

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056190	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Chestnut Ridge Post Acute LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	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** Based on observations, interview, and record reviews, the facility failed to ensure timely implementation of physician-ordered Passive Range of Motion (PROM) services and splint application for 1 of 2 sampled resident (Resident 88) reviewed for Restorative Nursing Assistant (RNA) services. This deficient practice resulted in a 22-day delay in PROM exercises and splint use, which placed Resident 88 at risk for increased joint stiffness, reduced mobility, and progression of contractures (the permanent shortening of a muscle or a joint, leading to a deformity and restricted range of motion). During a review of Resident 88's admission Record [AR], the AR indicated Resident 88 was originally admitted to the facility on [DATE], with diagnoses that included contracture right elbow and contracture right hand. During a review of Resident 88's History and Physical Examination (HPE, a comprehensive physician's note regarding the assessment of the patient's health status) signed by the attending physician on 8/29/2025, the HPE indicated Resident 88 had the capacity to understand and make decisions. During a review of Resident 88's Minimum Data Set (MDS, a resident assessment tool), dated 5/24/2025, the MDS indicated the Resident 88's cognition (thought process) was intact. During a review of Resident 88's Telephone Orders dated 9/2/2025, the order indicated restorative nursing assistant (RNA) to provide passive range of motion (PROM - joint movement by a person or device) exercises on right upper extremity every day 5 times a week during the day shift. The order further indicated that RNA was to apply right elbow splint and right resting hand splint for 4 to 6 hours with skin check every 2 hours every day 5 times a week during the day shift. During a review of Resident 88's Care plan titled Resident was at risk for decline in joint mobility and further contracture development on right upper extremity dated 9/2/2025, indicated interventions for RNA to provide PROM to Resident 88's right upper extremity (RUE), apply right elbow extension splint and right resting hand splint for 4 to 6 hours. During a review of Resident 88's RNA Documentation Survey Report dated September 2025, the report indicated that RNA services PROM to RUE, right elbow splint and right resting hand splint for Resident 88 started on 9/25/2025. During a concurrent interview and record review on 10/1/2025 at 10:13 AM with the Director of Rehab Services/Occupational Therapist (OTD), Resident 88's Electronic Health Record (EHR) under order summary report and RNA Documentation report were reviewed. OTD stated that there was an order 9/2/2025 for PROM to Resident 88's right upper extremity, right elbow splint and right resting hand splint should have started on 9/3/2025. OTD stated that the RNA Documentation report indicated RNA services started on 9/25/2025 which reflected a 22-day delay in ROM services. The OTD stated she was not informed of the delay during weekly meetings with the RNA. The OTD stated the delay placed Resident 88 at risk for joint stiffness, decreased mobility, and potential progression of contractures. During a concurrent interview and record review on 10/1/2025 at 10:36 AM with RNA 1, Resident 88's Electronic Health Record (EHR) under order summary report and RNA Documentation report were reviewed. RNA 1 stated that Resident 88 had an order for RNA to provide PROM, right elbow splint and right resting hand splint on 9/2/2025. RNA 1 stated that treatment should have begun on 9/3/2025 and stated that there was a 22-day delay and reported being unable to recall why services were not (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide a safe and hazard free environment to ensure electrical and extension cord devices were safely used for one of 1 of 8 sampled residents (Resident 75). This deficient practice has the potential to result in fire at the facility, electrical shock, and burns that could lead to residents' hospitalization and deaths. During a review of Resident 75's admission Record (AR), the AR indicated the resident was admitted on [DATE] with diagnoses including intervertebral disc degeneration(the cushions between the discs in your spine wear out and become thinner causing pain and irritation to nearby nerves) , urinary tract infection and dependence on supplemental oxygen (extra oxygen given to person when their body isn't getting enough on its own helping them breath better and keeps their oxygen levels in a safe range). During a review of Resident 75's Minimum Set Data (MDS- a resident assessment tool) dated 07/8/2025, the MDS indicated Resident 75 had a brief interview for mental status (BIMS) score of 15 indicating resident's cognition (thinking) is intact. The MDS indicated that the resident requires partial to moderate assistance (the helper dose less than half the effort , lifting, holding, or supporting the trunk or limbs) when performing tasks such as toileting hygiene, shower/ bathe self, upper body dressing, lower body dressing, putting on / taking off footwear and personal hygiene. During an observation on 09/29/2025 at 12:05 PM in Resident 75's room, Resident 75 was observed sitting on the bed. An electrical extension cord and power strip (an electrical device with a cord that has multiple outlets on one end, used to increase the number of devices that can be plugged into a single wall socket) was observed placed directly on Resident 75's bed. The outlets on the extension cord were all in use. The power strip was positioned on Resident 75's bed, directly by Resident 75's oxygen machine and nebulizer (a machine that turns liquid medication into a fine mist or aerosol for inhalation, allowing it to go deep into the lungs). During a concurrent observation and interview on 09/29/2025 at 12:10 PM with Registered Nurse (RN) 3 in Resident 75's room, RN 1 observed Resident 1's extension cord and power strip placed directly on Resident 75's bed, close to Resident 75's oxygen and nebulizer treatment. RN 1 stated the extension cord and power strip should not be placed on Resident 75's bed, and that it was dangerous, since it was a fire hazard. During a concurrent observation and interview on 09/29/2025 at 12:17PM with Maintenance Supervisor (MS) in Resident 75's room, a power strip with multiple electrical devices plugged into it was observed. The power strip was positioned on the Resident 75's bed. MS stated the cords should not be placed on the bed and must be on the floor. MS further stated we do not keep electrical outlets or power strips on the bed, because it was dangerous since it was a fire hazard. During a review of the facility's policy and procedure (P&P) Titled, Electrical Safety for Residents, with a revision date of January 2011, the P&P indicated the resident will be protected from injury associated with the use of electrical devices, including electrocution, burns and fire. When extension cords are in use precautions must be taken to secure extension cords ensuring they cannot cause trips, falls or overheating.		

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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. Based on observations, interviews, and record review, the facility failed to implement the facility's policies and procedures, titled storage of Food and Supplies, Procedures for Refrigerated Storage, and Preventing Foodborne illness- Employee Hygiene and Sanitary Practices, professional standards of practice on food storage, food service safety, sanitation and handling practices to prevent the outbreak of foodborne illness (food poisoning) by failing to ensure: 1. Discard one jar of turmeric powder, two (2) jars of curry powder, one jar of ground cumin, two (2) jars of ground Italian seasoning, one jar of ground paprika, one jar of steak sauce, one jar of dry basil leaves, one jar of chili powder, two bags of dried shredded coconut, one bag of pancake mix, one bag of brown rice; a bag of cornflakes, one bag of pepperoni slices when expired. 2. Label and store food that indicate the use-by-date or expiration date, including: a bag of scalloped potatoes, a 64-fluid-ounce bottle of pineapple juice, instant lemon pudding out of original box, individually-wrapped graham pie crust in a opened box, three unopened bags of frozen broccoli florets out of original package, one opened bag of frozen ravioli, one bag of frozen cauliflower, one five-pound bag of frozen ground pork out of original package, and several loose individual packets of cane sugar in a bin; 3. The Kitchen staff follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. These deficient practices had the potential to result food contamination (transfer of harmful bacteria or other germs to food, surfaces, or utensils) that placed residents at risk for foodborne illness and lead to other serious medical complications and hospitalization. Findings: During an initial kitchen tour and a concurrent interview on 9/29/2025 from 8:20 AM to 9 AM with the Dietary Service Supervisor (DSS), the following were observed: In the freezer: Three unopened bags of broccoli florets out of original packaging with no expiration date. One opened bag of ravioli with no expiration date. One unopened bag of cauliflower with no received-date or use-by-date. The following jars of spices were observed on wall shelf above the sink For Veggies: Turmeric powder expired on 4/10/2025 Curry powder expired on 6/14/2025 Ground cumin expired on 4/2/2025 Another curry powder expired on 6/14/2025 Ground Italian Seasoning expired on 5/17/2025 Ground ginger expired on 6/20/2025 Ground paprika with unclear expiration date The following were observed in dry storage room: An opened bag of Pancake mix expired on 6/25/2025 An opened bag of brown rice expired on 9/25/2025 In a concurrent interview on 9/29/2025 at 9 AM, the DSS stated that dry stored, frozen foods without label lacking expiration or use-by-date were considered unsafe for resident's consumption. DSS stated according to facility policy, the kitchen staff are required to label and date foods when storing food and supply be stored properly and in a safe manner. During an observation and concurrent interview on 9/29/2025 at 9:02 AM with the Kitchen Staff (KS) 1, KS 1 was observed wearing gloves rinsing dirty dishes, then with the same gloved hands KS 1 unloaded clean dishes from sanitizing dishwasher machine without changing gloves and performing hand hygiene between tasks. KS 1 stated she should have performed hand washing and replaced with new gloves after rinsing dirty dishes and before pulling out sanitized clean dishes from dishwasher. KS 1 stated without appropriate hand hygiene residents could get sick. During an interview on 9/29/2025 at 9:05 AM with the DSS, DSS stated cross contamination (transfer of harmful substances or disease-causing microorganisms to food by hands, food contact surfaces, sponges, cloth towels, or utensils which are not cleaned after touching raw food, and then touch ready-to-eat foods) could occur and residents could get sick from using those dishes handled by KS 1 who did not change gloves and preform hand hygiene between tasks. During a review of the facility's Policy and Procedures (P&P) titled Storage of Food and Supplies dated in 2023, the P&P indicated the procedures for dry storage: Dry bulk foods (flour, sugar, dry beans, food thickener, spices, etc) should be stored in seamless metal or plastic containers with tight covers, or in bins which are easily sanitized. Bins/ containers are to be labeled, covered, and dated. Food stores should be arranged in food groups to facilitate storing, locating, and taking (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inventories. Labels should be visible, and the arrangement should permit rotation of supplies so that oldest items will be used first. All food will be dated- month, day, year. No food will be kept longer than the expiration date on the product. Dry food items which have been opened, such as pudding, gelatin, biscuit mix, pancake mix, dry cereal, spices, coffee, noodles, etc., will be tightly closed, labeled, and dated. During a review of the facility's P&P titled Procedures for Refrigerated Storage dated in 2023, the P&P indicated that individual packages of refrigerated or frozen food taken from the original packing box need to be labeled and dated. During a review of the facility's P&P titled Procedures for Freezer Storage dated in 2023, the P&P indicated that all frozen food should be labeled and dated. During a review of the facility's P&P titled Preventing Foodborne Illness- Employee Hygiene and Sanitary Practices revised in 10/2017, the P&P indicated that employees must wash their hands after handling soiled equipment or utensils.		

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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** Based on interview, and record review, the facility failed to complete an informed consent (a process of communication between a person and the health care provider that often leads to agreement or permission for care, treatment, or services) for psychotropic/psychotherapeutic (any drug that affects behavior, mood, thoughts, or perception) drug for one of two sampled resident (Resident 101) who was prescribed Ativan (a psychotropic medication used for anxiety). This deficient practice had the potential for Resident 101's rights to be violated by not being providing a complete and accurate explanation of care and treatment provided to Resident 101, in which Resident 101 fully understood the risk, benefits, and expected outcomes. During a review of Resident 101's admission Record [AR], the AR indicated Resident 101 was originally admitted to the facility on [DATE], with diagnoses that included degenerative disease of the nervous system (a progressive brain and spinal cord disease that cause cell death and lose their functions) and major depressive disorder (a feeling of constant sadness and loss of interest). During a review of Resident 101's History and Physical Examination (HP, a comprehensive physician's note regarding the assessment of the patient's health status) signed by the attending physician on 11/25/2025, the HP indicated Resident 101 did not have the capacity to understand and make decisions. During a review of Resident 101's Minimum Data Set (MDS, a resident assessment tool), dated 5/24/2025, the MDS indicated the Resident 101's cognition (thought process) was severely impaired. ^ During a review of Resident 101's Order Summary Report dated 11/8/2024, the Report indicated Resident 101 had a physician order for Ativan Oral Tablet 0.5 mg (unit of measurement) to give 0.5 mg by mouth as needed every 6 hours for anxiety manifested by irritability and easily agitated. During a review of Resident 101's Informed Consent for Psychotropic Medication, the inform consent did not indicate the licensed nurse's (LN) signature and the date the informed consent was presented to Resident 101. During a concurrent interview and record review on 11/18/2025 at 12:30 PM with the Medical Records Assistant (MRA), Resident 101's medical chart under the consent section, and electronic health record (EHR, an electronic/digital collection of medical information about a person that is stored on a computer) was reviewed. The MRA stated the informed consent form for the use of Ativan was not signed or dated by the (LN). During a concurrent interview and record review on 11/18/2025 at 1:34 PM with Registered Nurse Supervisor (RN 1), Resident 101's medical paper chart under the consent section and EHR were reviewed. RN 1 stated that the informed consent for form for Resident 101 did not have a LN's signature and the date from the licensed nurse who admitted the resident. RN 1 stated the informed consent required a licensed nurse signature to indicate that the consent information was received, and the power of attorney (POA) understood the content of the consent. RN 1 stated since the consent form did not have a date, it was difficult to verify if the information was present to the POA regarding Resident 101's medication treatment for agitation. During an interview on 11/18/2025 at 1:47 PM with the Director of Nursing (DON), the DON stated he reviewed Resident 101's medical record (paper chart and EHR) and that the informed consent for psychotropic medication did not have the LN's signature and date. The DON stated consent forms required a LN's signature and date to verify the information was acknowledged by the POA. The DON stated ensuring a LN's had signed and dated the informed consent was based on facility's policy. The DON stated that it was important for the informed consent to be completed since the consent form validated the risks and benefits while taking the psychotropic medication, Ativan, and that other alternative treatments had been provided. The DON stated, not having an informed consent for psychotropic medications violated resident rights. ^ During a review of the facility's policy and procedure (P&P) titled Psychoactive Medication Informed Consent, dated 3/2024, the P&P indicated that prior to the administration of any psychoactive medications initiated, a quick assessment and non-pharmacological interventions that have been attempted and found ineffective, an informed consent for the specific medication will be obtained by the physician and (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	verified by the nurse. The P&P indicated if the resident or resident's representative cannot sign the form, a licensed nurse can sign the form and document the name of the person who gave consent and the date. The P&P indicated the signed written consent must be recorded in the resident's medical record and before initiating treatment with psychotherapeutic drugs, facility staff shall verify that the resident's health record contains written informed consent with the required signatures.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interviews and record reviews, the facility failed to ensure one of four sampled resident (Resident 65) and her representative was assisted to formulate an Advance Directives (AD-a written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) upon admission and to complete an Advance Directive Acknowledgement (ADA a document where a person confirms they have received information about their right to create an advance directive and understand their options for future medical decisions) form timely. This deficient practice had the potential to cause conflict with Resident 65's wishes regarding health care treatment especially in an event of emergency. During a review of Resident 65's admission Record (AR), the AR indicated the facility admitted Resident 65 on 9/10/2025 with diagnoses that included Parkinson's disease (a progressive brain disorder that affects movement and can lead to symptoms like tremors, balance problems, and stiffness) and hypertension (high blood pressure). During a review of Resident 65's Minimum Data Set (MDS, a assessment tool), dated 9/13/2025, the MDS indicated Resident 65 had moderately impaired cognition (ability to understand and make decisions) and memory. The MDS indicated Resident 65 was dependent on eating, oral hygiene, toileting hygiene, personal hygiene and shower/bathe self. During a review of Resident 65's ADA form, dated 9/15/2025, the ADA was incomplete since the ADA did not indicate Resident 65's name, attending physician, date of admission, medical records number, and the name of facility. The ADA also indicated Resident 65's Responsible Party (RP) did not initial on the following statements indicated on the ADA form: 1. I have been given written material and informed about my right to accept or refuse medical treatment. 2. I have been informed of my rights to formulate Advance Directives. 3. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility. 4. I understand that the terms of any Advanced Directives that I executed will be followed by the health care facility and my caregivers to the extent permitted by law. The ADA indicated Resident 65's RP did not checkmark on the form that he decline to execute an Advance Directive or wish to execute an Advance Directive. During a concurrent interview and record review on 9/29/2025 at 3:57 PM with the Social Service Director (SSD), Resident 65's ADA, dated 9/15/2025, was reviewed. The SSD stated she was responsible for explaining and assisting the residents with their AD. The SSD stated although RP signed and marked Resident 65 have not executed an Advance Directive on the ADA form, the ADA form was incomplete since, Resident 65's information acknowledging he was informed about their rights, and his decision on the AD was not indicated by a checkmark. The SSD stated the facility had the interdisciplinary team (IDT, a group of professionals from different fields who collaborate to work on a common goal by integrating their knowledge and methods) meeting Resident 65's RP on 9/15/2025, but SSD could not state whether staff explained to the RP about the resident's right to accept or refuse medical treatment and to formulate an AD during the IDT meeting. SSD stated not knowing if a follow up with Resident 65's RP was required to execute Resident 65's AD. The SSD stated it was important to complete the ADA forms in its entirety with Resident 65's information to ensure everyone would know the ADA form belonged to that specific resident, and to prevent confusion of care. The SSD stated it was also important to inform the residents and the RP about their rights to formulate an AD and complete the ADA form to ensure the facility staff follow the residents' wishes at the time of emergency. The SSD stated because Resident 65's ADA was incomplete; she must contact the RP to make sure he was informed about their rights and decision on the AD. During an interview on 11/18/2025 at 3:15 PM with the SSD, the SSD stated she called and spoke with the RP and explained to Resident 65's RP about the right to formulate and execute an Advance Directive. SSD stated Resident 65's ADA form was completed on 9/29/2025. The SSD stated it is important to inform the residents and the RP about their rights and complete the ADA form timely and accurately. During a (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop a base line comprehensive person-centered care plan for one of three residents (Resident 61), who was identified as having dental problems and required change in texture of to be able to chew food effectively. This deficient practice had the potential to delay care and services to Resident 61 and could negatively impact Resident 61's health and lead to nutritional problems. Cross reference to F791 Findings: During a review of Resident 61's admission record (AR), the AR indicated that the facility originally admitted Resident 61 on 9/21/2021 and recently readmitted her on 8/23/2025, with diagnoses including hypertensive heart disease (heart problems that occur because of high blood pressure that is present over a long time), anemia (a condition where the body does not have enough healthy red blood cells), and chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing.) During a review of Resident 61's Minimum Data Sheet (MDS- a Federally mandated resident assessment tool) dated 10/3/2025, the MDS indicated Resident 61 as having moderately impaired cognition (decision poor; cues/supervision required) that required supervision or touching assistance (helper provides verbal cues and/or contact guard assistance as resident completes activity) on oral hygiene and personal hygiene. The MDS also indicated that Resident 1 required change in texture of food or liquids while being a resident of the facility. During a review of Resident 61's Dental Progress Notes (DPN) dated 9/25/2025, the DPN indicated to resubmit treatment authorization request (TAR) for proposed/ recommended treatment plan. The DPN also acknowledged that Resident 61 requested dentures to replace missing teeth for mastication (the process of chewing food). During a review of Resident 61's History and Physical (H&P) dated 10/22/2025, the H&P indicated that Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 61's DPN dated 10/23/2025, the DPN indicated the following: Recommend 3PA's (three periapical [PA] X-rays) and 2BW's (two-film bitewing X-ray) dental x-rays for definitive diagnosis. Recommend oral prophylaxis for oral hygiene and for periodontal health. Recommend composite filling (a dental restorative material that comprises a mixture of plastic resin and powdered glass filler) on tooth #22 due to decay beyond dentine-enamel junction (a natural junction that unites two mechanically dissimilar calcified tissues of the tooth) Recommend full upper and partial dentures lower for mastication. Recommend extraction of root fragments #20&21 on emergency basis or if dentures are to be fabricated. During a review of Resident 61's Comprehensive Care Plan, there was no documented evidence indicating a care plan was developed to address Resident 61's need for dentures and concerns with chewing food. During an observation and concurrent interview on 11/18/2025 at 10:50 AM, Resident 61 was observed with missing teeth on the upper and lower. Resident 61 stated that she has been asking he social worker and the dentist that she needed dentures. Resident 61 stated it's been a long time (she referred months) since she asked and dentist had come but she never got an update as to the progress about her dentures. Resident 61 stated she felt forgotten. During a concurrent record review and an interview on 11/18/2025 at 11:20 AM with the Licensed Vocational Nurse (LVN) 2, LVN 2 stated that she could not find a care plan developed for Resident 61's issues about teeth or dentures. During a concurrent record review and an interview on 11/18/2025 at 12 PM with the Social Service Director (SSD), SSD stated she could not find a care plan in relation to Resident 61's problems about her teeth or needing a denture. , and IDT (Interdisciplinary teams- a group of professional and direct care staff for program, planning, and coordinating care) did not ask her to assist with developing a care plan. During a concurrent record review and an interview on 11/18/2025 at 3:20 PM with RN 1, RN 1 stated that she could not find a care plan developed for Resident 61's issues about teeth or dentures. RN 1 stated any staff who identified Resident 61's dental issues should have developed a care plan so interventions for Resident 61's needs would have been implemented and kept up to date. During an interview on 11/19/2025 at (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Chestnut Ridge Post Acute LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 525 South Central Avenue Glendale, CA 91204	
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:50 AM with the Director of Nursing (DON), the DON stated a comprehensive care plan was necessary to reflect a resident's needs being identified, person-centered care plan being developed, and the interventions being carried out and followed up timely. The DON stated the IDT team should have developed a care plan so they could communicate better and work together to address Resident 61's denture issues. During a review of the facility's policy and procedures (P&P) titled Care Plans, Comprehensive Person-Centered revised in 3/2022, the P&P indicated that 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. The P&P also indicated that the comprehensive, person-centered care plan will be: a. Measurable objectives and timeframes. b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. c. Include the resident's stated goals upon admission and desired outcomes. d. Build on the resident's strengths; and e. Reflect currently recognized standards of practice for problem areas and conditions.		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide medically-related social service in accordance with the facility's policy and procedure titled Social Services for one of three sampled residents (Resident 61), who had missing teeth and had requested new dentures (removable oral appliances that replace missing teeth). The Social Service Designee (SSD) failed to follow up with the dentist's recommendation to have a dental hygiene prior to obtaining new dentures for Resident 61. As a result of this deficient practice, Resident 61 did not receive new dentures and leaving Resident 61 to remain with difficulty chewing with the remaining teeth. Cross reference to F791 Findings: During a review of Resident 61's admission record (AR), the AR indicated that the facility originally admitted Resident 61 on 9/21/2021 and recently readmitted her on 8/23/2025, with diagnoses including hypertensive heart disease (heart problems that occur because of high blood pressure that is present over a long time), anemia (a condition where the body does not have enough healthy red blood cells), and chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing). During a review of Resident 61's Social Service History and Initial Assessment (SSHIA) dated 8/26/2025, the SSHIA indicated that Resident 61 having dental problems with broken teeth and needing to see a dentist were acknowledged by the social service director (SSD). During a review of Resident 61's hand-written Dental Progress Notes (DPN) dated 9/25/2025, the DPN indicated to resubmit treatment authorization request (TAR) for proposed/ recommended treatment plan. The DPN also acknowledged that Resident 61 requested dentures to replace missing teeth for mastication (the process of chewing food). During a review of Resident 61's Minimum Data Sheet (MDS- a Federally mandated resident assessment tool) dated 10/3/2025, the MDS indicated Resident 61 as having moderately impaired cognition (decision poor; cues/supervision required). The MDS indicated that Resident 61 required supervision or touching assistance (helper provides verbal cues and/or contact guard assistance as resident completes activity) on oral hygiene and personal hygiene. The MDS also indicated that Resident 1 required change in texture of food or liquids while being a resident of the facility. During a review of Resident 61's hand-written DPN dated 10/23/2025, the DPN indicated Annual Exam and the following: 1.Recommend 3PA's (three periapical [PA] X-rays) and 2BW's (two-film bitewing X-ray) dental x-rays for definitive diagnosis. 2. Recommend oral prophylaxis for oral hygiene and for periodontal health. 3.Recommend composite filling (a dental restorative material that comprises a mixture of plastic resin and powdered glass filler) on tooth # (Number) 22 due to decay (damage to a tooth's surface) beyond [NAME]-enamel junction (a natural junction that unites two mechanically dissimilar calcified tissues of the tooth). 4.Recommend full upper and partial dentures lower for mastication. 5.Recommend extraction of root fragments #20&21 on emergency basis or if dentures are to be fabricated (made). During a review of Resident 61's Social Service Progress Notes (SSPN) dated from 8/23/2025 to 11/17/2025, there was no documented evidence in the SSPN indicating any follow up regarding resubmission of TAR or the recommendations (listing above) indicated in the DPN. There was no documented evidence in the SSPN indicated any conversation with Resident 61 regarding concerns or updates about dentures. During an observation and a concurrent interview on 11/18/2025 at 11:20 AM, Resident 61 was observed to have several missing teeth on both upper and lower gums. Resident 61 stated that she needed new dentures to chew food and spoke to social services as well as the dentist many times but never got response. Resident 61 stated she felt forgotten. During an interview on 11/18/2025 at 1:25 PM with the SSD, SSD stated she was aware that Resident 61 asked for new dentures. SSD stated nurses are responsible for reading dentist notes but she was responsible for follow-ups with nurses. SSD stated she did not check with Resident 61 if Resident 61 was informed about dentist's recommendations. SSD stated she did not refer any X-ray exams or schedule treatment for Resident 61's tooth decay as (continued on next page)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommended in the DPN. SSD stated she could not provide documents indicating her follow-up call with the dentist's clinic about the update of dental insurance application for Resident 61. SSD stated she did not schedule any future appointment with the dentist for Resident 61 since after 10/23/2025. SSD also stated she did not have any plan for Resident 61 to have dentures fabricated and she had not developed a care plan in regard to Resident 61's dental issues. During an interview on 11/18/2025 at 2:10 PM with Registered Nurse (RN) 1, RN 1 stated SSD did not inform her when they placed the hand-written DPN in the resident's chart. RN 1 stated she and the social services were responsible for following up on the DPN's recommendations and follow up with the dentist for ordering exams or treatments. RN 1 stated resident's oral hygiene was important for each individual and the facility should provide care and referral to protect resident's oral health. During a review of the facility's policy and procedures (P&P) titled Social Services revised in 9/2021, the P&P indicated the following: 1.The director of social services is a qualified social worker and is responsible for meeting or assisting with the medically-related social service needs of residents. 2. Medically-related social services are provided to maintain or improve each resident's ability to control everyday physical needs (e.g. appropriate adaptive equipment for eating) and mental and psychosocial needs. 3. Obtaining or attempting to obtain medically-related social services on behalf of a resident are not contingent upon Medicaid coverage of needed services. During a review of the facility's Job Description (JD) titled Social Service Director, the JD indicated duties and responsibilities including: 1.Develops and maintains plan of care in conjunction with facility interdisciplinary team. 2. Ensures ongoing evaluations for dental, vision, and mental health exams and follow up. 3.Works with facility consultants as necessary and implements recommended changes as required. Ensures outside services are properly supervised and completed in accordance with contracts/ work orders. 4. Ensures documentation is accurate informative and descriptive of the care provided and the resident's response to the care. 5. Keep abreast of current federal and state regulations, as well as professional standards.		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interview, and record review, the facility failed to provide necessary dental care services to one of one sampled resident (Resident 61) who was not assisted to receive dental care as recommended by the dentist due to missing teeth and dental cavities and difficulty chewing food. As a result of these deficient practices Resident 61 had the potential for nutrition deficit, weight loss, choking due to difficulty chewing and pain due to untreated dental cavities. Findings: During a review of Resident 61's admission record (AR), the AR indicated that the facility originally admitted Resident 61 on 9/21/2021 and recently readmitted her on 8/23/2025, with diagnoses including hypertensive heart disease (heart problems that occur because of high blood pressure that is present over a long time), anemia (a condition where the body does not have enough healthy red blood cells), and chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing.) During a review of Resident 61's Minimum Data Sheet (MDS- a Federally mandated resident assessment tool) dated 10/3/2025, the MDS indicated Resident 61 as having moderately impaired cognition (decision poor; cues/supervision required) that required supervision or touching assistance (helper provides verbal cues and/or contact guard assistance as resident completes activity) on oral hygiene and personal hygiene. The MDS also indicated that Resident 1 required change in texture of food or liquids while being a resident of the facility. During a review of Resident 61's Dental Progress Notes (DPN) dated 9/25/2025, the DPN indicated to resubmit treatment authorization request (TAR) for proposed/ recommended treatment plan. The DPN also acknowledged that Resident 61 requested dentures to replace missing teeth for mastication (the process of chewing food). During a review of Resident 61's History and Physical (H&P) dated 10/22/2025, the H&P indicated that Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 61's DPN dated 10/23/2025, the DPN indicated the following: Recommend 3PA's (three periapical [PA] X-rays) and 2BW's (two-film bitewing X-ray) dental x-rays for definitive diagnosis. Recommend oral prophylaxis for oral hygiene and for periodontal health. Recommend composite filling (a dental restorative material that comprises a mixture of plastic resin and powdered glass filler) on tooth #22 due to decay beyond dentine-enamel junction (a natural junction that unites two mechanically dissimilar calcified tissues of the tooth) Recommend full upper and partial dentures lower for mastication. Recommend extraction of root fragments #20&21 on emergency basis or if dentures are to be fabricated. During a review of Resident 61's Social Service Progress Notes (SSPN) dated from 8/23/2025 to 11/17/2025, there was no documented evidence in the SSPN indicating any follow up regarding dentures and/or dentist's recommendations indicated in DPN. During an observation and concurrent interview on 11/18/2025 at 10:50 AM, Resident 61 was observed with missing teeth on the upper and lower. Resident 61 stated that she has been asking he social worker and the dentist that she needed dentures. Resident 61 stated it's been a long time (she referred months) since she asked and dentist had come but she never got an update as to the progress about her dentures. Resident 61 stated she felt forgotten. During a concurrent record review and an interview on 11/18/2025 at 11:20 AM with the Licensed Vocational Nurse (LVN) 2, LVN 2 stated that Resident 61 never wore a denture, and LVN 2 stated never heard from social worker that Resident 61 asked for dentures. During an interview on 11/19/2025 at 11:50 AM with the Director of Nursing (DON), the DON stated she and the IDT team should have could have communicated better and work together to address Resident 61's denture issues.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to implement infection control measures for two of eight sampled residents (Resident 75 and Resident 83) by failing to: 1.Ensure Resident 75's respiratory equipment was properly labeled and stored in a plastic bag with the resident's name and the date the tubing was changed. 2. Ensure Resident 83's Peripherally inserted Central Catheter ICC a long, thin tube inserted into a vein in the upper arm that extends to a large vein near the heart.)) site was labeled with the date of the last dressing (typically a transparent, secure, and often antimicrobial dressing that protects the insertion site from infection) change. These deficient practices had the potential to place Resident 75 and Resident 83 at risk for infection. During a review of Resident's 75's admission Record (AR), the AR indicated Resident 75 was admitted to facility on 01/26/2024, with a diagnosis of intervertebral disc degeneration (a condition where the discs between your spine's bones begin to wear down over time) , urinary tract infection (when bacteria gets into the urinary tract and starts to multiply) , chronic obstructive pulmonary disease (a group of lung conditions where air has trouble getting out of the lungs). During a review of Resident 75's Order Summary Report dated 09/25/2025, the Report indicated Albuterol Sulfate (medication used to relax muscles around the airways and improve breathing for individuals with lung conditions) inhalation Nebulization Solution 0.63 milligrams (mg a unit of measurement) per 3 milliliter (ml- A unit of measurement) 1 vial inhale orally via nebulizer (a small machine that turns liquid medicine into a mist that can be easily inhaled) every 2 hours as needed for Shortness of breath. A review of Resident 75's Minimum Data Set (MDS -a resident assessment tool) dated 07/08/ 2025, the MDS indicated the resident has no significant cognitive impairment (can understand, remember and make decisions appropriately) and requires partial assistance meaning the helper does less than half the effort with lift, hold or supports trunk or limbs for most activities such as toileting hygiene, showering, and dressing. During a review of Resident 83's AR, the AR indicated Resident 83 was admitted readmitted to facility on 09/24/2025 with a diagnosis of metabolic encephalopathy (a change in mental status due to a medical issue like infection, dehydration, low oxygen) , type 2 diabetes mellitus (chronic condition where the body does not use insulin properly) , epilepsy (when brain has moments where its electrical signals misfire, causing a seizure) , and heart failure (when the heart is not pumping blood as well as it should). During a review of Resident 83's H&P dated 6/6/2025, H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 83's MDS dated [DATE], MDS indicated the resident has moderate to severe cognitive impairment with decreased memory and impaired decision making requiring increased supervision and assistance with daily activities such as personal hygiene, dressing, and toileting. During an observation on 09/29/2025 at 10:15 AM in Resident 83's room, Resident 83 was observed with a PICC on the right forearm. The PICC line was covered with a dressing, and the dressing was not dated. During a concurrent observation and interview on 9/29/2025 at 10:35 AM with Registered Nurse (RN) 2 in Resident 83's room, Resident 83's PICC line dressing was observed. RN1 stated the PICC line site should have a date and time indicated on the dressing to determine when the next dressing change should be done. RN 1 stated changing the PICC line dressing was important to prevent possible infections. During an observation on 9/29/2025 at 12:05 PM in Resident 75's room, Resident 75's breathing treatment mask (a medical device that covers a patient's nose and mouth to facilitate the delivery of various respiratory therapies, such as medication in the form of a mist (aerosol therapy) or concentrated oxygen) was observed without a date or name, to indicated who the mask belonged to or when the mask needed to be changed. During a concurrent observation and interview on 9/29/2025 at 12:10 PM with Registered Nurse (RN) 3 in resident 75's room, a breathing treatment mask and tubing were observed. RN2 stated Resident 75's breathing mask should be dated to ensure staff know when the equipment needs to be changed. RN 2 stated not labeling (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 75's mask with the name and date was an infection control issue. During a concurrent observation and interview on 11/19/2025 at 2:20 PM with the Director of Nursing (DON), an observation of a photograph of Resident 83's PICC line site was made. The photograph showed no date or staff initials on the PICC line dressing. The DON stated the PICC line dressing should include the date to indicate when the last dressing change occurred. The DON further state that at the time of admission, it is the RN's responsibility to obtain or request information regarding the resident's most recent PICC line dressing change. DON stated Resident 83's undated PICC line dressing was an infection control issue. A review of the facility's policy and procedure dated 2010, titled Administering medications through a Small Volume (Handheld) Nebulizer, indicated the purpose of the procedure is to safely and aseptically administer aerosolized particle of medication into the resident's airway. Steps in the procedure shall include storing the equipment in a plastic bag with the resident's name and the date on it. To change the equipment and tubing every seven days. A review of the facility's policy and procedure titled Peripheral and Midline IV Dressing Changes, revised March 2022, indicated the purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter related infections associated with contaminated, loosened or soiled catheter - site dressings. The P&P indicated to maintain sterile dressing (transparent semi-permeable membrane [TSM] dressing or sterile gauze) for all peripheral catheter sites. The P&P indicated to changes the dressing at least every 7 days for TSM dressing and at least every two days for sterile gauze dressing. The P&P indicate to check expiration dates of dressing.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to maintain a safe and sanitary environment for one of three sampled residents (Resident 74); by failing to ensure Resident 74's room was clean and free from stains and dust. 1. Resident 74's room was observed with more than one brown stains on the wall in 2. Resident 74's exhaust vent (a mechanical device designed to pull stale or polluted indoor air out of a room and expel it outdoors) was observed covered in dust. These deficient practices had the potential to result in Residents' discomfort. During a review of Resident 74's admission Record (AR), the AR indicated the facility originally admitted Resident 74 on 9/1/2023 and readmitted on [DATE] with diagnoses that included dementia (an overall term for a decline in mental ability that affects memory, thinking, and daily activities, not a specific disease itself) and type II diabetes mellitus (a condition that happens when your blood sugar is too high). During a review of Resident 74's Minimum Data Set (MDS, a resident assessment tool), dated 8/19/2025, the MDS indicated Resident 74 had moderately impaired cognition (ability to understand and make decisions) and memory. The MDS indicated Resident 74 required setup or clean-up assistance with eating, oral hygiene, toileting hygiene, personal hygiene and chair/bed-to-chair transfer, and supervision or touching assistance with shower/bathe self. During a concurrent observation and interview on 9/29/2025 at 9:53 AM with Resident 74, Resident 74's room was observed with dry brown stains on the wall and dust was covering the exhaust vent in Resident 74's room. Resident 74 stated the brown stains were already on the wall when Resident 74 moved into the room. Resident 74 stated she has not seen anyone clean the vent on the wall that was covered in dust. Resident 74 stated the room was not clean and she did not feel comfortable. During a concurrent observation and interview on 9/29/2025 at 9:56 AM with Maintenance Assistant (MA) 1, MA 1 stated the multiple dry brown stains on the wall were coffee stains. MA 1 stated the exhaust vent in Resident 74's room was dusty. MA 1 stated housekeeping staff were supposed to remove the stains on the wall and clean the exhaust vent cover. During a concurrent observation and interview on 9/29/2025 at 10 AM with Housekeeper (HK) 1, HK 1 stated the HK did not clean the wall to remove the stains on Resident 74's wall and did not clean the dusty vent. HK 1 stated he was not sure for how long the stains had been on the wall and when was the last time they cleaned the exhaust vent cover in Resident 74's room. During an interview on 9/29/2025 at 11:36 AM with the Housekeeper Supervisor (HKS), the HKS stated the housekeepers did not clean the wall and the exhaust vent cover in Resident 74's room. The HKS stated the housekeepers should clean every room every day and check if the wall and the vent cover was clean. HKS stated it was important to keep each resident and to provide a sanitary environment for all the residents at the facility. During a review of the facility' policy and procedures (P&P) titled, Homelike Environment, dated 2/2021, the P&P indicated Residents are provided with a safe, clean, comfortable and homelike environment.		