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	10/04/2024

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882 Based on observation, interview, and record review, the facility failed to obtain an informed consent for psychotropic (any drug that affects behavior, mood, thoughts, or perception) drug for one of one sampled resident (Resident 99) who was prescribed Quetiapine (medication used to treat a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions), and Zolpidem (medication used for used to treat insomnia (trouble sleeping) . This deficient practice had violated Resident 99's rights to be informed when choosing the type of care or treatment to be received, make decisions on alternative measures the resident or responsible party preferred, which could negatively affect Resident 99 ' s quality of life. Findings: A review of the admission record indicated Resident 99 was admitted on [DATE] with diagnoses that included dementia (a group of related symptoms associated with an ongoing decline of the brain and its abilities), psychotic disorder (affect the mind, where there has been some loss of contact with reality), and cognitive communication deficit. A review of Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 6/4/2024, indicated Resident 99 ' s cognitive status was severely impaired. The MDS indicated Resident 99 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and or contact guar assistance as resident completes activity) with eating, partial/moderate assistance (helper does less than half the effort) with toileting and substantial/maximal assist (helper does more than half the effort) with bathing and personal hygiene. During an observation on 10/1/2024 at 10:03 AM in the facility dining room, Resident 99 on a wheelchair with activity staff verbalizing nonsensical (having no meaning; making no sense) words. During a concurrent observation and interview on 10/3/2024 at 11:00 AM with certified nurse assistant (CNA) 3 Resident 99 was in bed asleep. CNA 3 stated, Resident 99 gets confused with episodes of agitation, and the staff would just redirect resident 99 ' s attention. (continued on next page)

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	10/04/2024

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/3/2024 at 11:15 AM with Director of Staff Development (DSD) stated, Resident 99 was receiving psychotropic medications, and it should have a consent obtained and signed by the physician as per policy. DSD stated, the physician needs to explain the cause and effect of the medication and other alternatives. DSD stated, not having consent for psychotropic medication, violates resident rights. During a concurrent interview and record review, on 10/3/2024, at 11:30 AM, with Director of Nurses (DON), Resident 99 ' s Informed Consent for psychotropic drugs Quetiapine and Zolpidem, (undated) was reviewed. The documents did not have a date and a physician name or signature who obtained consent. DON stated, the psychotropic informed consent should have a signature of the doctor per policy. DON stated, she did not have any documented proof, consent for psychotropic drugs was obtained by the doctor from Resident 99 or responsible party. DON stated, it was important for the doctor to obtain the consent for psychotropic medication, so he can explain pros and cons of the medications and alternative options. DON stated, not having not having psychotropic medication consents violates Resident 99 ' s rights. A review of Resident 99 ' s facility document Order Summary Report (OSR), dated 10/1/2024, , the document indicated order for: a) Quetiapine Fumarate 25 mg (unit of weight) to give 1 tablet at bedtime for schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves) ordered 5/31/2024, and b) Zolpidem Tartrate 10 mg to give 1 tablet at bedtime for insomnia manifested by inability to sleep, ordered 9/23/2024. A review of the facility ' s policy and procedure (P&P) titled Informed Consent, dated 6/2019, indicated: a) to involve residents in their care decisions by facilitating information and obtaining consent for the use of psychotropic drugs, b) if resident is determined not to have the capacity to make informed decisions a surrogate decision maker is identified, c) when initiating a new order in psychotropic drugs the attending physician will obtain inform consent from resident or responsible party. A review of the facility ' s policy and procedure (P&P) titled Resident Rights, dated 2/2021, indicated, federal and state law guarantee certain basic rights to all residents of the facility, these rights included rights to: a) be notified of his or her medical condition and of anu changes in his or her condition, and b) be informed of , and participate in, his or her care planning and treatment.

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	10/04/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview, and record review, the facility failed to provide communication board (a sheet of symbols, pictures, or photos that one can use by point to, to help people who have limited spoken language ability to communicate with others.) to facilitate and help residents express and have their needs met for one of twenty-three sampled residents (Resident 23). This failure had a potential to result in Resident 23's needs not met, feeling upset, potential decline in quality of care provided to her and her overall quality of life. Findings: During a review of Resident 23's Admission Record indicated the facility initially admitted Resident 23 on 4/1/2015 and readmitted on [DATE] with diagnoses that included hemiplegia (a condition that causes partial or complete paralysis or weakness on one side of the body and hemiparesis (weakness or an inability to move on one side of the body) following cerebral infraction (stroke, a serious condition that occurs when blood flow to the brain is disrupted, causing brain tissue to die) affecting right dominant side, muscle weakness, cognitive communication deficit, aphasia (loss of the ability to understand or express spoken or written language), and dysphagia (difficulty swallowing). During a review of Resident 23 ' s Speech Therapy SLP (Speech-Language Pathologist, a communication expert that assess and treat people who have speech, language, voice, and fluency disorders) Evaluation and Plan of Treatment, dated 7/15/2023, indicated Resident 23 had profound expressive language skills characterized by mostly nonverbal speech. The record indicated Resident 23 was able to express occasional yes/no answers to questions, follow directions, read written text but unable to write, and recommended interventions included implementation of simple communication boards to facilitate with wants/needs. During a review of Resident 23's History and Physical, dated 8/12/2024, indicated Resident 23 had fluctuating capacity to understand and make decisions. During a review of Resident 23's care plan (a document that outlines the facility ' s plan to provide personalized care to a resident based on the resident ' s needs), dated 3/6/2024, indicated Resident 23 was at risk of communicate her needs due to problems with inability to express self making self-understood by others. The goal was to use a form of communication to help Resident 23 effectively communicate with others and ensure all her needs anticipated and met by the facility. The interventions included to provide alternative means of communication, including use of communication board. During a concurrent dining observation and interview on 10/1/2024 at 12:15 PM with Resident 23 in her room, Resident 23 was observed eating alone with no assistant and unable to cut up a piece of adult palm size chicken. Resident 23 pointed to her right arm to express that her right arm could not move and that she could not use her right hand to cut up the chicken to eat. (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	10/04/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 10/1/2024 at 12:45 PM with Certified Assistant Nurse (CNA) 4 in Resident 23's room, Resident 23 was pointing at the lunch tray and making gesture with four fingers while CNA 4 was observed guessing what Resident 23 wanted for approximately 10 minutes. CNA 4 stated, she could not understand what Resident 23 wanted. When surveyor asked Resident 23 if she wanted to cut the chicken up in four pieces, Resident 23 nodded her head. CNA 4 stated, she usually guessed what Resident 23 wanted and she had never seen any communication board in the facility. CNA 4 stated, there should be a communication board with pictures to help understand the resident better because Resident 23 could read and understand when staff communicated with her. During a concurrent observation and interview on 10/3/2024 at 4:04 PM with CNA 9 in Resident 23 ' s room, Resident 23 was observed upset, lying on the right-hand side and making left hand gesture toward CNA 9, CNA 9 was observed guessing what Resident 23 wanted. CNA 9 stated, she was not Resident 23 ' s regular CNA so she did not understand what Resident 23 was trying to say. CNA 9 stated, she would come out and request help from her coworker. CNA 9 stated, she had never seen any communication board in the facility. During a concurrent observation and interview on 10/3/2024 at 4:10 PM with CNA 10 in Resident 23 ' s room, CNA 10 stated, she came to help CNA 9 to understand what Resident 23 wanted. CNA 10 stated, she could not understand what Resident 23 wanted. CNA 10 stated, she had not seen any communication board with pictures and simple languages in the facility. During an interview on 10/3/2024 at 6:08 PM with the Director of Nurses (DON), the DON stated, the facility had communication board with pictures to assist in helping staff communicate with the residents who had difficulty in expressing their needs. The DON stated, without communication board, the staff could neglect what Resident 23 ' s needs and not able to provide the services that she needed. The DON stated, the resident could feel upset for not able to communicate what she wanted, and her health could decline. During a review of the facility ' s policy and procedure (P&P) titled, Accommodation of Needs, dated March 2021, the P&P indicated in order to accommodate individual needs and preferences, staffs are to interact with the residents in ways that accommodate the physical or sensory limitations of the residents, promote communication, and maintain dignity.

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	10/04/2024

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on interview, observation and record review, the facility failed to ensure the facility ' s recent (last survey was on 10/5/2023) survey binder with past survey result (outcome of the survey that were conducted to protect residents and to ensure that all residents receive the quality of care) were accessible and available for all the residents, including Resident 27, 102 and 106 who attended the facility ' s resident council meeting on 10/2/2024. This deficient practice had the potential for the residents and their legal representatives to not fully informed of the facility's deficient practices and how they were corrected. Findings: During a review of Resident 27's Admission Record indicated the facility admitted Resident 27 on 5/7/2024 with diagnoses that included diabetes mellitus (a group of diseases that result in too much sugar in the blood), malnutrition (inadequate intake of food as a source of protein, calories, and other essential nutrients), and lack of coordination. During a review of Resident 27 ' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/9/2024, indicated Resident 27 was cognitively intact, had capacity to understand and make decisions. During a review of Resident 102's Admission Record indicated the facility admitted Resident 27 on 8/28/2024 with diagnoses that included malnutrition, hypertension (high blood pressure), and lack of coordination. During a review of Resident 102 ' s MDS, dated [DATE], indicated Resident 102 was cognitively intact, had capacity to understand and make decisions. During a review of Resident 106's Admission Record indicated the facility admitted Resident 106 on 9/13/2024 with diagnoses that included lack of coordination, pain in right foot, and depression (mood disorder that causes a persistent feeling of sadness and loss of interest in life). During a review of Resident 106 ' s MDS, dated [DATE], indicated Resident 106 was cognitively intact, had capacity to understand and make decisions. During the facility ' s resident council meeting interview on 10/2/2024 at 10:55 AM with ten residents included Resident 27, Resident 102, and Resident 106, stated they were not aware of the availability and location of the survey report and how the facility corrected the deficiencies that were identified in the past survey. The residents stated they would like to know the facility's latest survey inspection results and the corrections that the facility put into place. (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	10/04/2024

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and observation on 10/2/2024 at 11:02 AM with the Director of Nurses (DON), the DON stated, the facility had a binder which content all past survey results. The DON stated, they have a designated table in the entrance area where they usually left the binder in the drawers. The DON was observed opening the designated table ' s drawers and could not find the survey binder. The DON stated, she could not locate the survey binder and would ask Medical Record (MR) where survey binder went. During an interview on 10/2/2024 at 11:34 AM with the facility ' s MR, the MR stated, she took the survey binder to her office the day before and did not bring it back. During an interview on 10/4/2024 at 1:22 PM with the DON, the DON stated, the survey binder should be accessible to the residents and visitors, because they had the right to know what was going on with the facility. The DON stated, if the binder was not available, the residents and their representatives could be frustrated not able to know the past deficiencies and how the facility corrected them. The DON stated, the residents and their representatives had the right to know facility ' s past deficient practices and how they were corrected. During a review of the facility ' s policy and procedure (P&P) titled, Resident Rights, revised February 2021, the P&P indicated, Federal and state laws guarantee certain basic rights to all residents of this facility, these rights include the resident ' s right to examine survey results.

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	10/04/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779 Based on interview and record review, the facility failed to implement facility's written abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish) policy and procedure for two of three sampled residents (Resident 106 and Resident 29) by not conducting a thorough investigation when the two residents were involved in a resident-to-resident altercation. Resident 106 allegedly physically abused by Resident 29 during a resident -to-resident altercation on 9/26/24. Resident 29 poured a cup of water on Resident 106, who was sleeping on his bed around 7:30 PM on 9/26/24. Resident 29 walked out the room with Resident 106 following behind him. Resident 29 and Resident 106 stopped and stood face to face about one foot away from each other in front of the nursing station #1. Resident 106 asked Resident 29 loudly why did you pour water me? Resident 29 stayed quiet and did not say anything. These deficient practices resulted in the residents not protected from repeat abuse and residents at risks from injury from abuse, feeling of intimidation and neglect. Findings: During a review of Resident 106's Admission Record indicated the facility admitted Resident 106 on 9/13/24 with diagnoses that include schizophrenia (a mental health condition that is marked by a mix of symptoms, such as hallucinations and delusions, mood disorder depression, and mania) and anxiety disorder (a mental illness that causes a person to experience excessive and uncontrollable feelings of fear or anxiety). During a review of a Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/17/24, indicated Resident 106 had moderately impaired cognitive (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 106 required supervision or touching assistance with eating, and partial/moderate assistance with oral hygiene, toilet hygiene, shower/bathe self and personal hygiene, and chair/bed-to-chair transfer. During a review of Resident 29's Admission Record indicated the facility originally admitted Resident 29 on 2/13/24 and readmitted on [DATE] with diagnoses that include schizophrenia (a mental health condition that is marked by a mix of symptoms, such as hallucinations and delusions, mood disorder depression, and mania) and dementia (a chronic condition that causes a decline in cognitive abilities, such as thinking, remembering, and reasoning, that interferes with daily life). During a review of a Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/4/24, indicated Resident 29 had moderately impaired cognitive (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 29 required supervision or touching assistance with eating, and partial/moderate assistance with oral hygiene, toilet hygiene, shower/bathe self and personal hygiene, and chair/bed-to-chair transfer. (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	10/04/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 106 ' s Progress Notes, dated from 9/26/24 to 10/4/24, the Progress Notes indicated there was no documentation and investigation related to the altercation between Resident 106 and Resident 29. During a review of Resident 29 ' s Progress Notes, dated from 9/1/24 to 10/2/24, the Progress Notes indicated there was no documentation related to the altercation between Resident 106 and Resident 29. During an interview on 10/1/24 at 3:20 PM, with Resident 106, Resident 106 stated, he remembered the day Resident 29 was transferred to his room, and they became roommates. Resident 106 stated it was at around 7:30 PM while he was sleeping on his bed, Resident 29 walked toward his bed suddenly poured a cup of water on him. Resident 106 stated Resident 29 immediately walked out their room right away, he then followed Resident 29 to the nursing station #1. Resident 106 stated he asked Resident 29 why he poured water on him, but Resident 29 did not answer and pretended he did not do it. Resident 106 stated Resident 29 had issues and he always tried to look for trouble. Resident 106 stated Resident 29 poured the water on him on purpose. Resident 106 stated the staff separated them immediately after the incident occurred. Resident 106 stated he was upset at that time, and he had to keep an eye on Resident 29 all the time to make sure he did not try to do something to him again. During an interview on 10/2/24 at 4:25 PM, with Licensed Vocational Nurse (LVN) 4, LVN 4 stated he could not remember if it happened on 9/25/24 or 9/26/24 around 7:30 PM, he saw Resident 29 walked out the room with Resident 106 following behind him. LVN 4 stated Resident 29 and Resident 106 stopped and stood face to face about one foot away from each other in front of the nursing station #1. LVN 4 stated Resident 106 asked Resident 29 loudly why did you pour water me? LVN 4 stated Resident 29 stayed quiet and did not say anything. LVN 4 stated Resident 106 and Resident 29 got really close to each other, then, the staff separated the residents. LVN 4 stated he did not witness how Resident 29 pour water on Resident 106, but he saw Resident 106 ' s bed was wet, so the Certified Nursing Assistant (CNA) 3 changed the wet bed linens for Resident 106 and housekeeping came to clean the floor. LVN 4 stated he thought the altercation was reported and the DON was aware because the DON was in the facility at that time. During an interview on 10/2/24 at 4:30 PM, with CNA 3, CNA 3 stated she did not witness Resident 29 poured water on Resident 106, but after the incident, she was sent to change Resident 106 ' s bed. CNA 3 stated she saw Resident 106 ' s bed was wet, and she changed the bed linens for Resident 106. CNA 3 stated she only remembered the altercation occurred sometime last week but could not remember the exact date. During an interview on 10/4/24 at 11:20 AM, with the Director of Nursing (DON), the DON stated she did not know about the altercation between Resident 106 and Resident 29 occurred last week and no staff had reported it to her until the surveyor informed her. The DON stated she did not investigate since she did not know about it. The DON stated a resident-to-resident altercation between Resident 106 and Resident 29 should be investigated and intervene effectively to protect the residents in the facility. During an interview on 10/4/24 at 1:08 PM, with Registered Nurse (RN) 4, RN 4 stated Resident 29 was transferred to Resident 106 ' s room on 9/26/24. (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	10/04/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/4/24 at 5:00 PM, with the Administrator (ADM), the ADM stated he and the DON did not know about the altercation between Resident 106 and Resident 29 until today. The ADM stated he did not know that the staff who were aware of the altercation on 9/26/24 did not report or document it. The AMD stated a thorough investigation should be conducted to prevent reoccurrence of the altercation and protect the residents. During a review of Report of Suspected Dependent Adult/Elder Abuse (SOC 341, a form, as adopted by the California Department of Social Services CDSS, is required under Welfare and Institutions Code WIC. Use SOC 341 to report suspected dependent adult/elder abuse), dated 10/4/24, indicated the incident was reported to the Department on 10/4/24 at 2:02 PM via facsimile transmission. During a review of the facility ' s policy and procedure (P&P) titled, Abuse Reporting and Investigation, dated 11/2018, indicated When the Abuse Prevention Coordinator receives a report of an incident or suspected incident of resident abuse, mistreatment, neglect, exploitation or injuries of an unknown source, the APC will initiate an investigation immediately. The P&P indicated to inform resident of results of investigation or Corrective Action and provide a written report of the results of all abuse investigations and appropriate action taken to the California Department of Public Health Licensing and Certification and others that may be required by state or local laws, within five working days for the reported allegation

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	10/04/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779 Based on interview and record review, the facility failed to report immediately and within two hours an allegation or suspicion of physical abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish) to the Administrator (the facility ' s Abuse Coordinator), state agency, responsible party, police department and ombudsman (state personnel that advocates for the residents in the facility) for one of three sampled residents (Resident 106) in accordance with the facility ' s policy Abuse Reporting and Investigation. LVN 4 witnessed the confrontation between Resident 106 and Resident 29 in front of the nursing station #1 after Resident 106 allegedly poured water on Resident 29 while the resident was asleep, and did not report the incident to the Abuse Coordinator or designee within two hours. CNA 3 changed Resident 106's wet bed linens and wet floor in the resident's floor and heard about the altercation, but did not report the incident immediately to the Abuse Coordinator. The Social Services Director (SSD) reported the abuse incident to the enforcement agencies on 10/4/24 at 2:02 PM (eight days after the incident happened). This deficient practice had the potential to result in repeat altercation and abuse between the residents and also result in unidentified abuse in the facility that could result in injury and psychosocial decline (emotional being). Findings: During a review of Resident 106's Admission Record indicated the facility admitted Resident 106 on 9/13/2024 with diagnoses that include schizophrenia (a mental health condition that is marked by a mix of symptoms, such as hallucinations and delusions, mood disorder depression, and mania) and anxiety disorder (a mental illness that causes a person to experience excessive and uncontrollable feelings of fear or anxiety). During a review of a Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/17/2024, indicated Resident 106 had moderately impaired cognitive (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 106 required supervision or touching assistance with eating, and partial/moderate assistance with oral hygiene, toilet hygiene, shower/bathe self and personal hygiene, and chair/bed-to-chair transfer. During a review of Resident 106 ' s Progress Notes, dated 10/4/24, the Progress Notes indicated there was no documentation on the altercation-to-altercation between Resident 106 and Resident 29. (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	10/04/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 29's Admission Record indicated the facility originally admitted Resident on 2/13/24 and readmitted on [DATE] with diagnoses that include schizophrenia (a mental health condition that is marked by a mix of symptoms, such as hallucinations and delusions, mood disorder depression, and mania) and dementia (a chronic condition that causes a decline in cognitive abilities, such as thinking, remembering, and reasoning, that interferes with daily life). During a review of a Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/4/24, indicated Resident 29 had moderately impaired cognitive (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 29 required supervision or touching assistance with eating, and partial/moderate assistance with oral hygiene, toilet hygiene, shower/bathe self and personal hygiene, and chair/bed-to-chair transfer. During a review of Resident 29 ' s Progress Notes, dated from 9/1/24 to 10/2/24, the Progress Notes indicated there was no documentation on the altercation-to-altercation between Resident 106 and Resident 29. During a review of Report of Suspected Dependent Adult/Elder Abuse (SOC 341, a form, as adopted by the California Department of Social Services CDSS, is required under Welfare and Institutions Code WIC. Use SOC 341 to report suspected dependent adult/elder abuse), dated 10/4/24, indicated that the incident related to Residents 109 and 29 ' s altercation was reported to the Department on 10/4/24 at 2:02 PM via facsimile transmission. During an interview on 10/1/24 at 3:20 PM, with Resident 106, Resident 106 stated he remembered the altercation occurred the day Resident 29 was transferred to his room, and they became roommates. Resident 106 stated at around 7:30 PM while he was asleep on his bed, Resident 29 suddenly walked toward his bed and poured a cup of water on him. Resident 106 stated Resident 29 walked out the room right away, and he followed Resident 29 to the nursing station #1. Resident 106 stated he asked Resident 29 why he poured water on him, but Resident 29 did not answer and pretended he did not pour water on him. Resident 106 stated Resident 29 had issues and he always tried to look for trouble. Resident 106 stated Resident 29 poured the water on him on purpose. Resident 106 stated the staff separated them immediately after the incident occurred. Resident 106 stated he was upset at that time, and he had to keep an eye on Resident 29 all the time to make sure he did not try to do something to him again. During an interview on 10/2/24 at 4:25 PM, with Licensed Vocational Nurse (LVN) 4, LVN 4 stated he could not remember when, but he saw Resident 29 walked out the room with Resident 106 following behind him. LVN 4 stated Resident 29 and Resident 106 stopped and stood face to face about one foot away from each other in front of the Nursing Station #1. LVN 4 stated Resident 106 asked Resident 29 loudly why did you pour water me? LVN 4 stated Resident 29 stayed quiet and did not say anything. LVN 4 stated Resident 106 and Resident 29 got really close to each other, then, the staff separated the residents. LVN 4 stated he did not witness how Resident 29 pour water on Resident 106, but he saw Resident 106 ' s bed was wet, so the Certified Nursing Assistant (CNA) 3 changed the wet bed linens for Resident 106 and housekeeping came to clean the floor. LVN 4 stated he thought the altercation was reported and the DON was aware because the DON was in the facility at that time. (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	10/04/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/2/24 at 4:30 PM, with CNA 3, CNA 3 stated she did not witness Resident 29 poured water on Resident 106, but after the incident, she was sent to change Resident 106 ' s bed. CNA 3 stated she saw Resident 106 ' s bed was wet, and she changed the bed linens for Resident 106. CNA 3 stated she only remembered the altercation occurred sometime last week but could not remember the exact date. During an interview on 10/4/24 at 11:20 AM, with the Director of Nursing (DON), the DON stated she did not know about the altercation between Resident 106 and Resident 29 occurred last week and no staff had reported it to her until the surveyor informed her. The DON stated the facility did not report since she did not know about it. The DON stated a resident-to-resident altercation between Resident 106 and Resident 29 should be reported immediately within two hours after the incident occurred. During an interview on 10/4/24 at 1:08 PM, with Registered Nurse (RN) 4, RN 4 stated Resident 29 was transferred to Resident 106 ' s room on 9/26/24. During an interview on 10/4/24 at 5PM, with the Administrator (ADM), the ADM stated he and the DON did not know about the altercation between Resident 106 and Resident 29 until today. The ADM stated he did not know that the staff who were aware of the altercation on 9/26/24 did not report or document it. The AMD stated the staff should reported to the DON or himself immediately, so they did not delay the reporting process. During a review of the facility ' s policy and procedure (P&P) titled, Abuse Reporting and Investigation, dated 11/2018, indicated The facility will report ALL allegations of abuse as required by law and regulations to the appropriate agencies within 2 hours .Allegations of abuse, neglect, mistreatment, or exploitation are to be reported to the Abuse Prevention Coordinator immediately.

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	10/04/2024

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on interview and record review, the facility failed to ensure the quarterly Minimum Data Sets (MDS - a federally mandated resident assessment tool) were completed within the required time frame for four out of four sampled residents (Residents 2, 30, 60, and 77). This deficient practice had the potential to negatively affect the provision of necessary care and services for Residents 2, 30, 60, and 77. Findings: During a review of Resident 2's Admission Record, indicated the facility initially admitted Resident 2 on 8/4/2020 and readmitted on [DATE]. During a review of Resident 30's Admission Record, indicated the facility admitted Resident 30 on 2/21/2024. During a review of Resident 60's Admission Record, indicated the facility admitted Resident 60 on 11/10/2022. During a review of Resident 77's Admission Record, indicated the facility initially admitted Resident 77 on 2/13/2023 and readmitted on [DATE]. During an interview on 10/2/2024 at 3:52 PM with the MDS Nurse, the MDS Nurse stated, all residents were required to have MDS assessment quarterly after their admitted . The MDS Nurse stated, the system had a list of residents with their Assessment Reference Date (ARD-referring to resident assessments), and she had 14 days to complete the assessment after the ARD. During a concurrent record review and interview on 10/2/2024 at 3:57 PM with the MDS Nurse, Resident 2's quarterly MDS was reviewed. The MDS Nurse stated, based on the record, Resident 2's most recent quarterly MDS assessment ' s ARD was 8/16/2024 and her deadline to complete the assessment was 8/30/2024. The MDS Nurse stated, she completed Resident 2's assessment on 10/1/2024, which was 33 calendar days late. During a concurrent record review and interview on 10/2/2024 at 4:05 PM with the MDS Nurse, Resident 30's quarterly MDS was reviewed. The MDS Nurse stated, based on the record, Resident 30's most recent quarterly MDS assessment ' s ARD was 8/20/2024 and her deadline to complete the assessment was 9/3/2024. The MDS Nurse stated, she completed Resident 30's assessment on 10/2/2024, which was 29 calendar days late. During a concurrent record review and interview on 10/2/2024 at 4:10 PM with the MDS Nurse, Resident 60's quarterly MDS was reviewed. The MDS Nurse stated, based on the record, Resident 60's most recent quarterly MDS assessment ' s ARD was 8/22/2024 and her deadline to complete the assessment was 9/5/2024. The MDS Nurse stated, she completed Resident 60 ' s assessment on 10/2/2024, which was 27 calendar days late. (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	10/04/2024

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review and interview on 10/2/2024 at 4:20 PM with the MDS Nurse, Resident 77's quarterly MDS was reviewed. The MDS Nurse stated, based on the record, Resident 77's most recent quarterly MDS assessment's ARD was 8/15/2024 and her deadline to complete the assessment was 8/29/2024. The MDS Nurse stated, she completed Resident 77's assessment on 9/27/2024, which was 29 calendar days late. During an interview on 10/2/2024 at 4:30 PM with the MDS Nurse, the MDS Nurse stated, she had been late for the residents assessment because there was a pilling of a number of residents assessment, and she did not have enough time to complete them all. During an interview on 10/4/2024 at 1:12 PM with the Director of Nurses (DON), the DON stated, she was aware that residents assessment had been completed late. The DON stated, there was an MDS consultant that oversaw the MDS Nurses. The DON stated, if the residents assessment were late, there might be something wrong with the resident that we would not be able to assess and update the care plan timely. The DON stated, she would coordinate with the MDS consultant to make sure the residents are assessed and submitted timely. During a review of the facility's policy and procedure (P&P) titled, MDS Completion and Submission Timeframes, revised July 2017, the P&P indicated, the facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes, timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument (RAI) Manual. During a review of the facility's P&P titled, RAI OBRA-required (Omnibus Budget Reconciliation Act, federal law passed in 1987 that established standards for nursing home care and the rights of nursing home residents) Assessment Summary, dated October 2024, indicated for the non-comprehensive quarterly MDS assessment, the MDS completion date must be no later than 14 calendar days following the ARD.

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	10/04/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a document that outlines the facility's plan to provide personalized care to a resident based on the resident's needs) for four of five sampled residents (Resident 58, 3, 70 and 63) by failing to: 1. Develop a care plan for dementia Resident 58 with dementia (a progressive state of decline in mental abilities) 2. Develop a plan of care for Resident 3 and Resident 70 while receiving psychoactive medications (medications that affects mood and behavior). 3. Develop a plan of care for Resident 63 who refused to have the nasal canula (a device used to deliver supplemental oxygen placed directly on a resident's nostrils) placed in a bag when not in use. These deficient practices had the potential for the residents not to recieve the necesary care and services to achieve their highest potential and/or in adverse side effects (undesired effect) from the use of psychoactive medications. Findings: 1. During a review of Resident 58's Admission Record indicated the facility initially admitted Resident 58 on 4/27/2021 and readmitted on [DATE] with diagnoses that included dementia, schizophrenia (a mental illness that is characterized by disturbances in thought), and anxiety disorder(a group of mental disorders characterized by significant feelings of fear that affect with daily activities). During a review of Resident 58 ' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/9/2024, indicated Resident 58 ' s cognition (a term for the mental processes that take place in the brain, including thinking, attention, language, learning, memory and perception) was severely impaired. During a review of Resident 58 ' s History and Physical, dated 1/13/2024, indicated Resident 58 did not have the capacity to understand and make decisions. During a concurrent interview and record review on 10/4/2024 at 9:41 AM with Licensed Vocational Nurse (LVN) 1, Resident 58 ' s care plan was reviewed. LVN 1 stated, there was no care plan initiated for Resident 58 ' s dementia. LVN 1 stated, Resident 58 ' s diagnosis included dementia upon admission and there should have been a care plan for Resident 58 ' s dementia diagnosis. LVN 1 stated care plans were necessary for resident care, and not having a care plan for a resident ' s specific needs was a risk to resident ' s health and care, since staff would not know what interventions to implement or what to monitor. LVN1 stated the care plan was needed to ensure interventions were effective or not, and by implementing a care plan licensed nurses could monitor residents more effectively. (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	10/04/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/4/2024 at 12:57 PM with the Director of Nurses (DON), the DON stated, it was important to have a care plan addressing each of the diagnosis for Resident 58 including dementia so staffs would know how to take care of the resident and to discuss in the Interdisciplinary Team meeting (IDT, a coordinated group of experts from several different fields). The DON stated, Resident 58 would not have the right interventions for the specific behavior, and facility staff could not provide the care and services needed for Resident 58 ' s specific needs. During a review of the facility ' s policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated March 2022, the P&P indicated, a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional needs is developed and implemented for each resident. 46779 2. During a review of Resident 3's Admission Record indicated the facility admitted Resident 3 on 6/3/24 with diagnoses that include schizoaffective disorder (a mental health condition that is marked by a mix of symptoms, such as hallucinations [a perception of something that seems real but is not, and can involve any of the senses] and delusions [a false belief or judgement about external reality], mood disorder [a mental health condition that primarily affects the emotional state] and mania [a condition in which you have a period of abnormally elevated, extreme changes in your mood or emotions, energy level or activity level]) and dementia (a group of thinking and social symptoms that interferes with daily functioning). During a review of a Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/3/24, indicated Resident 3 had moderately impaired cognition (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 3 required partial/moderate assistance with eating and chair/bed-to-chair transfer, and required substantial/maximal assistance with oral hygiene, toilet hygiene, shower/bathe self and personal hygiene. During a review of Resident 3's Order Summary Report (OSR), dated 9/30/24, the OSR indicated physician ordered the resident to receive Olanzapine (a medication that can treat several mental health conditions) 10 milligram (MG, a unit of measurement) one tablet by mouth at bedtime for psychosis (a condition that causes a person to lose touch with reality, making it difficult to distinguish what is real and what is not) manifested by delusional (holding a false belief or judgement about external reality). During a review of Resident 3's Medication Administration Record (MAR), dated from 6/2024 to 10/2024, the MAR indicated Resident 3 received Olanzapine 10 MG one tablet by mouth at bedtime from 6/3/24 to 10/3/24. During a concurrent interview and record review on 10/3/24 at 2:10 PM, with Licensed Vocational Nurse (LVN) 5, Resident 3's Care Plan (CP) was reviewed. LVN 4 stated Resident 3 was receiving psychotropic medication-Olanzapine. LVN 5 stated Resident 3 did not have a care plan to address interventions in the use of a psychotropic medication, there should have been a care plan developed to provide guidance to the staff how to care for the resident safely. (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	10/04/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/3/24 at 2:15 PM, with Registered Nurse (RN) 3, Resident 3's CP was reviewed. RN 3 stated there was no CP to address the use of a psychotropic medication for Resident 3. RN 3 stated it was important to develop and implement the CP for Resident 3 regarding the use of olanzapine because the CP could guide staff what to monitor the side effects of olanzapine and how to intervene effectively to ensure Resident 3 ' s safety. 3. During a review of Resident 70's Admission Record indicated the facility originally admitted Resident 70 on 6/1/23 and readmitted on [DATE] with diagnoses that include dementia and psychotic disorder (severe mental illnesses that cause abnormal thinking and perceptions, and a loss of touch with reality). During a review of Resident 70 ' s MDS, dated [DATE], indicated Resident 70 had intact cognitive (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 70 required setup or clean-up assistance with eating and oral hygiene, partial/moderate assistance with personal hygiene, substantial/maximal assistance with chair/bed-to-chair transfer, and was dependent with toileting hygiene. During a review of Resident 70's OSR, dated 10/3/24, the OSR indicated the physician ordered for Resident 70 to receive medications list below, started on 6/27/24: a. Divalproex sodium (a medication is used to stabilize mood) 500 MG one tablet by mouth every 12 hours for mood stabilizer b. Olanzapine 10 MG one tablet by mouth two times a day for striking out at staff and/or roommate c. Paliperidone Palmitate (a medication is used to treat the symptoms of mental disorders) 235 MG/1.5 milliliter (ML, a unit of measurement) inject 0.5 ML intramuscularly one time a day starting on the 23rd and ending on the 23rd every month for rapid mood cycling sudden shifts in mood from pleasant to extreme anger as evidence by screaming and yelling d. Risperidone (a medication is used to treat the symptoms of mental disorders) one MG one tablet by mouth one time a day for striking out at staff and/or roommate e. Sertraline (a medication is used to treat the symptoms of a mental disorder) 100 MG one capsule by mouth one time a day for irritability manifested as verbal aggression During a review of Resident 70 ' s MAR, dated from 6/2024 to 10/2024, the MAR indicated Resident 70 received Divalproex sodium 500 MG one tablet by mouth every 12 hours, Olanzapine 10 MG one tablet by mouth two times a day, Risperidone one MG one tablet by mouth one time a day, and Sertraline 100 MG one capsule by mouth one time a day from 6/28/24 to 10/2/24. The MAR indicated Resident 70 received Paliperidone Palmitate 235 MG/1.5 ML inject 0.5 ML intramuscularly one time a day on 7/23/24 and 8/23/24. (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	10/04/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/3/24 at 2:12 PM, with Licensed Vocational Nurse (LVN) 5, Resident 70 ' s Care Plan (CP) was reviewed. LVN 4 stated Resident 70 s was receiving multiple psychotropic medications and the CP to address the intervention while receiving these psychotropic medications should be developed to provide guidance to the staff how to care for the resident safely. The LVN 5 stated the CP of the use of multiple psychotropic medications was not completely developed for Resident 70. During a concurrent interview and record review on 10/3/24 at 2:17 PM, with Registered Nurse (RN) 3, Resident 70 ' s CP was reviewed. RN 3 stated the CP to address interventions to monitor the resident while receiving Divalproex, Risperdal and Olanzapine including their adverse effects and side effects, were not initiated on 6/27/24, but there was no intervention documented on the CP. RN 3 also stated there was no CP to address interventions to monitor the resident while receiving the use of Divalproex, Sertraline, and Paliperidone Palmitate for Resident 70. RN 3 stated it was important to develop and implement the complete CP for Resident 70 regarding the use of multiple psychotropic medications because the CP could guide staff what to monitor the side effects of her psychotropic medications and how to intervene effectively if the side effects occurred to ensure Resident 70 ' s safety. During an interview on 10/4/24 at 11:16 AM, with the Director of Nursing (DON), the DON stated if a resident was on a psychotropic medication, the nurse should develop and implement the complete care plan regarding the use of the psychotropic medication to ensure safe care to the resident. During a review of the facility ' s policy and procedure (P&P) titled, Behavior/Psychotropic Drug Management, dated 6/2019, the P&P indicated The Care Plan shall reflect .use of psychoactive medication(s), adverse reactions to psychoactive medication(s) .experienced by the resident and interventions taken. 50012 4. During a review of Resident 63 ' s Admission Record (Face Sheet), dated 2/18/2022, the face sheet indicated the facility admitted Resident 63 on 2/18/2022, and readmitted on [DATE] with diagnoses including Chronic Obstructive Pulmonary disease (COPD - lung disease which makes breathing difficult), and bronchiectasis (a condition where your airways widen or develop pouches). During a review of Resident 63 ' s History and Physical dated 3/3/2024, indicated, Resident 63 had the mental capacity to make medical decisions. During a review of Resident 63 ' s Order Summary Report, dated 10/2/2024, the Order Summary Report indicated an order on 3/3/2024, the order indicated may use oxygen at two (2) liters per minute (L/min) via nasal cannula (device use for delivery of oxygen) to maintain oxygen saturation (amount of oxygen carried in blood) at 92% (normal range 90-100%). During a review of Resident 63's MDS, dated [DATE], indicated the cognitive (the ability to think and process information) skills for daily decisions making was intact, and independent for activities of daily living. During a concurrent observation and interview on 10/1/2024 11:33 a.m., CNA 4 stated Resident 63 refuses to put the nasal cannula in a bag. (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	10/04/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 63's Care Plans did not indicate the resident refused to have nasal canula placed in a bag when not in use. During a concurrent observation and interview on 10/4/2024 at 11:34PM with Resident 63 in resident's room. Resident 63 stated, he likes the tubbing just like it is. He does not like it in a bag. During an interview on 10/4/2024 at 3:20 PM with the Director of Nursing (DON), stated the resident's behavior of not wanting the nasal canula in a bag should have been addressed and care planned accordingly. During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated the comprehensive, person-centered care plan is developed for each resident within seven days of completion of required MDS assessment, and no more than 21 days after admission. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 4/2022, P&P indicated, a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed for each resident.

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	10/04/2024

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview, and record review, the facility failed to ensure assistance was provided ADLS (Activities of Daily Living- (routine tasks, activities such as eating, that a person performs daily to care for themselves) during mealtimes for one of twenty-three sampled residents (Resident 23). This failure resulted in Resident 23's feeling upset, not able to eat her chicken during lunch on 10/1/2024, and a potential risk for malnutrition and weight loss. In addition, could result in a decline in the resident ' s ability to perform ADLS. Findings: During a review of Resident 23's Admission Record indicated the facility initially admitted Resident 23 on 4/1/2015 and readmitted on [DATE] with diagnoses that included hemiplegia (a condition that causes partial or complete paralysis or weakness on one side of the body and hemiparesis (weakness or an inability to move on one side of the body) following cerebral infraction (stroke, a serious condition that occurs when blood flow to the brain is disrupted, causing brain tissue to die) affecting right dominant side, muscle weakness, cognitive communication deficit, aphasia (loss of the ability to understand or express spoken or written language), and dysphagia (difficulty swallowing). During a review of Resident 23 ' s Speech Therapy SLP (Speech-Language Pathologist, a communication expert that assess and treat people who have speech, language, voice, and fluency disorders) Discharge Summary, dated 9/29/2023, indicated the treatment included utilization of safe swallow strategies such as small bites/sips. During a review of Resident 23 ' s History and Physical, dated 8/12/2024, indicated Resident 23 had fluctuating capacity to understand and make decisions. During a review of Resident 58 ' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/3/2024, indicated Resident 23 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with eating (ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident) and oral hygiene. During a review of Resident 23 ' s care plan (a document that outlines the facility ' s plan to provide personalized care to a resident based on the resident ' s needs), dated 9/6/2024, indicated Resident 23 was at risk for weight loss, decline in functional status, and aspiration/choking during meals. The goals were to reduce/minimize risk of aspiration/choking during meals, and to receive adequate nutrition/hydration daily. The interventions included diet for mechanical soft diet with thin liquid, provide assist during meals as needed, and monitor tolerance with texture of food. During a review of Resident 23's Nutritional Screening, dated 9/5/2024, indicated Resident 23 ' s diet order was Regular, mechanical soft texture, and supervision was needed during eating. (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	10/04/2024

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 23's Order Summary Report, indicated Resident 23 had a physician order on 7/16/2023 for Regular diet with mechanical soft texture, regular/thin consistency. During a concurrent dining observation and interview on 10/1/2024 at 12:15 PM with Resident 23 in her room, Resident 23 was observed in bed eating alone with no assistance. Resident 23 was observed using a spoon to cut up a piece of chicken that was close to 2x3 inches (unit of length) in size. A knife and a fork were observed on the right side of the lunch tray, and Resident 23 was observed unable to reach her left hand to the fork. When surveyor asked if she could reach to her fork, Resident 23 shook her head and pointed to her right arm expressing that her right arm could not move. During an observation on 10/1/2024 at 12:35 PM in Resident 23's room, no staff was observed coming to check on Resident 23. Resident 23 was observed getting upset not able to use the spoon to cut and eat the chicken. Resident 23 nodded her head when the surveyor asked if Resident 23 needed assistance from the nurses during meals. Surveyor walked to the nurses ' station to request for assistance for Resident 23. During a concurrent observation and interview on 10/1/2024 at 12:45 PM with Certified Assistant Nurse (CNA) 4 in Resident 23 ' s room, Resident 23's lunch tray was observed. CNA 4 stated, the chicken looked too big for the resident to eat. CNA 4 stated, the resident should be assisted to cut the chicken into bite size or grounded (meat that has been finely chopped using a meat grinder or chopping knife) to make it easy for Resident 23 to scoop the food and put in her mouth. CNA 4 stated, Resident 23 had right side weakness and used only her left hand to eat during meals time. CNA 4 stated, Resident 23 should have been assisted during meals time. During an interview on 10/3/2024 at 6:15 PM with the Director of Nurses (DON), the DON stated, Resident 23 should have been assisted during mealtimes due to her right-side weakness. The DON stated, Resident 23 could be upset not able to eat her food and would be potential at risk for malnutrition and weight loss. During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADL), Supporting, dated March 2018, indicated appropriate care and services will be provided for residents who are unable to carry out ADLs independently, including appropriate support and assistance with dining (meals and snacks).

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	10/04/2024

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** 50012 Based on interview and record review, the facility failed to ensure residents provide necessary care and services for skin breakdown and pressure injuries (localized damage to the skin and underlying soft tissue, usually occurring over a bony prominence or related to medical devices) to prevent skin breakdown for one of three sampled residents (Resident 4) by failing to ensure Resident 4 who uses a low air loss mattress (LAL Mattress -air filled mattress used to relieve pressure) was set according to resident's weight. As a result of this deficient practice placed Resident 4 at additional risk for developing pressure injuries. Findings: During a review of Resident 4's Admission Record (Face Sheet), dated 9/12/2023, the face sheet indicated the facility admitted Resident 4 on 9/12/2023, and readmitted on [DATE] with diagnoses including Chronic Obstructive Pulmonary disease (COPD - lung disease which makes breathing difficult), muscle weakness and generalized osteoarthritis (degenerative joint disease, in which the tissues in the joint break down over time). During a review of Resident 4's Minimum Data Set (MDS-a federally mandated resident assessment tool.), dated 6/4/2024, indicated has severe cognitive impairment (the ability to think and process information). The MDS indicated the resident is totally dependent on staff for dressing, toilet use, personal hygiene, and bathing. During a review of Resident 4's History and Physical (H&P), dated 6/24/2024, indicated, Resident 4 had the mental capacity to make medical decisions. During a review of Resident 4's Order Summary Report, dated 8/2/2024 indicated to provide a low air loss mattress (LAL Mattress) to Resident 4 for wound management set mode for alternating and settings base on comfort and/or comfort and/or weight of the resident check setting and functionality every shift. During a review of Resident 4's Weight Summary, dated 9/6/2024, indicated Resident 4' s weight 204 pounds (lbs.-unit of measurement). During an observation on 10/2/2024 at 12:24 PM, Resident 4 was observed with a LAL Mattress was set for a person weighing 550 lbs. (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	10/04/2024

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	During a concurrent interview and record review on 10/2/2024 AM 2:20 PM with Treatment Nurse (TN) 1, Resident 4's Weight Summary, dated 9/6/2024 was reviewed. The Weight Summary indicated Resident 4 weight was 204 lbs. TN1 stated the LAL Mattress getting goes by weight and Resident 4's LAL Mattress was not set correctly. TN 1 stated the LAL Mattress setting for Resident 4 should be at 250 since Resident 4's weigh is 204 lbs. TN 1 stated incorrect settings of LAL mattress places the resident at higher risk for further skin breakdown. TN 1 stated that setting the LAL Mattress was set at a weight higher than Resident 4's actual weight makes the mattress too hard which prevents the wounds from healing, therefore there was a potential to cause harm, when setting of LAL Mattress were incorrectly set. A review of manufacturer's recommendation of Low Air Loss Mattress Owner's Manual, (undated), indicated, The Med Aire Edge Mattress Replacement System is a high-quality powered air support surface that is specifically designed for the prevention and treatment of pressure injuries while optimizing patient comfort. The owner ' s manual also indicated This digital control unit includes intuitive controls for adjusting the air pressure based on the patient ' s weight and comfort levels. Weight settings range from =250-1,000 lbs and can be used to adjust the pressure of the inflated cells based on the patient ' s weight and comfort level.

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	10/04/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview, and record review, the facility failed to provide appropriate device and appropriate rehabilitation services (assessment and evaluation of the residents to determine exercises or devices needed to improve or maintain mobility) to maintain or improve mobility for one of two sampled residents (Resident 58). with limited mobility and contractures (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) on both arms was observed with towel between the arms. This failure practice had a potential to result in Resident 58's worsened elbow contractures that could lead to pain, discomfort and high risk for fractures (broken bones). Findings: During a review of Resident 58's Admission Record indicated the facility initially admitted Resident 58 on 4/27/2021 and readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), schizophrenia (a mental illness that is characterized by disturbances in thought), and anxiety disorder (a group of mental disorders characterized by significant feelings of fear that affect with daily activities). During a review of Resident 58 ' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/9/2024, indicated Resident 58 ' s cognition (a term for the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) was severely impaired, and was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) in roll left and right, sit to lying, lying to sitting on side of bed, sit to stand. During a review of Resident 58 ' s History and Physical, dated 1/13/2024, indicated Resident 58 was bed bound (confined to bed due to illness/weakness), his arms were contracted, and he did not have the capacity to understand and make decisions. During a review of Resident 58 ' s care plan (a document that outlines the facility ' s plan to provide personalized care to a resident based on the resident ' s needs), dated 4/11/2024, indicated Resident 58 had limitation noted to shoulders, elbows and fingers, with the goal of minimizing the risk of further loss of ROM daily, and the interventions included to position resident to prevent further contractures with pillow or splints as needed. During an observation on 10/1/2024 at 12:05 PM in Resident 58 ' s room, Resident 58 was lying in bed, left and right arms were bent at the elbow with stiffness and contracted. Four rolled towels were observed in the elbow between the bent contracted arms. (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	10/04/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 10/3/2024 at 2:23 PM with Certified Nurse Assistant (CNA) 8 in Resident 58 ' s room, CNA 8 was placing one rolled towel in each of Resident 58 ' s contracted arm. CNA 8 stated, Resident 58 ' s arms had been severely contracted since admission to the facility and she usually place rolled towels between his upper and lower arms to help his arms to relax, prevent further contractures and pain if any. During an interview on 10/3/2024 at 2:28 PM with Physical Therapist (PT) 1, PT 1 stated. The facility usually utilizes a splint to prevent the resident ' s further contractures. PT 1 stated, she would not recommend using a rolled towel to help prevent further contractures because it could fall off and will not be effective. During a concurrent interview and observation on 10/3/2024 at 2:48 PM with Rehabilitation Director (RHD), RHD was able to flex Resident 58's arms to 45 degrees (unit of angle). RHD stated, the facility always utilizes a splint for residents with contracted arms who could flex more than 30 degree and based on her assessment, Resident 58 should already have a splint to prevent further contractures. RHD stated, rolled towels are not a standard of practice to use in preventing resident ' s worsen contractures because it ' s not therapeutic. RHD stated, he was not referred to Rehabilitation since 8/13/2021 for both arms with contractures to determine the device to use to prevent further decline. RHD stated, she would readmit Resident 58 to Rehabilitation for reassessment and evaluation. During an interview on 10/4/2024 at 1:07 PM with the Director of Nurses (DON), the DON stated, the towels should not be used to prevent worsen arms and elbow contractures because they are too soft and not able to prevent any contracture. The DON stated, the resident should have been reevaluated. The DON stated, not using a proper device such as a splint, the resident is at risk for further arms and elbow contracture. During a review of the facility ' s policy and procedure (P&P) titled, Resident Mobility and Range of Motion, dated July 2017, indicated: Residents with limited ROM will receive treatment and services to increase and/or prevent a further decrease in ROM. Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable.

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	10/04/2024

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** 46779 Based on observation, interview and record review, the facility failed to provide a safe and hazard free environment to two of three sampled residents (Resident 87 and 63) by failing to ensure: 1. Resident 87's bed alarm (a device used to monitor a patient's movements in bed) was monitored and in functioning condition. This deficient practice placed Resident 87 at risk for falls or accidents when Resident 87 was getting out of bed without supervision. 2. Resident 63 who was a smoker and receives oxygen therapy via nasal cannula tubing (a device used to deliver supplemental oxygen placed directly on a resident's nostrils) retained bag of tobacco at the bedside. As a result of this deficient practice, the potential for an accidental fire in the facility and can lead to injury to the residents and other people in the facility. Findings: During a review of Resident 87's Admission Record indicated the facility originally admitted Resident 87 on 9/15/23 and readmitted on [DATE] with diagnoses that include dementia (a group of thinking and social symptoms that interferes with daily functioning) and muscle weakness. During a review of a Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/16/24, indicated Resident 87 had severely impaired cognitive (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 87 required partial/moderate assistance with eating, oral hygiene, toilet hygiene, shower/bathe self, personal hygiene, chair/bed-to-chair transfer and sit to stand. During a review of Resident 87's Order Summary Report (OSR), dated 9/30/24, the OSR indicated a physician order to apply bed alarm: monitor placement every shift for fall prevention to alert staff to respond quickly and assist residents. During an observation on 10/1/24 at 9:29 AM, Resident 87 was lying on her bed awake, but she did not have eye contact and did not respond to the surveyor. A bed alarm monitor was observed hanging on the right bed siderail (barriers attached to the side of a bed to prevent falls and provide support) of Resident 87 ' s bed. Resident 87 ' s bed pad sensor (connects wirelessly with a handheld monitor and the alarm will sound when weight is removed from the pad) was observed not connected to the bed alarm monitor, and the light on the bed alarm monitor was off. (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	10/04/2024

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	During a concurrent observation and interview on 10/1/24 at 9:38 AM, with Certified Nursing Assistant (CNA) 6, Resident 87 ' s bed alarm monitor was observed. CNA 6 stated the bed alarm was not in a working condition because the bed pad sensor connector was unplugged from the bed alarm monitor and there was no green light flash on the bed alarm monitor to indicate the bed alarm was functioning. CNA 6 stated Resident 87 was confused and attempted to get out of bed without assistance. CNA 6 stated if the bed alarm was not working properly, Resident 87 was at risk for falls. During an interview on 10/1/24 at 9:47 AM, with CNA 7, CNA 7 stated checking on Resident 87 around 7:10 AM and 7:20 AM this morning. CNA 7 stated she did not pay attention to Resident 87 ' s bed alarm because she was too busy to care for other residents. CNA 7 stated she did not know for how long Resident 87 ' s bed alarm was not on and functioning. CNA 7 stated she should check the bed alarm to ensure it was working properly to prevent fall and injury to the resident. During an interview on 10/2/24 at 3:10 PM, with the Director of Nursing (DON), the DON stated facility staff should check residents ' bed alarms to make sure they were in working condition so that when the residents were attempting to get out of the bed, the staff could respond quickly to prevent fall and accident to the residents. During a review of the facility ' s policy and procedure (P&P) titled, Protekt Ultimate Alarm, dated 2024, the P&P indicated Top mounted flashing lights helps to verify that the monitor is armed (slow green flash) . During a review of the facility ' s policy and procedure (P&P) titled, Fall Risk Assessment, dated 3/2018, the P&P indicated to identify and address fall risk factors and interventions to minimize the consequences of fall risk factors. 50012 2. During a review of Resident 63's Admission Record (Face Sheet), dated 2/18/2022, the face sheet indicated the facility admitted Resident 63 on 2/18/2022, and readmitted on [DATE] with diagnoses including Chronic Obstructive Pulmonary disease (COPD - lung disease which makes breathing difficult), and bronchiectasis (a condition where your airways widen or develop pouches). During a review of Resident 63's History and Physical (H&P), dated 3/3/2024, indicated, Resident 63 had the mental capacity to make medical decisions. During a review of Resident 63's Smoker's Risk Assessment, dated 7/21/2024, indicated Resident 63 was an independent smoker (no supervision needed). During a review of Resident 63's Order Summary Report, dated 10/2/2024, the Order Summary Report indicated a physician order on 3/3/2024, ordered Resident 63 to receive oxygen at two (2) liters per minute (L/min) via nasal cannula (device use for delivery of oxygen) to maintain oxygen saturation (amount of oxygen carried in blood) at 92% (normal range 90-100%). During a review of Resident 63's Minimum Data Set (MDS-a federally mandated resident assessment tool.), dated 8/15/2024, indicated the cognitive (the ability to think and process information) skills for daily decisions making was intact, and independent for activities of daily living. (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	10/04/2024

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	During a concurrent observation and interview on 10/2/2024 at 11:30 a.m., Resident 63 was observed sitting at the edge of his bed in his room. Oxygen machine was observed in resident ' s room. A white grocery bag with a bag of tobacco a pipe at the resident ' s bedside. Resident 63 stated he makes his own cigarettes. Resident 63 stated the bag with tobacco pipe was bought by his family. During an interview on 10/2/2024 at 9:05 a.m. with the Social Worker Designee (SSD) stated the resident was not allowed to have tobacco in his room. The SSD stated Resident 63 was non-compliant and had one bag of tobacco confiscated (taken away) previously. SSD stated she does not know how the Resident 63 was obtained to obtain the bag of tobacco. During a concurrent observation and interview on 10/3/2024 at 9:30 a.m., with the Registered Nurse Supervisor 4 (RN 4), the RN4 confirmed that the resident had the bag of tobacco in his room, and he should not have tobacco inn his room because he has oxygen in his room. The RN 4 stated the bag will be confiscated. During an interview on 10/4/2024 at 3:15 p.m. with the Director of Nursing (DON), DON stated it was not safe for Resident 63 to have tobacco in his room, We do not allow anyone to have cigarettes in the room. We inform the family as well that residents are not allowed to have cigarettes in their possession because the cigarettes need to be given to the activities staff. DON stated it is against the facility's policy for the resident to keep smoking materials in the room. The DON stated residents should not keep lighters or smoking materials with them or at the bedside due to safety reasons. During a review of the facility ' s policy and procedure (P&P) titled, Smoking by Resident, released 9/2018, P&P indicated, Use of Oxygen of Oxygen in prohibited in Smoking areas. Residents who smoke and are on oxygen may not be allowed to retain smoking materials in the room and/or in their possession and smoking shall be prohibited in any room or other locations in the facility where combustible gases or oxygen is used or stored in other hazardous locations.

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	10/04/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779 Based on observation, interview, and record review, the facility failed to ensure residents who needs respiratory care were provided such care, consistent with professional standards of practice, care plan goals, and facility's policy and procedure for four of four sampled residents (Resident 258, 63, 26 and 55) by failing to ensure: 1. Resident 258, 63 who uses and was receiving oxygen in the room had an oxygen in use warning sign was posted on the resident's doorway. 2. Resident 258 does not receive oxygen therapy since 9/16/2024 without a physician ' s order. 3. Resident 26 and Resident 55 nebulizers (a small machine that turns liquid medicine into a mist that can be easily inhaled) were stored in a sanitary manner and changed according to facility's policy and procedure. These deficient practices had the potential to cause a fire at the resident(s) in the facility that resulting in injuries and death. In addition, for Resident 258 could receive excessive oxygen that could result in oxygen toxicity (develop toxins in the body and result in lung damage due breathing in too much oxygen), and for Residents 26 and 55 had the potential for the transmission of bacteria and the risk for respiratory infection (any infectious disease of the parts of the body involved in breathing). Findings: 1. During a review of Resident 26's Admission Record indicated the facility initially admitted Resident 26 on 1/31/23 and readmitted on [DATE] with diagnoses that include respiratory failure (a serious condition that makes it difficult to breathe on your own) and dementia (a group of thinking and social symptoms that interferes with daily functioning). During a review of a Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/10/24, indicated Resident 26 had severely impaired cognitive (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 26 required supervision or touching assistance with eating, and required partial/moderate assistance with oral hygiene, toilet hygiene, shower/bathe self, chair/bed-to-chair transfer. During a review of Resident 26 ' s Order Summary Report (OSR), dated 9/30/24, the OSR indicated the physician ordered to administer albuterol sulfate (a medication is used to prevent and treat wheezing, difficulty breathing, chest tightness, and coughing) inhalation nebulizer solution (2.5 milligram [MG, unit of measurement]/3 milliliter (ML, unit of measurement]) 0.083 % [percent]) six ML inhale orally via nebulizer every four hours for shortness of breath and wheezing while awake, started on 9/6/24. During a review of Resident 26 ' s Medication Administration Record (MAR), dated 9/1/24 to 9/30/24 and 10/1/24 to 10/31/24, the MAR indicated Resident 26 received Albuterol sulfate inhalation nebulizer solution inhale orally via nebulizer every four hours from 9/7/24 to 10/2/24. (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	10/04/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/1/24 at 10:52 AM, Resident 26 was sitting at the edge of her bed. Resident 26 had a nebulizer mask covering her nose and mouth with a blue head strap over her head, securing the nebulizer mask in place. Resident 26 was observed receiving breathing treatment via nebulizer mask. During a concurrent observation and interview on 10/1/24 at 11:41 AM, in Resident 26 ' s room, Resident 26 ' s nebulizer mask was observed inside the top drawer of the nightstand on the right side of the Resident 26 ' s bed, not stored in a bag. A stained paper drawer liner was covering the bottom of the top drawer. Inside Resident 26 ' s drawer there were five disposable plastic cups lying on top of the stain of the paper drawer liner. One white dirty bottle cap, a hairbrush, one unopen paper straw, an undated mask, and a roll of plastic bags were observed inside the top drawer. The nebulizer mask had direct contact with the hairbrush, the straw and the paper liner. During a concurrent observation and interview on 10/1/24 at 11:50 AM, with Licensed Vocational Nurse (LVN) 5, Resident 26 ' s nebulizer, kept in Resident 26 ' s nightstand was observed. LVN 5 stated Resident 26 ' s nebulizer mask should be kept inside a plastic bag with the date and the resident ' s name on the bag. LVN 5 stated not knowing how long Resident 26 ' s mask was stored, uncovered. LVN5 stated since Resident 26 ' s nebulizer mask was not stored in a bag while not in use, there was a risk for respiratory infection, due to inappropriate storage of the nebulizer mask. During an interview on 10/2/24 at 3:09 PM, with the Director of Nursing (DON), the DON stated the nebulizer mask should be stored in a plastic bag, labeled with the resident ' s name and dated to ensure the nebulizer mask was clean, and to prevent infection. During a review of the facility's policy and procedure (P&P) titled, Administering Medications through a Small Volume (Handheld) Nebulizer, dated 10/2010, the P&P indicated to store equipment, including mask, in a plastic bag with the resident ' s name and the date on it. 2. During a review of Resident 55's Admission Record indicated the facility initially admitted Resident 55 on 1/28/21 and readmitted on [DATE] with diagnoses that include acute respiratory failure (a condition where there's not enough oxygen in your body) and diabetes mellitus (a group of diseases that result in too much sugar in the blood). During a review of Resident 55's MDS, dated [DATE], indicated Resident 1 had severely impaired cognitive (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 55 was dependent with eating, oral hygiene, toilet hygiene, shower/bath self, personal hygiene, and chair/bed-to-chair transfer. During a review of Resident 55's OSR, dated 9/30/24, the OSR indicated the physician ordered to administer ipratropium (a medication that relaxes and opens the airways to help with breathing) albuterol inhalation nebulizer solution 0.5-2.5 MG/3 ML three ML inhale orally every four hours for shortness of breath and wheezing, and acetylcysteine (a medication is used to help with breathing) inhalation solution 10% two ML inhale orally every four hours for shortness of breath and wheezing, started on 7/24/24. During a review of Resident 55's MAR, dated 10/1/24 to 10/31/24, the MAR indicated Resident 55 received ipratropium-albuterol inhalation nebulizer solution and acetylcysteine inhalation solution 10% inhale orally via nebulizer every four hours from 10/2/24 to 10/4/24. (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	10/04/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/4/24 at 9:14 AM, Licensed Vocational Nurse (LVN) 4 was holding Resident 55's nebulizer mask at bedside and squeezed a vial of ipratropium-albuterol inhalation nebulizer solution 0.5-2.5 MG/3 ML into the medication chamber of the nebulizer mask. Resident 55's nebulizer mask was labeled 9/25/24. During a concurrent observation and interview on 10/4/24 at 9:15 AM, in Resident 55 ' s room, with the Infection Preventionist (IP) and LVN4, Resident 55's nebulizer treatment was observed. The IP stopped LVN 4 from placing the nebulizer mask on Resident 55 and instructed LVN 4 to obtain a new nebulizer mask. The IP stated the nebulizer mask should be changed every seven days. The IP stated Resident 55's nebulizer mask was dated 9/25/24. The IP stated the staff did not change the mask after 7 days and continued to use on Resident 55 for another three days, which put the resident at risk for infection. During an interview on 10/4/24 at 11:12 AM, with the Director of Nursing (DON,) the DON stated nebulizer mask should be changed every seven days to prevent infection. During a review of the facility's policy and procedure (P&P) titled, Administering Medications through a Small Volume (Handheld) Nebulizer, dated 10/2010, the P&P indicated to change equipment, including mask, every seven days. 47882 2. A review of Resident 258's Admission Record, indicated the resident was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure (a progressive condition in which the lungs cannot meet the body ' s oxygen demands)chronic obstructive pulmonary disease (COPD) (lung disease causing restricted airflow and breathing problems) and malignant neoplasm of upper lobe, right bronchus or lung (lung cancer). A review of Resident 258's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 9/20/2024, the MDS indicated, Resident 258's cognitive status (ability to think and remember or thought process) was moderately impaired. The MDS indicated Resident 258 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and or contact guar assistance as resident completes activity) with eating, partial/moderate assistance (helper does less than half the effort) with personal hygiene, roll left and right , sit to stand, and required substantial/maximal assist (helper does more than half the effort) with toileting and bathing. During an observation on 10/1/2024 at 9:30 AM in Resident 258's room, Resident 258 was asleep while continuously receiving oxygen at 2 liters per minute. The doorway of Resident 258 ' s room or in the room did not have an oxygen in use warning sign posted. During an interview on 10/1/2024 at 9:45 AM with Licensed Vocational Nurse (LVN) 3 by Resident 258's room. LVN 3 stated, Resident 258's doorway should have a posted warning sign oxygen in use as per facility's policy, because the facility allows smokers in designated area, and smoking and oxygen had the potential to cause fire. (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	10/04/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/1/2024 at 10AM with Registered Nurse (RN) 3. RN 3 stated, Resident 258 had been receiving oxygen since admitted to the facility, and his doorway should have a warning sign of oxygen in use as per policy, because we have smokers in the building, to prevent potential accident or fire. During a concurrent interview and record review, on 10/2/2024, at 4 PM, with Licensed Vocational Nurse (LVN) 2, Resident 258 ' s facility document titled Order Summary Report dated 10/2/2024 was reviewed. The document indicated, Resident 258 was admitted on [DATE] and the order to administer oxygen at 2 liters per minute via nasal cannula was just ordered 10/2/2024. LVN 2 stated, Resident 258 had been receiving oxygen since admission to the facility on [DATE] without a physician ' s order. During a concurrent interview and record review, on 10/2/2024 at 4:15 PM, with LVN 3, Resident 258 ' s documents titled ' Progress Notes (PN) dated 9/16/2024 and Medication Administration Record (MAR) for the month of September 2024 was reviewed. The PN indicated Resident 258 had been receiving oxygen at 2 liters per minute upon admission to the facility on [DATE] and Resident 258 was receiving oxygen continuously without a physician ' s order since. LVN 3 stated, he missed getting an order for oxygen. LVN 3 stated, oxygen should have an order before administering because it could cause oxygen toxicity. During a concurrent interview and record review, on 10/2/2024 at 4:25 PM, with Director of Nurses (DON), Resident 258 ' s facility document titled Order Summary Report dated 10/2/2024 was reviewed. DON stated, Resident 258 was receiving oxygen since admission to the facility on [DATE], but did not have an order until today 10/2/2024. DON stated, the admitting nurse and the staff missed getting an order for oxygen until today. DON stated oxygen is a drug so it should have a physician order prior to administration because it has a potential to cause oxygen toxicity. DON also stated, Resident 258 who was receiving oxygen should have had a warning sign oxygen in use posted on the doorway because the facility allows smoking, and smoking and oxygen has a potential to cause fire. A review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated 10/2010, indicated: a) the purpose is to provide guidelines for safe oxygen administration, b) preparation includes to verify that there is a physician order for the procedure, c)equipment necessary when performing the procedure includes No Smoking/Oxygen in Use sign, and d) remove all potentially flammable items (smoking articles) from the immediate area where oxygen is to be administered. A review of the facility's policy and procedure (P&P) titled, Physician Orders, (undated), indicated: a) ensure all physician orders are followed and documented as given without errors, and b) do not start any due medications if not yet verified from the physician or nurse practitioner. 50012 3. During a review of Resident 63 ' s Admission Record dated 2/18/2022, the record indicated the facility admitted Resident 63 on 2/18/2022 and readmitted on [DATE] with diagnoses including Chronic Obstructive Pulmonary disease (COPD - lung disease which makes breathing difficult), and Bronchiectasis (a condition where your airways widen or develop pouches). During a review of Resident 63 ' s History and Physical (H&P), dated 3/3/2024, indicated, Resident 63 had the capacity to make medical decisions. (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	10/04/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 63 ' s Order Summary Report, dated 10/2/2024, the Order Summary Report indicated an order on 3/3/2024, indicating may use oxygen at two (2) liters (a unit of measurement) per minute (L/min) via nasal cannula (device use for delivery of oxygen) to maintain oxygen saturation (amount of oxygen carried in blood) at 92%. During a review of Resident 63's Minimum Data Set (MDS-a federally mandated resident assessment tool.), dated 8/15/2024, indicated the cognitive (the ability to think and process information) skills for daily decisions making was intact, and independent for activities of daily living. During an observation on 10/2/2024 at 11:30 a.m., Resident 63 was observed sitting at the edge of his bed in his room. Resident 63 ' s oxygen machine was observed in resident ' s room. There was no precautionary signage posted on Resident 63 ' s door indicating oxygen was in used in the room or smoking was prohibited. During a concurrent observation and interview on 10/1/2024 11:33 a.m. CNA 4 stated that there was no precautionary signage posted on Resident 63 ' s door indicating oxygen was in use, or smoking was prohibited. During an interview on 10/3/2024 at 9:30 a.m., with the Registered Nurse Supervisor 4 (RN 4), RN4 stated smoking signage should be posted at the entrance door of residents receiving oxygen therapy to alert staff and visitors that oxygen was in use, and to avoid smoking for resident safety. During a review of the facility ' s policy and procedure (P&P) titled, Oxygen Administration, revised 10/2010, P&P indicated, equipment and supplies are necessary when performing the procedure to place No smoking/Oxygen in Use signs.

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	10/04/2024

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. 46779 Based on observation, interview and record review, the facility failed to verify one of seven sampled residents (Resident 89)'s identity before medication was administered to the resident in accordance with the facility's policy and procedure. The deficient practice had put Resident 89 at risk of receiving the wrong and unnecessary medications that could cause the adverse effects (an undesired effect of a drug or other type of treatment). Findings: During a review of Resident 89's Admission Record indicated the facility admitted Resident 89 on 9/29/23 with diagnoses that included diabetes mellitus (a group of diseases that affect how the body uses blood sugar) and hypertension (high blood pressure). During a review of a Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 7/10/24, indicated Resident 89 had moderately impaired cognitive (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 89 required setup or clean-up assistance with eating, partial/moderate assistance with oral hygiene, substantial/maximal assistance with chair/bed-to-chair transfer, and was dependent with toilet hygiene, shower/bathe self and personal hygiene. During a review of Resident 89 ' s Order Summary Report (OSR), dated 9/30/24, the OSR indicated physician ordered to administer multivitamin-minerals (a supplemental medication is used to support health needs) one tablet by mouth one time a day for supplement. During a review of Resident 89's Medication Administration Record (MAR), dated 10/1/24 to 10/31/24, the MAR indicated Resident 89 received multivitamin-minerals one tablet by mouth at 9 AM on 10/2/24. During an observation on 10/2/24 at 9:32 AM, Resident 89 was lying on his bed. Licensed Vocational Nurse (LVN) 1 went into Resident 89 ' s room and stood at the foot of Resident 89 ' s bed. Observed Resident 89 did not have identification (ID) band on his wrists. LVN 1 called Resident 89 ' s last name and told Resident 89 that she would administer his medication. Resident 89 stated OK. LVN 1 returned to the medication cart and checked Resident 89 ' s physician order on the electronic health record (HER). The EHR had no profile picture of Resident 89 on his EHR. LVN 1 prepared one tablet multivitamin-minerals and walked to Resident 89 ' s room. LVN 1 administered the medication to Resident 89 without confirming his name and date of birth to ensure Resident 89 ' s identity. During a concurrent interview and record review on 10/2/24 at 9:35 AM, with LVN 1, Resident 89 ' s profile picture on EHR was reviewed. LVN 1 stated there was no picture of Resident 89 on the EHR and she could not identify if Resident 89 was right resident just by calling his last name. (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	10/04/2024

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	During a concurrent observation and record review on 10/2/24 at 9:36 AM, with LVN 1, Resident 89 did not have a wrist ID band. LVN 1 stated the wrist ID band was important because it helped the staff to identify the residents correctly. During an interview on 10/2/24 at 9:40 AM, with LVN 1, LVN 1 stated she only called Resident 89 ' s last name to verify his identity before she administered the medication to Resident 89. LVN 1 should use three identifiers, including the name, wrist band, e-MAR, birthday, picture, and room number, to verify the resident ' s identity to prevent administer the wrong medications to the wrong resident. During a concurrent interview and record review on 10/2/24 at 3:07 PM, with the Director of Nursing (DON), the facility ' s policy and procedure (P&P) titled, Administering Medications, dated 4/2019, was reviewed. The DON stated according to the P&P, the nurse should verify the resident ' s identity before giving medications by checking identification band, checking photograph attached to medical record, and verifying resident identification with other facility personnel. The DON stated by calling only the resident ' s last name was not enough to identify the resident and could put the resident at risk of medication error and adverse consequences.

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	10/04/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview, and record review, the facility failed to ensure two of five sampled residents (Resident 58 and 4) were free of unnecessary psychotropic medications (any medication capable of affecting the mind, emotions, and behavior) in accordance with the facility's policy and procedureby [NAME] to ensure: (any medication capable of affecting the mind, emotions, and behavior) in accordance with the facility policy and procedure. Resident 58 1. Resident 58 with diagnoses of schizophrenia (a mental illness that is characterized by disturbances in thought) and depression (mood disorder that causes a persistent feeling of sadness and loss of interest in life) recieved specific indication for Risperidone (medication used to treat symptoms of schizophrenia) and Trazodone (medication used to treat depression), and behavior for the indication of use were monitored and documented from the period of 7/1/2024 to 10/4/2024. These efficient practices had potential to result in placing Resident 58 at risk for significant adverse consequence (unwanted, uncomfortable, or dangerous effects that a drug may have) from the use of unnecessary psychotropic drug, which could result to impairment or decline in the residents' mental, physical condition, functional, and psychosocial status. 2. Resident 4 was administered Lorazepam (brand name Ativan, a medication to treat anxiety [fear of the unknown or extreme worry] disorders) without a physician order and clinical reason for use. As a result of this deficient practice the resident was at risk for the use of unnecessary medication, or non-therapeutic use of psychotropic medication. Findings: During a review of Resident 58's Admission Record indicated the facility initially admitted Resident 58 on 4/27/2021 and readmitted on [DATE] with diagnoses that included schizophrenia, depression, dementia (a progressive state of decline in mental abilities), and anxiety disorder (a group of mental disorders characterized by significant feelings of fear that affect with daily activities). During a review of Resident 58 ' s Order Summary Report, indicated Resident had a physician order on 1/8/2024 for Trazodone HCl tab 50 mg (milligram, unit of weight) to give 0.5 tablet by mouth at bedtime for depression and a physician order on 1/10/2024 for Risperidone tab 3 mg to give 1 tablet by mouth two times a day for Schizophrenia manifested by mumbling to himself. During a review of Resident 58 ' s History and Physical, dated 1/13/2024, indicated Resident 58 was aphasia (a disorder that makes it difficult to speak), bed bound (confined to bed due to illness/weakness), and did not have the capacity to understand and make decisions. (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	10/04/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 58 ' s care plan (a document that outlines the facility ' s plan to provide personalized care to a resident based on the resident ' s needs), titled Behavioral Symptoms, dated 4/11/2024, indicated Resident 58 had potential altered behavioral patterns manifested by mumbling to himself with the goals that minimize frequency of behavior exhibited, reduce risk for potential harm and ensure resident ' s safety and the interventions included to monitor behavior indicators as needed. During a review of Resident 58 ' s care plan, titled Psychotherapeutic Medication Use, dated 4/11/2024, indicated resident has periods of psychosis manifested by mumbling to himself with medication used as Risperdal (brand name for Risperidone), and resident has periods of depression manifested by sad facial expression with medication used as Trazodone. The record indicated, the goals were to maximize resident ' s functional potential, reduce risk of potential adverse effects of medication usage and minimize noted behaviors. The interventions included to monitor and record episodes of behavior per facility policy/protocol. During a review of Resident 58 ' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/9/2024, indicated Resident 58 ' s cognition (a term for the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) was severely impaired, and was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) in oral/personal hygiene, bathe self, upper and lower body dressing. During a review of Resident 58 ' s Psychotropic Assessment, dated 1/8/2024, indicated Resident 58 was on Risperidone 3 mg BID (two times a day) for diagnosis of Schizophrenia with auditory hallucination, and no specific description of auditory hallucination was documented. During a review of Resident 58 ' s Note to Attending Physician/Prescriber, dated 7/10/2024, documented by the facility ' s Consultant Pharmacist (CP) indicated Resident 58 has been receiving Risperidone 3 mg BID and Trazodone 25 mg QHS (at bedtime) to manage behavior, stabilize mood or treat a psychoactive condition. The record indicated the CP recommended for a review of the resident associated behaviors and monitoring parameters for worsening of behaviors to determine if the behaviors noted have been non to minimal. The record indicated, Federal nursing facility regulations require that gradual dosage reduction (GDR) be attempted in two separate quarters (with at least one month between attempts) within the first year in which a resident is admitted on a psychopharmacologic medication, or after the facility has initiated such medication, and then every 6 months thereafter unless clinically contraindicated. The record indicated, Resident 58 ' s physician disagreed with the CP ' s recommendations due to the benefits out-weight the risks with no explanation of benefits and risks were documented. During an observation on 10/2/2024 at 10:15 AM in Resident 58 ' s room, Resident 58 was in bed and awake. Resident 58 did not answer, not nodding or shaking head with any questions asked by the surveyor. During a concurrent observation and interview on 10/3/2024 at 2:23 PM with Certified Nurse Assistant (CNA) 8, Resident 58 was observed in bed, staring at the ceiling. CNA 8 stated, Resident 58 had been nonverbal and required total care since his admission on 1/8/2024. CNA 8 stated, she had not seen Resident 58 talking to himself and stated, Resident 58 ' s facial expression had been flat. (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	10/04/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview on 10/4/2024 at 9:41 AM with Licensed Vocational Nurse (LVN) 1, Resident 58 ' s Psychotropic Assessment, and care plan were reviewed. LVN 1 stated, based on the records, Resident 58 was on Risperidone for hallucination manifested by mumbling to himself and Trazodone for depression manifested by sad face expression. LVN 1 stated, Resident 58 had been nonverbal and bedbound with total care upon admission on 1/8/2024. LVN 1 stated, when Resident 58 made a long arggggg sound sometimes, she believed that was how he was mumbling to himself. LVN 1 stated, Resident 58 had been having a flat face with no expression. During an interview on 10/4/2024 at 11:22 AM with Registered Nurse (RN) 4, RN 4 stated, Resident 58 had been nonverbal since admission on 1/8/2024. RN 4 stated, per policy, when a resident was on psychotropic medications with specific target behaviors, the LVNs are responsible to check the episodes of manifesting behavior and document them, then the RN would count the total number of episodes at the end of the month. RN 4 stated, they needed to count and monitor so that they could decrease or discontinue the medications if the resident did not have any episode of noted behaviors anymore. During a concurrent record review and interview on 10/4/2024 at 12:05 PM with RN 4, Resident 58 ' s Psychotropic Summary Sheet was reviewed. RN 4 stated, the form was used to monitor monthly total number of episodes that Resident 58 exhibited behaviors of mumbling to himself and sad face expression and the RNs are responsible to count and document them. RN 4 stated, based on the record, there was no total count from the month of July 2024. During a concurrent record review and interview on 10/4/2024 at 12:10 PM with RN 4, Resident 58 ' s electronic Medication Administration Record (eMAR) for August, September and October 2024 were reviewed. RN 4 stated, the eMAR indicated no numbers of episode of mumbling to self was documented since 8/1/2024. RN 4 stated, the LVNs had been documenting incorrectly or there must be a mistake from IT department that they could not document a number in the record. RN 4 stated, there was no episodes tracking since 8/1/2024. RN 4 stated, with no tracking, they could not assess the resident to initiate GDR, and they would not know if the resident still needed the medications or not, so the resident would be at risk for unnecessary psychotropic medications. During a concurrent record review and interview on 10/4/2024 at 12:20 PM with RN 4, Resident 58 ' s Psychiatric notes, since admission on 1/8/2024 were reviewed. RN 4 stated, there had been no GDR attempted in the past 9 months. (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	10/04/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/4/2024 at 12:33 PM with the Director of Nurses (DON), the DON stated, mumbling to himself should not be the indication of Risperidone use for schizophrenia and auditory hallucination is too general because it should specify what hallucinations, what he saw, what he heard. The DON stated, sad face alone should not be an indicator for Trazodone use to treat depression. The DON stated, a long sound arggg could not indicate that he was mumbling to himself. The DON stated, the facility ' s CP usually reviewed the medications record alone and send the recommendation to her, she would then review it and suggest it to the doctor. The DON stated, she did not review the suggestion from the pharmacist, which was documented in Resident 58 ' s Note to Attending Physician/Prescriber, dated 7/10/2024. The DON stated, she just brought the recommendation to the doctor and asked him to sign it. The DON stated, she should have reviewed the recommendation and assessed the resident for need to continue the medications or not and discuss with the doctor for possible GDR. The DON stated, the doctor should have explained in detail why he disagrees with GDR and wanted to continue Risperidone and Trazodone. The DON stated RNs are assigned to count the episodes every month and bring it to IDT meeting. The DON stated, the staffs did not properly monitor the resident ' s behaviors. The DON stated, they need to know how many episodes of hallucinations so that they know if the medication is effective, if it needed to be discontinued or decrease. The DON stated the indications for Risperidone and Trazodone were not accurate and should be more specific to use. The DON stated, Resident 58 is at risk for unnecessary psychotropic medications. During a review of the facility ' s policy and procedure (P&P) titled, Psychoactive Drug Monitoring, dated March 2023, indicated the following: -The continued need for the psychoactive medication shall be reassessed regularly by the prescriber and the care planning team. If continuation is deemed necessary, this is indicated in the medical record. Effects of the medications are documented as a part of the care planning process. Unless medically contraindicated, periodic dosage reductions shall be attempted, and the results documented. -Conditions shall be satisfied prior to initiation and/or continuation of therapy included: long-term daily use has been accompanied by unsuccessful gradual dosage reductions. -Residents receive antipsychotic medication only for behaviors that are quantitatively and objectively documented through the use of behavioral monitoring charts or a similar mechanism. -Residents receive antipsychotic medication only for behaviors that are persistent, that are not caused by preventable reasons and are causing the resident to: present a danger to self or others, continuously screaming/yell/space, and experience psychotic symptoms. During a review of the facility's P&P titled, Antipsychotic Medication Use, dated December 2016, indicated the following: -Residents who are admitted from the community or transferred from a hospital and who are already receiving antipsychotic medications will be evaluated for the appropriateness and indications for us. Re-evaluate the use of the antipsychotic medication at the time of admission to consider whether or not the medication can be reduced, tapered, or discontinued. (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	10/04/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses alone do not warrant the use of antipsychotic medication. Antipsychotic medications will generally only be considered if the behavioral symptoms present a danger to the resident or others, and (1) the symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations); or (2) behavioral interventions have been attempted and included in the plan of care. -The Physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) why the benefits of the medication out-weight the risks or suspected or confirmed adverse consequences. 50012 2. During a review of Resident 4's Admission Record (Face Sheet), dated 9/12/2023, the face sheet indicated the facility admitted Resident 4 on 9/12/2023, and readmitted on [DATE] with diagnoses including Chronic Obstructive Pulmonary disease (COPD - lung disease which makes breathing difficult), and muscle weakness. During a review of Resident 4's Minimum Data Set (MDS-a federally mandated resident assessment tool.), dated 6/4/2024, indicated has severe cognitive impairment (the ability to think and process information). The MDS indicated the resident is totally dependent on staff for dressing, toilet use, personal hygiene, and bathing. During a review of Resident 4's History and Physical (H&P), dated 6/24/2024, indicated, Resident 4 had the mental capacity to make medical decisions. During a review of Resident 4's Order Summary Report, dated 10/3/2024, the Order Summary Report indicated an order dated 8/1/2024, to administer Lorazepam (Ativan) Tab (tablet) 0.5mg (milligram)- Give one tablet by mouth every six hours as needed for anxiety for 14 days m/b (manifested by) sudden outburst of anger with an order end date of 8/14/2024. During a review of nursing notes dated 9/5/2024 at 9:15 PM, Lorazepam 0.5 mg tablet given p.o. (by mouth) PRN (as needed) to administer for anxiety. During a review of nursing notes dated 9/5/2024 at 11:36 PM, Ativan 0.5 mg given at 9:15 PM and was effective at 11:30 PM, no anxiety noted. During a review of nursing notes dated 9/14/2024 at 5:30 AM, Ativan 0.5 mg tablet 1 tablet given p.o. PRN anxiety m/b (manifested by): sudden outburst of anger. During a review of nursing notes dated 9/14/2024 at 5:30 AM, Ativan given at 5:30 PM effective at 6:30 PM. During a review of nursing notes dated 9/26/2024 at 5AM, Lorazepam 0.5 mg tablet 1 tablet given p.o. PRN anxiety, effective at 6PM During a review of nursing notes dated 9/26/2024 at 5:50 AM, Late entry: Lorazepam 0.5 mg tablet 1 tablet given p.o. PRN anxiety, m/b agitation, effective at 7PM (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	10/04/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Record of Controlled Substance indicated, Lorazepam was administered to Resident 4 as follow: 8/31/2024 at 9:30PM 9/5/2024 at 9:15PM 9/14/2024 at 5:30PM 9/26/2024 at 5PM 9/27/2024 at 5:50PM During a concurrent interview and record review on 10/3/2024 at 4:38 PM, with the Registered Nurse Supervisor 4 (RN 4), Resident's 4 record of Controlled substances, was reviewed. The record of Controlled Substances indicated Resident 4 was administered Lorazepam on 8/31/24, 9/15/24, 9/14/24, 9/26/24, and 9/27/24 (a total of five times) without a physician's order. RN 4 stated that medication such as Ativan should not had been administered without the ordered and every medication needs some orders. During an interview on 10/3/2024 at 4:55 PM with the DON stated the medication should had been given the Ativan to me after the medication was discontinue. DON stated that if the medication was discontinued and if the resident needs it, they need to call the doctor to obtain an order for the medication before administering the medication. The DON stated the nurse should not have administered the Ativan without a physician order. I understand that lorazepam is just ordered for 14 days and then the resident need to be reassessed for the need to Ativan. During a concurrent interview and record review on 10/3/2024 at 5:18 PM, Licensed Vocational Nurse 2 (LVN 2) stated, she was aware that the Ativan was due for renewal. LVN 2 stated she thought the Ativan order was renewed. LVN 2 stated there is monitoring for the medication but no order to administer Lorazepam in the medication administration record (MAR). LVN 2 stated she could not remember where she documented that she administered the medication. LVN 2 confirmed there is no record of her administering the medication in the MAR. During a review of the facility's policy and procedure (P&P) titled, Administering Medication, revised on 4/2019, P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required timeframe. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.

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	10/04/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779 Based on observations, interviews, and record reviews, the facility failed to ensure drugs and biologicals used in the facility were, stored under proper temperature, are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable in accordance with the facility's policy and procedures. The facility failed to: 1. Ensure the medication room [ROOM NUMBER] ' s thermometer readings were monitored and recorded in the Daily Room Temperature Log to assure a safe temperature range for medication storage. 2. Label Resident 257's opened multi-dose medication bottles (a bottle of medication in the forms of liquid, tablet, or capsule, that contains more than one dose of medication) with the name in the Medication Cart #1 for: a. Ascorbic acid (vitamin C, a dietary supplement) 500 milligram (mg, a unit of measurement) b. Vitamin E (a dietary supplement) 400 unit (a unit of measurement) c. Vitamin D3 (a dietary supplement) 25 micrograms (mcg, a unit of measurement) 3. Label the opened multi-dose medication bottle with the open date in the medication cart #2 for: a. Pro-Stat (a medical food that is a concentrated liquid protein supplement) 15 grams (g, a unit of measurement) of protein in one fluid ounce (fl oz, a unit of measurement) b. Bismuth subsalicylate (a medication to relieve upset stomach, gas, heartburn, and diarrhea) 525 mg/30 milliliter (ml, a unit of measurement) c. Geri-Lanta (a medication is used to treat upset stomach, heartburn, and bloating) 355 ml d. One battle of Sterile normal saline (a mixture of salt and water) 100 ml This deficient practice had the potential for harm to residents due to the potential loss of strength of the drugs, the potential for the residents to receive ineffective drug dosages, and the potential to result in medication error. Findings: (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	10/04/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. During a concurrent observation and interview on 10/3/24 at 10:52 AM, with Licensed Vocational Nurse (LVN) 6, the digital thermometer was attached to the wall, next to the Daily Room Temperature Log, in the medication room [ROOM NUMBER], but the thermometer display was blank. LVN 6 stated the night shift nurse was responsible to check the temperature and document it on the Daily Room Temperature Log every day, but the temperature for 10/3/24 was not documented. LVN 6 stated she did not know for how long the thermometer was not working. During a concurrent interview and record review on 10/3/24 at 11AM, with the Director of Staff Development (DSD), the updated Daily Room Temperature Log was reviewed. The Daily Room Temperature Log indicated there was no documentation on the specific month and the location of the temperature log was monitoring. The DSD stated the updated Daily Room Temperature Log was the current log for October for the medication room [ROOM NUMBER]. The DSD stated the 3 on the log indicated the date for 10/3/24. The DSD stated the nurse, who worked the night shift last night, should check the temperature and documented it on the log before the end of her shift. The DSD stated the nurse only documented her signature and the shift 11-7 AM, but she did not document the temperature on the log. The DSD stated the night shift nurse might not be able to read the temperature because the thermometer was not working during her shift. The DSD stated it was important to monitor the temperature in the medication room to ensure the temperature was within the range and assure the potency of the medication stored in the medication room. 2. During a review of Resident 257's Admission Record indicated the facility admitted Resident 257 on 9/20/24 with diagnoses that include hypertension (high blood pressure) and muscle weakness. During a review of Resident 257 ' s MDS, dated [DATE], indicated Resident 257 had moderately impaired cognitive (ability to understand and make decisions) skills for daily decision making. During a review of Resident 257 ' s Order Summary Report (OSR), dated 10/4/24, the OSR indicated the physician ordered to administer Ascorbic acid 500 mg give 500 mg by mouth in the morning for supplement and Vitamin E 400-unit one tablet by mouth in the morning for supplement. During a concurrent observation and interview on 10/3/24 at 11:22 AM, with LVN 6, observed an opened multi-dose bottle of Ascorbic acid 500 mg, an opened multi-dose bottle of Vitamin E 400 unit, and an opened multi-dose bottle of Vitamin D3 25 microgram were stored in a drawer in the medication cart #1. Observed these opened bottles were only labeled with Resident 257 ' s room number without the resident ' s name on it. LVN 6 stated Resident 257 brought these medications to the facility, and they kept them in the medication cart. LVN 6 stated she should write Resident 257 ' s name on the bottles instead of the room number to prevent loss and/or administered it to the wrong resident if Resident 257 was transferred to a different room. (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	10/04/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During a concurrent observation and interview on 10/3/24 at 4:13 PM, with LVN 7, observed an opened multi-dose bottle of liquid form of Pro-Stat 15 g of protein in one fluid ounce , an opened multi-dose bottle of liquid form of bismuth subsalicylate 525 mg/30 ml, an opened multi-dose bottle of liquid form of Geri-Lanta 355 ml, and an opened bottle of sterile normal saline were stored in a drawer in the Medication Cart #2. LVN 7 stated these four bottles of medication were not labeled with an opened date. LVN 7 stated these liquid medications were only good for 30 days after they were opened, and it was important to label the bottle on when it was opened so that the nurse will know when to discard the expired medications. LVN 7 stated the nurse, who opened the multi-dose bottle of medication, should label the date it was opened to ensure the potency of the medication and prevent infection from the overgrowth of the germs in these liquid medications. During an interview on 10/4/24 at 10AM, with the Infection Preventionist (IP), the IP stated an opened bottle of an over the counter (OTC) liquid medication was good for three months after the date it was opened. The IP stated the nurse should label the open date of the medication when he or she opened it to ensure the medication potency and prevent infection which bacteria might overgrow in it. During an interview on 10/4/24 at 11:17 AM, with the Director of Nursing (DON), the DON stated it was important to ensure the thermometers in the medication rooms were working, the staff monitor the temperature and document it in the log every day, and the staff label the opened bottles with the open date to prevent the loss of medication potency and infection. The DON stated the staff should label the resident ' s medication with his or her name on the bottle to prevent the loss of the medication and medication error. During a review of the facility ' s policy and procedure (P&P) titled, Medication Labeling and Storage, dated 2/2023, the P&P indicated The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. The P&P indicated the medication label included resident ' s name. The P&P indicated multi-dose vials that have been opened are dated.

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	10/04/2024

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview, and record review, the facility failed to provide food prepared in a form designed to meet individual needs for one of twenty-three sampled residents (Resident 23) with dysphagia (difficulty swallowing) and was ordered by the physician to be served Regular diet (diet that does not include any restrictions) with mechanical soft texture (any foods that can be blended, mashed, pureed, or chopped using a kitchen tool such as a knife, a grinder, a blender, or a food processor) since 7/16/2024. This failure resulted in Resident 23 received regular texture instead of mechanical soft texture as ordered from 7/16/2024 to 10/3/2024, which could place her at risk for aspiration (happens when food, liquid, or other material enters a person ' s airway by accident. It can happen as a person swallows) and choking. Findings: During a review of Resident 23's Admission Record indicated the facility initially admitted Resident 23 on 4/1/2015 and readmitted on [DATE] with diagnoses that included hemiplegia (a condition that causes partial or complete paralysis or weakness on one side of the body and hemiparesis (weakness or an inability to move on one side of the body) following cerebral infraction (stroke, a serious condition that occurs when blood flow to the brain is disrupted, causing brain tissue to die) affecting right dominant side, muscle weakness, cognitive communication deficit, aphasia (loss of the ability to understand or express spoken or written language), and dysphagia . During a review of Resident 23 ' s Speech Therapy SLP (Speech-Language Pathologist) Discharge Summary, dated 9/29/2023, indicated the treatment included utilization of safe swallow strategies such as small bites/sips. During a review of Resident 23 ' s History and Physical, dated 8/12/2024, indicated Resident 23 had fluctuating capacity to understand and make decisions. During a review of Resident 23 ' s care plan (a document that outlines the facility ' s plan to provide personalized care to a resident based on the resident ' s needs), dated 9/6/2024, indicated Resident 23 was at risk for weight loss, decline in functional status, and aspiration/choking during meals. The goals were to reduce/minimize risk of aspiration/choking during meals, and to receive adequate nutrition/hydration daily. The interventions included mechanical soft diet with thin liquid, assistance during meals as needed, and staffs to monitor resident ' s tolerance with food ' s texture. During a review of Resident 23 ' s Nutritional Screening, dated 9/5/2024, indicated Resident 23 ' s diet order was Regular, mechanical soft texture, and supervision was needed during eating. During a review of Resident 23 ' s Order Summary Report, indicated Resident 23 had a physician order on 7/16/2023 for Regular diet with mechanical soft texture. (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	10/04/2024

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent dining observation and interview on 10/1/2024 at 12:15 PM with Resident 23 in her room, Resident 23 was observed in bed eating alone with no assistance. Resident 23 was observed using a spoon to cut up a piece of chicken that was close to 2x3 inches (unit of length) in size. During a concurrent observation and interview on 10/1/2024 at 12:45 PM with Certified Assistant Nurse (CNA) 4 in Resident 23 ' s room, Resident 23 ' s lunch tray and tray card was observed. CNA 4 stated, Resident 23 ' s tray card indicated Regular diet with no indication for mechanical soft texture as ordered. During a concurrent interview and record review on 10/3/2024 at 2:25 PM with the Dietary Service Supervisor (DSS), the facility ' s policy and procedure (P&P) titled, Regular Mechanical Soft Diet, dated 2023, was reviewed. The DSS stated, the facility only provided grounded meat for dysphagia residents who had diet order for mechanical soft texture to prevent aspiration and choking. The DSS stated, when a resident was admitted to the facility, the nurse would bring a slip with the resident ' s name and diet order to him. The DSS stated, he usually based on the information in the slip to transfer it to his computer and create a tray card for that resident. The DSS stated, he was not aware that Resident 23 had order for mechanical soft texture because Resident 23 ' s tray card only showed Regular diet. The DSS stated, they had been providing Resident 23 with regular texture diet since her admission on 7/16/2023. The DSS stated, Resident 23 ' s diet order could have been revised and he was not aware to update with the new texture. The DSS stated, there could be a risk that Resident 23 could aspirate or choke when the facility provided her with the wrong diet texture. During a concurrent record review and interview on 10/3/2024 at 6:15 PM with the Director of Nurses (DON), Resident 23 ' s Order Summary Report was reviewed. The DON stated, Resident 23 ' s physician diet order had been mechanical soft texture since 7/16/2023. The DON stated, Resident 23 ' s tray card should have indicated mechanical soft texture. The DON stated, the DSS must have transferred Resident 23 ' s diet order incorrectly into his system. The DON stated, they have been providing Resident 23 with regular texture instead of grounded meat since 7/16/2023. The DON stated, Resident 23 could have aspirated or choked when provided with the wrong diet texture. During a review of the facility ' s P&P titled, Diet Order, dated 2023, indicated diet orders prescribed by the Physician will be provided by the Food & Nutrition Services Department. Nursing will send a Diet Order Communication slip to the Food & Nutrition Services Department. The FNS Director or [NAME] in charge will make or adjust the diet profile and tray card as prescribed. During a review of the facility ' s P&P titled, Regular Mechanical Soft Diet, dated 2023, indicated the mechanical soft diet is designed for residents who experience chewing or swallowing limitations. The regular diet is modified by mechanically altering, chopped or ground. Food including meats, poultry and fish are allowed in ground form, avoid whole. Chopped meat only allowed when ordered by Speech Therapist, and is recommended to chop in bite size, 0.5 inches moist.

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	10/04/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50012 Based on observation, interview, and record review, the facility failed to ensure the food were stored prepared and distributed of food under sanitary conditions to all the residents in the facility by failing to: 1.Ensuring to store food with label and open date. 2.Ensure expired food was not stored in the kitchen. 3.Monitoring and documenting Sanitization Bucket Log. 4.Monitoring and documenting Ice Machine cleaning log. 5.Monitoring and documenting cleaning and maintenance schedule log. These deficient practices placed the residents at risk for foodborne illnesses (refers to illness caused by the ingestion of contaminated food or beverages). Findings: a. During a concurrent observation and interview on [DATE] at 8:55 a.m., during an initial Kitchen tour in the presence of [NAME] (Cook) 1. There were several open items without label and open date. Those items were a liquid whole egg carton, three squeeze bottles containing apple sauce, cottage cheese container, a sliced watermelon covered with plastic wrap with no use by date, Buttermilk Ranch dressing container with no open date, Sliced potatoes in a container covered with plastic wrap with no used by date. [NAME] 1 stated that the items should have been labeled with open date and use by date. During a review of the facility's policy and procedure (P&P) titled, Labeling and Dating of Foods , indicated newly opened food items will need to be closed and labeled with an open date and used by the date. b. During a concurrent observation and interview on [DATE] at 9:30 a.m. during the kitchen tour with the Dietary Service Supervisor (DSS) observed several items that were expired and stored in the kitchen. in the walk-in fridge Parmesan cheese with a use by date of [DATE], Turkey salad observed with a use by date of [DATE] were observed. The Dietary Service Supervisor (DSS) stated the food was no good and had to be discarded. The following condiments were observed Nutmeg ground expired [DATE] and Turmeric ground expiration date [DATE]. DSS they should have been discarded. During a review of the facility's policy and procedure (P&P) titled, Labeling and Dating of Foods , indicated No food will be kept longer than the expiration date on the product. (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	10/04/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. During a concurrent observation and interview on [DATE] at 9:45 a.m. during an initial kitchen tour with the DSS, a review of the log for the month of [DATE] titled Sanitizer Bucket Log had missing dates with the test results from [DATE] and [DATE] from 1 p.m. to 7 pm. On [DATE] and [DATE] had missing test results for the entire day. DSS stated staff is supposed to fill out the log after each meal, after each use. The DSS verified that log entries were missing for the dates mentioned above. The DSS stated the sanitizing bucket is used to sanitize the food preparation area to reduce the number of bacteria on non-food contact surfaces. The incomplete log indicated the facility's kitchen was not sanitized according to the facility's policy. On [DATE] at 9:45 a.m., during an initial tour of the kitchen with Dietary Services Supervisor (DSS), the Record of Sanitizer Bucket Log was reviewed. The form indicated to use Quaternary sanitizing solution: Concentration range 200ppm (parts per million or ppm means out of a million), immerse test strip for 10 seconds. The form had columns to enter the data eight times a day at 5 a.m., 7 a.m., 9 a.m., 11 a.m., 1 p.m., 3 p.m., 5 p.m., and 7 p. m. however, there were many blank columns. The last entry on the record was at 7 p.m., on [DATE]. During an interview with the DSS on [DATE] at 9:50 a.m., when asked about the procedure of completing the Record of Sanitizer Agent, DSS stated staff is supposed to fill out the log after each meal, after each use. Or if the PPM is not within acceptable range, make new sanitizer and retest. Change more often as needed. The DSS verified that log entries were missing from [DATE] and [DATE] from 1 p.m. to 7 pm, [DATE] and [DATE] had missing test results for the entire day. During an interview with the DSS on [DATE] at 9:50 a.m., DSS stated he is responsible making sure the log is filled out after each use of the test strip. When asked about the missing entries on the Record of Sanitizer bucket log. The DSS stated that every staff member of the kitchen is responsible for completing the log. The DSS stated he may have missed it. The DSS stated he would follow up and make sure everyone follows through. The DSS stated he would make sure the log is filled out accurately and consistently. During a review of the facility's policy and procedure (P&P) titled, Quaternary Ammonium Log Policy, indicated the concentration of the ammonium in the quaternary sanitizer will be tested to ensure the effectiveness of the solution. Food and Nutrition Services staff will record the readings twice a day, once in the morning and once in the PM, to document the process was completed. d. During a concurrent observation and interview on [DATE] at 10:00 a.m., a review of the log for the month of [DATE] titled Ice Machine Cleaning Log had missing dates with staff initials for [DATE], [DATE], [DATE] and [DATE]. DSS stated staff is supposed to fill out the log daily. It is the kitchen staff responsibility to clean the outside of the ice machine and scoop daily. DSS stated it is his responsibility to follow up with the staff, so they understand their duties, but I did not follow up. e. During a concurrent observation, review and interview on [DATE] at 10:10 a.m., a log titled Cleaning and maintenance Schedule for the month of July was observed posted in the Refrigerator 2, which was observed to have multiple missing entries. The DSS stated that the log is for the month of [DATE], but he forgot to change the month to September when he printed the log. The DSS provided the log for August and July logs that were incomplete. The DSS stated that this log was recently implemented in the month of July and the kitchen staff did complete the logs. The DSS stated it his responsibility to make sure the log is filled out accurately and consistently. (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	10/04/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Sanitation, indicated The FNS (food & nutrition services) Director will write the cleaning schedule in which he designates by job title and/or employee who is to the task.

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	10/04/2024

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 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** 47882 Based on observation, interview, and record review, the facility failed to implement the facility's infection control program (a system in preventing, controlling infections and communicable diseases) for six of six sampled residents (Residents 258, 86, 55, 95, 43 and 257). The facility failed to: 1. Ensure for Resident 258 the nasal cannula (a device that delivers extra oxygen through a tube and into your nose), the hand held nebulizer (HHN- machine that turns liquid medication into a mist so that it can be breathed directly into the lungs mouthpiece) circuit were not labeled of the date of the initial use, the HHN circuit was not placed in a plastic bag and the humidifier bottle was not labeled with date and initials upon opening. 2. Ensure for Resident 86 the feeding syringe (a tool used to deliver small amounts of liquid into a person ' s [gastric tube [G-tube, a tube that is inserted into the stomach to provide food, liquids, or drugs, or to remove substances from the stomach] was not changed every 24 hours. 3. Ensure for Resident 55 the blood pressure (BP, the force of the blood pushing against the walls of the arteries [tubelike structures transporting blood from the heart to the rest of the body) monitor was not Cleaned and disinfected (remove dirt or stains, and apply a chemical to a surface in order to destroy germs) a before and after each use. 4. Ensure the nasal cannula (NC, a flexible tube that provides oxygen through the nose) for Resident 95 was labeled when the NC will be changed. 5. Ensure facility staff performed hand hygiene while distributing resident meal trays for two sampled residents (Resident 43 and Resident 257) according to policy and procedure. These deficient practices had the potential for the device to contact contaminated (containing disease causing organism) areas and cause the spread of infection (a process when a microorganism, such as bacteria, fungi, or a virus, enters a person's body and causes harm) to the residents and others in the facility. Findings: 1. A review of Resident 258's Admission Record, indicated Resident 258 was admitted to the facility on [DATE] with diagnoses that included acute and chronic respiratory failure (a condition in which the lungs have a hard time loading the blood with oxygen or removing carbon dioxide), chronic obstructive pulmonary disease (COPD) (lung disease causing restricted airflow and breathing problems) and malignant neoplasm of upper lobe, right bronchus or lung (lung cancer). (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	10/04/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 258's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 9/20/2024, the MDS indicated, Resident 258 cognitive status was moderately impaired. The MDS indicated Resident 258 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and or contact guar assistance as resident completes activity) with eating, partial/moderate assistance (helper does less than half the effort) with personal hygiene, roll left and right , sit to stand, and required substantial/maximal assist (helper does more than half the effort) with toileting and bathing. During an observation on 10/1/2024 at 9:30 AM in Resident 258's room, Resident 258 lying in bed with eyes close receiving oxygen at 2 liters per minute (a unit of measurement) the nasal cannula, oxygen humidifier, HHN circuit was not labeled of dated on when the tube was first used, also the HHN circuit was not stored inside the plastic bag to prevent the tube from contacting contaminated surface. During an interview on 10/1/2024 at 9:45 AM with Licensed Vocational Nurse (LVN) 1 inside Resident 258's room, LVN 1 stated, Resident 258's had been receiving oxygen since admission to the facility on [DATE] and his nasal cannula, oxygen humidifier and HHN circuit should have been labeled and dated of initial use, also the HHN circuit should be in a plastic bag. LVN 1 stated, not having a label of the date the device was initially used, would not let the nurses know the last time it was change. LVN 3 stated, if the oxygen equipment's are old it will harbor bacteria and virus and could cause and/or spread of infection and diseases. During an interview on 10/1/2024 at 10 AM with Registered Nurse (RN) 1, RN 1 stated, Resident 258's nasal cannula and oxygen humidifier should be labeled of the dated it was initially used, and the HHN circuit should be placed in a plastic bag and should be labeled and dated it was initially used. RN 1 stated, nursing would not know the last time it was used and if it was old, and it could harbor bacteria and virus and can cause or even spread infection. During an interview on 10/1/2024 at 10:15 AM with Infection Preventionist Nurse (IPN), IPN stated, Resident 258's nasal cannula, humidifier should be labeled and dated it was initially used and the HHN circuit should be in a plastic bag and dated of when it was initially used and labeled. IPN stated, otherwise it could be old equipment and could harbor bacteria or virus that can cause and spread infection. A review of Resident 258's facility document titled 'Progress Notes (PN) dated 9/16/2024 was reviewed, the PN indicated Resident 258 was receiving oxygen at 2 liters per minute upon admission on 9/16/2024. A review of Resident 258's facility document titled Order Summary Report dated 10/2/2024 was reviewed. The document indicated a physician order for Albuterol Sulfate (medication used for to prevent and treat wheezing, difficulty breathing), inhalation nebulization solution 2.5mg/0.5 ML to be administered every four hours as needed via HHN. 46779 (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	10/04/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.During a review of Resident 86's Admission Record indicated the facility initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that include dementia (a group of thinking and social symptoms that interferes with daily functioning) and dysphagia (difficulty swallowing foods or liquids). During a review of a Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/2/24, indicated Resident 86 had severely impaired cognition (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 86 required substantial/maximal assistance with eating, and was dependent with oral hygiene, toilet hygiene and personal hygiene. During a review of Resident 86 ' s Order Summary Report (OSR), dated 8/29/24, indicated the physician ordered the resident to receive Jevity 1.5 (a liquid nutritional supplement that can be used for patients who are at risk of malnutrition or have altered taste perception) at 100 milliliter (ML, unit of measurement) per hour for 12 hours via pump per G-tube from 7 PM to 7 AM and to flush G-tube with 20-30 ML of water before and after administration of medication pass. During a concurrent observation and interview on 10/1/24 at 9:56 AM, with the Director of Staff Development (DSD), in Resident 86 ' s room, Resident 86 was sitting on his bed and a G-tube feeding pump was secured on an intravenous (IV, a way of giving a drug or other substance through a needle or tube inserted into a vein) pole (a medical device to provide a secure place to hang bags of medicine or fluid for administration to a patient) next to his bed. The G-tube feeding pump was currently off. A feeding syringe was inside a pole bag, which was hung on a hook of the IV pole. The pole bag was labeled as 9/29/24 at 9 AM. The DSD stated the feeding syringe was used for flushing the G-tube, check placement of the G-tube and administering medications to the resident. The DSD stated the feeding syringe should be changed every 24 hours by the night shift nurse, but the nurse did not change the feeding syringe for 2 days which put the resident at risk of contracting an infection. During an interview on 10/2/24 at 3:08 PM, the Director of Nursing (DON), the DON stated the night shift nurse should change the feeding syringe every 24 hours and label the bag with the date and time to prevent infection. During a review of the facility ' s Policy and procedure (P&P) titled, Enteral Feedings-Safety Precautions, dated 11/18, the P&P indicated Change syringe every 24 hours during 11-7 shift and as needed. During a review of Resident 1's Admission Record indicated the facility initially admitted Resident 1 on 10/1/96 and readmitted on [DATE] with diagnoses that include sepsis (a life-threatening medical emergency that occurs when the body has an extreme response to an infection or injury) and diabetes mellitus (a group of diseases that result in too much sugar in the blood). During a review of Resident 1 ' s MDS, dated [DATE], indicated Resident 1 had moderately impaired cognition (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 1 was dependent with eating, oral hygiene, toilet hygiene, shower/bath self, personal hygiene, and chair/bed-to-chair transfer. (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	10/04/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 55's Admission Record indicated the facility initially admitted Resident 55 on 1/28/21 and readmitted on [DATE] with diagnoses that include acute respiratory failure (a condition where there's not enough oxygen in your body) and diabetes mellitus (a group of diseases that result in too much sugar in the blood). During a review of Resident 55 ' s MDS, dated [DATE], indicated Resident 55 had severely impaired cognition (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 55 was dependent with eating, oral hygiene, toilet hygiene, shower/bath self, personal hygiene, and chair/bed-to-chair transfer. During an observation on 10/3/24 at 9:10 AM, Registered Nurse (RN) 5 used a wrist (BP) monitor to check Resident 55 ' s BP, then, she placed the used wrist BP monitor on top of the medication cart without cleaning and disinfecting. During an observation on 10/3/24 at 9:14 AM, RN 5 took the BP monitor that was not disinfected from the top of the medication cart and used it to check Resident 55 ' s BP. During an interview on 10/3/24 at 9:16 AM, with RN 5, RN 5 stated she did not disinfect the BP monitor after using it on Resident 55 and did not disinfect it before using it on Resident 55. LVN 4 stated she should disinfect the BP monitor after and before each use to prevent the spread of infection to the residents. During an interview on 10/4/24 at 11:15 AM, with the DON, the DON stated staff should disinfect the wrist BP monitor and other re-usable equipment before and after each to prevent infection spreading to other residents. During a review of the facility ' s P&P titled, Cleaning and disinfection of Resident-Care Items and Equipment, dated 9/2022, the P&P indicated Reusable items are cleaned and disinfected .between residents (e.g., stethoscopes, durable medical equipment). 47467 4. During a review of Resident 95's Admission Record indicated the facility initially admitted Resident 95 on 2/8/2024 and readmitted on [DATE] with diagnoses that included spondylosis (a condition in which there is abnormal wear on the cartilage [strong, flexible connective tissue supports and protects bones] and bones of the neck), disorder of the lung, and metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance in the blood that affects the brain's normal functioning). During a review of Resident 95 ' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/9/2024, indicated Resident 95 ' s cognition (a term for the mental processes that take place in the brain, including thinking, attention, language, learning, memory and perception) was moderately impaired, During a review of Resident 95 ' s Order Summary Report, indicated the physician ordered on 9/18/2024 for Resident 95 to receive oxygen at 2 liters per minute (LPM) via NC or face mask as needed for shortness of breath or oxygen saturation (measures how much oxygen blood carries in comparison to its full capacity) below 90% (normal range 90-100%) (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	10/04/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/1/2024 at 10:25 AM in Resident 95 ' s room, Resident 95 was observed lying in bed with oxygen in use at 2 LPM via NC without a date of when it was to be changed. During a concurrent observation and interview on 10/1/2024 at 11:41 AM with Licensed Vocational Nurse (LVN) 1 in Resident 95 ' s room. LVN 1 stated, she could not find the label with date on when the NC was to be changed on the resident ' s NC. LVN 1 stated, the NC was required to be labeled with the date that the NC was last changed to track and make sure the NC was changed weekly to prevent infection per facility ' s policy. During an interview on 10/4/2024 at 1:05 PM with the Director of Nurses (DON), the DON stated, it was in the facility ' s policy that all NCs to be dated so they could track and make sure to have them changed every 7 days to prevent infection, such as lung infection. During a review of the facility ' s policy and procedure (P&P) titled, Departmental (Respiratory Therapy) - Prevention of Infection, revised November 2011, the P&P indicated, change the oxygen cannula and tubing every 7 days, as needed. 50012 5. During a review of Resident 43 ' s Admission Record dated 1/27/2022, the record indicated the facility admitted Resident 43 on 1/27/2022, and readmitted on [DATE] with diagnoses including Spinal Stenosis (abnormal narrowing of the spinal canal that may occur in any of the regions of the spine), Chronic Obstructive Pulmonary disease (COPD - lung disease which makes breathing difficult), and Dysphagia (difficulty swallowing). During a review of Resident 43's Minimum Data Set (MDS-a federally mandated resident assessment tool.), dated 7/24/2024, indicated the cognitive (the ability to think and process information) skills for daily decisions making was moderately impaired, and required moderate assistance for activities of daily living. During a review of Resident 43 ' s Order Summary Report, dated 10/03/2024, the Order Summary Report indicated an order on 6/02/2024 to provide the resident a consistent carbohydrate, No Added Salt Diet mechanical soft texture (a texture-modified diet that restricts foods that are difficult to chew or swallow), Regular/Thin consistency finely chopped. During a review of Resident 257 ' s Admission Record dated 9/20/2024, the record indicated the facility admitted Resident 43 on 9/20/2024, with diagnoses including Muscle weakness, and Hypertension (HTN - elevated blood pressure. During a review of Resident 257's Minimum Data Set (MDS-a federally mandated resident assessment tool.), dated 9/24/2024, indicated the cognitive (the ability to think and process information) skills for daily decisions making was moderately impaired, and required moderate assistance for activities of daily living. During a review of Resident 257 ' s Order Summary Report, dated 10/03/2024, the Order Summary Report indicated an order on 10/02/2024 to provide the resident a consistent carbohydrate diet, Regular/Thin consistency. (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	10/04/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/2/2024, at 12:30 p.m., Certified Nurse Assistant (CNA 4) was observed obtaining a meal tray from the meal tray cart and entered Resident 43 ' s room. CNA 4 was observed setting up the meal tray for Resident 43.CNA 4 was then observed exiting Resident 43 ' s room and then obtaining another meal tray from the meal tray cart for Resident 257. CNA 4 entered Resident 257 ' s room, CNA 4 was observed not performing hand hygiene in between meal tray distribution and set up for Resident 43 and Resident 257. During an interview on 10/2/2024 at 12:35 p.m., CNA 1 stated not performing hand hygiene in between assisting Resident 43 and 257. CNA 1 stated she should have performed hand hygiene before and after entering or exiting any resident ' s room. CNA 1 stated it was important to performed hand hygiene to prevent cross contamination between residents. During an interview on 10/4/2024 at 3:20 p.m. with the Director of Nursing (DON), the DON stated according to the facility's policy, all nursing staff were supposed to wash their hands prior to any physical contact or providing care and to wash their hands before and after the procedure. During a review of the facility's policy and procedure (P&P) titled, Hand Hygiene indicated use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: Before and after assisting a resident with meals. A review of the facility's policy and procedure (P&P) titled, [Departmental (Respiratory Therapy) - Prevention of Infection], dated 11/2011, indicated: a) the purpose is to guide prevention of infection associated with respiratory therapy task and equipment, among residents and staff, b) use distilled water for humidification per facility protocol, mark bottle with date and initials upon opening and discard after twenty-four (24) hours, b) change the oxygen cannula and tubing every seven (7) days, or as needed, c) infection control consideration related to medication nebulizers includes store the circuit in a plastic bag, marked with date and resident's name between uses, and discard the administration set-up every seven days. A review of the facility's policy and procedure (P&P) titled, [Administering Medications through a small volume (Handheld) Nebulizer], dated 10/2010, indicated: a) when equipment is completely dry, store in a plastic bag with the resident's name and the date on it, b) change equipment and tubing every seven days, or according to facility protocol.

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	10/04/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779 Based on interview and record review, the facility failed to screen for the need of pneumococcal (PNA) vaccine (an administration of vaccine that stimulate the body's own immune system to protect the person against infection or disease) and offer the vaccine to one of five sampled residents (Resident 160) when the resident was initially admitted to the facility as indicated in the facility's policy and procedure titled, Pneumococcal Vaccine The deficient practice had the potential to result in Resident 160 did not receive the PNA vaccine as recommended by the Department of Public Health and Centers of Disease Control and Prevention (CDC), which out the resident at risk for contracting pneumonia (a severe lung infection). Findings: During a review of Resident 160's Admission Record indicated the facility admitted Resident 160 on 9/5/24 with diagnoses that include depression (a common mental disorder, involving a depressed mood or loss of pleasure or interest in activities for long periods of time) and low back pain. During a review of a Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/9/24, indicated Resident 160 had moderately impaired cognition (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 160 required supervision or touching assistance with eating, partial/moderate assistance with oral hygiene, personal hygiene and chair/bed-to-chair transfer, and substantial/maximal assistance with toileting hygiene and shower/bathe self. During a concurrent interview and record review on 10/3/24 at 8:45 AM, with the Infection Preventionist (IP), Resident 160 ' s Informed Consent (a process that ensures a person has enough information to make an informed decision about a medical procedure, treatment, or clinical trial) for Pneumococcal Vaccine, dated 9/27/24, was reviewed. The IP stated she was responsible to screen the pneumococcal vaccine to all the residents upon their admission or couple days after the admission. The IP stated Resident 160 was admitted on [DATE] and she did not screen and offer Resident 160 the pneumococcal vaccine until 9/27/24 because she was busy with other tasks in the facility. The IP stated she should have screened the resident for the pneumococcal vaccine timely so that the resident was informed about the vaccine and how to protect herself from contracting pneumonia. During an interview on 10/4/24 at 11:13 AM, with the Director of Nursing (DON), the DON stated the staff should screen the residents for the need to have pneumococcal vaccine when the resident was admitted into the facility to ensure the resident was informed about the vaccine and offered the vaccine to protect the residents from contracting pneumococcal infection. During a review of the facility ' s policy and procedure (P&P) titled, Pneumococcal Vaccine, dated 3/2022, indicated Assessments of pneumococcal vaccination status are conducted within five working days of the resident ' s admission .

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	10/04/2024

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 46779 Based on observation, interview, and record review, the facility failed to maintain a safe and sanitary environment for one of three sampled residents (Resident 160) who was observed with stained and soiled both upper bed siderails (one of the long narrow members connecting the headboard and footboard of a bed). This deficient practice had the potential to result in Resident 160's discomfort and the spread of infection. Findings: During a review of Resident 160's Admission Record indicated the facility admitted Resident 160 on 9/5/24 with diagnoses that include depression (a common mental disorder, involving a depressed mood or loss of pleasure or interest in activities for long periods of time) and low back pain. During a review of a Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/9/24, indicated Resident 160 had moderately impaired cognitive (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 160 required supervision or touching assistance with eating, partial/moderate assistance with oral hygiene, personal hygiene and chair/bed-to-chair transfer, and substantial/maximal assistance with toileting hygiene and shower/bathe self. During a concurrent observation and interview on 10/1/24 at 10:41 AM, with Resident 160, Resident 160 was observed lying in bed. Resident 160's siderails were observed with multiple brown stains and clumped accumulations of dust. Resident 160 stated since admission to the facility two weeks ago, Resident 160's siderails already had the brown stains and dust. Resident 160 stated informing the maintenance supervisor (MS) when Resident 160 was admitted to the facility regarding the dirty side rails, however no one came to clean Resident 160's siderails. Resident 160 stated utilizing siderails to move herself in bed and to get out of bed, but she did not want to touch the siderails because they were dirty. Resident 160 stated she did not feel comfortable staying in a bed with dirty bed siderails. During a concurrent observation and interview on 10/1/24 at 10:45 AM, with Certified Nursing Assistant (CNA) 5, Resident 160 ' s side rails were observed. CNA 5 stated Resident 160 ' s siderails were dirty and that Resident 160 ' s side rails should be cleaned to provide a clean and sanitary environment. CNA 5 stated housekeeping was responsible for cleaning resident side rails. During an interview on 10/1/24 at 10:58 AM, with Housekeeping (HK) 1, HK 1 stated the bed siderails were considered as the high touch area (those that people frequently touch with their hands) which required daily cleaning to prevent the spread of infection and provide a sanitary environment to the resident. HK 1 stated not cleaning Resident 160 ' s siderails. During an interview on 10/4/24 at 11:14 AM, with the Director of Nursing, the DON stated staff should clean the bed siderails daily to maintain a safe and sanitary environment for all residents in the facility. (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	10/04/2024

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P&P) titled, Homelike Environment, dated 2/2021, the P&P indicated Resident are provided with a safe, clean, comfortable and homelike environment .