supervision while the resident smokes. During a review of Resident 7's MDS dated [DATE], the MDS indicated the resident's cognition was intact and currently using tobacco products. During an observation on 5/19/2026 at 11:45 AM, Resident 7 had two lighters and cigarettes within his possession. 5. During a review of Resident 8's AR, the AR indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included DM, unsteadiness on feet, and generalized muscle weakness. During a review of Resident 8's H&P dated 3/2/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 8's Smoking Care Plan dated 3/5/2026, the Care Plan goal was for (continued on next page)

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