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	06/03/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one (1) of three sampled residents (Resident 1) were administered medications, in accordance with the physician's order and facility's policy and procedure (P&P) titled, Administering Medications. This deficient practice placed Resident 1 at risk of complications associated with the possible mismanagement of the resident's diseases process.Findings:During a review of Resident 1's admission Record (AR), the AR indicated resident was admitted on [DATE] with diagnoses that included metabolic encephalopathy (a brain dysfunction, leading to symptoms like confusion, personality changes), diabetes mellitus (DM, a metabolic condition characterized by persistently high blood sugar (glucose) levels), and hyperlipidemia (elevated blood cholesterol level). During a review of Resident 1's History and Physical (H&P), dated 12/15/2025, the H&P indicated the resident has the capacity to understand and make decisions. The H&P also indicated that the resident had a history of suicide attempt by way of overdosing on lisinopril (a medication used to control high blood pressure). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 4/10/2026, the MDS indicated that the resident has intact cognitive (the ability to process thoughts and emotions) skills for daily decision making. The MDS also indicated Resident 1 required supervision (the helper provides verbal cues and/or touching assistance as resident completes the activity) on activities of daily living (ADL) such as oral hygiene, toileting hygiene, bathing, and dressing. The MDS also indicated Resident 1 required setup assistance (the helper sets up or cleans up prior to or following the activity) with eating. During a review of Resident 1's Physician's Orders as of 6/2/2026, the Physician's Orders included the following:Jardiance (a medication used to control DM) oral tablet 10 milligrams (MG, a unit of measuring weight) give 1 tablet by mouth in the morning for DM, ordered on 12/12/2025.Metformin Hydrochloride (a medication used to control DM) oral tablet 1000 MG give 1 tablet by mouth two times a day for DM with meals (Hold if blood sugar [BS, the amount of glucose {a type of sugar} present in the bloodstream, which is the body's main source of energy] [is less than] 100), ordered on 3/31/2026.Probiotic (a supplement) oral capsule give 1 capsule by mouth one time a day for digestive supplement, ordered on 5/19/2026.Venlafaxine Hydrochloride (a medication used to treat depression [a serious, common mood disorder characterized by a persistent feeling of sadness, emptiness, and a significant loss of interest in activities]) oral capsule extended release 24-hour 75 MG give 1 capsule by mouth one time a day for depression, ordered on 3/31/2026.Vitamin C oral tablet give 1000 MG by mouth one time a day for supplement, ordered on 5/19/2026.During a review of Resident 1's Medication Administration Record (MAR), for the month of 6/2026, the MAR included the resident's Jardiance, Probiotic, Venlafaxine, and Vitamin C are prescribed to be administered at 9AM. The MAR also indicated that Resident 1's Metformin is prescribed to be administered at 7:30 AM. All five medications were initialed as administered to Resident 1. During a review of Resident 1's Medication Audit Report from 6/1/2026 to 6/2/2026, the Report indicated that Resident 1's Venlafaxine, Jardiance, Vitamin C, and Probiotic were documented as administered on 6/2/2026 at 9:28 AM by Licensed Vocational Nurse (LVN) 1. The Report also indicated that Resident 1's Metformin (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was documented as administered on 6/2/2026 at 8:25 AM by LVN 1. During a review of Resident 1's assessment Note titled, Self-Administration of Medication, dated 5/19/2026, the Note indicated that the resident is not approved for the self-administration of medications. The Note also indicated that Resident 1 may not keep medications at the bedside. The Note further indicated that Resident 1 requires assistance in actions such as stating the time to take the medications, stating the proper dosage of the medications, dispensing the proper amount of the medications, documenting the self-administration of medications, and naming the medications and their prescribed use. During a review of Resident 1's Care Plan for skilled nursing care, initiated on 12/17/2025, the Care Plan indicated that the resident requires skilled nursing care related to the resident's need for medical management, cognitive impairment, and metabolic encephalopathy. The care plan interventions included were to assist the resident with ADLs and administer medications as ordered. During an interview and observation on 6/2/2026 at 10:47 AM inside Resident 1's room, Resident 1 was observed grabbing a medication cup from her bedside table. Resident 1 stated that there are 5 medications in the cup. Resident 1 was then observed taking one pill from the medication cup and proceeded to put it in her mouth. Resident 1 stated that she ingested one of the medications in the cup, and it was vitamin C. Resident 1 then stated that she does not know the other four pills in the medication cup. During a concurrent observation and interview on 6/2/2026 at 10:51 AM with Licensed Vocational Nurse (LVN) 1 inside Resident 1's room, LVN 1 stated that there is a medication cup with four pills on Resident 1's bedside table. LVN 1 stated that the medications are Resident 1's Jardiance, Probiotic, Venlafaxine, and Metformin. During a follow-up interview on 6/2/2026 at 10:54 AM with LVN 1, LVN 1 stated that that she gave the medications to Resident 1, but the resident stated she wanted to sleep. LVN 1 stated that she left the medication cup containing the medications at around 8:30 AM because the medications were due at that time. LVN 1 further added that the medications are now late and do not fall within one hour of the prescribed time of administration. During an interview on 6/5/2026 at 11:06 AM with Registered Nurse 1 (RN 1), RN 1 stated that nurse must not leave medications with the resident. RN 1 stated that if the resident chooses not to take the medications at the time, the nurse can offer the medications later. During the same interview on 6/3/2026 at 2:45 PM with the DON, the DON stated that the nurse must ensure that all medications are successfully swallowed by the resident before leaving the resident to ensure that the resident's medications are taken on time. The DON added that the resident's medication regimen is affected if the medications are not taken on time. The DON further added that if medications are not taken within one hour of its prescribed time, the resident's disease will not be effectively managed. During a review of the facility's P&P titled, Administering Medications, reviewed 6/2025, the P&P indicated that only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so. The P&P also indicated that medications are administered within one (1) hour of their prescribed time. The P&P also indicated that the individual administering the medication initials the resident's [Medication Administration Record] on the appropriate line after giving each medication.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the facility's two out of three shower rooms (SR) were clean and sanitary, in accordance with the facility's policy and procedure titled, Infection Prevention and Control. On 6/2/2026 SR 1 and SR 2 were observed to have brown-colored substances that were smeared on the floor and shower chairs (a specialized, waterproof seat designed to allow individuals to sit while bathing). This deficient practice had the potential to spread infection to all the facility's residents who use the shower rooms.During a review of Resident 1's admission Record (AR), the AR indicated, the resident was admitted on [DATE] with diagnoses that included metabolic encephalopathy (a brain dysfunction, leading to symptoms like confusion, personality changes), diabetes mellitus (a metabolic condition characterized by persistently high blood sugar (glucose) levels), and hyperlipidemia (elevated blood cholesterol level). During a review of Resident 1's History and Physical (H&P), dated 12/15/2025, the H&P indicated, the resident has the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 4/10/2026, the MDS indicated, the resident has intact cognition (the ability to process thoughts and emotions). The MDS also indicated, the resident requires supervision (the helper provides verbal cues and/or touching assistance as resident completes the activity) on activities such as oral hygiene, toileting hygiene, bathing, and dressing. The MDS also indicated, the resident requires setup assistance (the helper sets up or cleans up prior to or following the activity) on activities such as eating. During an interview on 6/2/2026 at 10:29 AM with Resident 1, Resident 1 stated the facility's shower rooms are always filthy. Resident 1 stated the nurses do not clean up the shower room after they shower residents. Resident 1 stated that whenever she uses the shower rooms, there are always feces on the floor and the shower chairs. Resident 1 added that when she went to the shower room on 6/1/2026, the shower room's floor had feces. During a concurrent observation and interview on 6/2/2026 at 11:17 AM with Housekeeper (HK), the facility's SR 1 was inspected. HK stated that there are brown stains or smudges that appear to be feces on the shower room floor and the shower chair's lower legs. During a concurrent observation and interview on 6/2/2026 at 11:23 AM with the Director of Nursing (DON), the facility's SR 3 was observed. The DON stated SR 3 floor has feces. The DON added the shower chair inside SR 3 appears to have feces on its bottom frame. The DON also stated the Certified Nursing Assistant's (CNA) are responsible for cleaning up the shower room after each resident use it. During an interview on 6/3/2026 at 3:12 PM with the facility's Infection Preventionist Nurse (IP), IP stated feces that are left in the shower rooms could potentially transmit infections to residents. IP stated, after a resident defecates in the shower room, the nurse should throw away the feces in the trash and disinfect the floor and equipment using disinfectant wipes. During an interview on 6/3/2026 at 3:45 PM with the DON, the DON stated CNAs and nurses must ensure that shower rooms are clean and free from feces after each resident use. The DON added, the shower room must be clean before another resident uses it to prevent the spread of infections. The DON further added teces that are left in the shower room could potentially cause infections on whoever uses the shower room. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control, dated 2001, the P&P indicated that infection prevention policies and procedures apply to all personnel. The P&P indicated that the objectives of the infection prevention and control policy include for the facility to maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to ensure that the water filter was changed at least once a year for the facility kitchen's coffee maker and juice machine. This deficient practice had the potential to affect the residents' appetite and fluid consumption because of the water palatability of the facility-served coffee and juice.During a concurrent observation and interview on 6/2/2026 at 3:11 PM with Dietary Supervisor (DS), the facility's kitchen was inspected. During the inspection, the facility's water filter was observed with a label indicating that the filter was changed on 5/28/2025. DS stated the water filter supplies water to the facility's coffee maker and juice making sure the water, which is served for the residents. During a follow-up interview on 6/2/2026 at 3:32 PM with DS, DS stated, about one month ago at the beginning of the month of 5/2026, DS observed that the water filter had not been changed since 5/28/2025. DS stated he intended to contact the vendor of the water filter to change the filter, but DS forgot. DS added that the water filter needs to be changed timely because it supplies water to the facility's coffee maker and juice making sure the water is palatable or no after taste. During a concurrent interview and record review on 6/2/2026 at 3:35 PM with DS, the water filter's manufacturer's catalog (dated 2026) was reviewed. DS stated the manufacturer's catalog indicated that the water filter must be replaced at least once a year. DS added if the water filter was last changed on 5/28/2025, the filter should have been changed on or before 5/28/2026. During an interview on 6/3/2026 at 2:11 PM with Maintenance Supervisor, MS stated he did not know that it was his responsibility to ensure that the coffee and juice machine's water filter is replaced at least once a year. MS also stated he thought that the vendor would automatically go to the facility to change the water filter for the coffee and juice maker. MS further stated he did not know that he should call the vendor to remind the vendor to replace the water filter. During an interview on 6/3/2026 at 3:45 PM with the Director of Nursing (DON), the DON stated it is the responsibility of the MS to ensure that the coffee and juice maker's water filter is changed timely. The DON, added that failure to change the water filter on time could affect the water quality that the residents drink and could place the residents at risk of potential foodborne infections and/ or loss of appetite because the water was not palatable. During a review of the facility's policy and procedure (P&P) titled, Maintenance Service, reviewed 6/2025, the P&P indicated maintenance service shall be provided to all areas of the building, rounds, and equipment. The P&P indicated the maintenance personnel shall follow the manufacturer's recommended maintenance schedule. The P&P further indicated that the maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. The P&P also indicated that the maintenance personnel's functions include the maintenance of plumbing fixtures.