STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055288	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Hills Health Care Center	430 N.Glendale Ave Glendale, CA 91206

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. 44429 Based on interview and record review, the facility failed to report an incident of unusual occurrence to the California Department of Public Health (CDPH) according to the facility ' s policy and procedure for one of three sampled residents (Resident 1). This deficient practice resulted in the facility underreporting allegations of abuse and placing Resident 1 at risk for further abuse. Findings: During a review of Resident 1 ' s Admission Record (AR), the AR indicated the facility admitted the resident on 11/14/2022, with a diagnosis of major depressive disorder (a persistent feeling of sadness and loss of interest) and paraplegia (loss of muscle function that affects the legs). During a review of Resident 1 ' s History and Physical Examination (HPE, a comprehensive physician ' s note regarding the assessment of the resident ' s health status) dated 9/25/2024, indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set (MDS, a federally mandated assessment tool) dated 9/12/2024, indicated the resident ' s cognition (thought process) was intact. During a review of Resident 1 ' s Situation, Background, Assessment, Recommendation (SBAR) Communication Form and Narrative Note dated 9/4/2024 at 10:52PM, indicated two police officers (PO) came to the facility and stated that Resident 1 reported that she was mistreated by certified nurse assistant (CNA) 1. The SBAR indicated the PO reported to the facility that CNA 1 pointed his fingers, like a gun, to Resident 1, and that Resident 1 stated feeling threatened. The SBAR indicated PO spoke to Family Member (FM) 1 and the facility notified the Medical Director (MD) 1. There was no indication on the SBAR that the facility reported the incident to CDPH. (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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(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 1 ' s Investigation Summary (IS) dated 9/5/2024, the IS indicated that Resident 1 called for transportation and went to the police department (PD) on 9/4/2024. The IS indicated that Resident 1 reported to the PD that she did not feel safe because Resident 1 alleged CNA1 was carrying a gun in the facility. The IS indicated CNA1 gave Resident 1 a candy for Valentine ' s Day on 2/14/24, and Resident 1 felt special. The IS indicated a misunderstanding between Resident 1 and CNA 1 ' s reasoning for giving Resident 1 a candy. The IS indicated Resident 1 wanted to punish CNA1 therefore, made a false report to the PD, since Resident 1 ' s expectation between her and CNA 1 was not met. During a review of Resident 1 ' s Interdisciplinary Team (IDT) Conference Record dated 9/6/2024, indicated that Resident 1 ' s FM 1 asked the facility if any report was made to the California Department of Public Health (CDPH) regarding the unusual occurrence (Resident 1 making a false allegation to the PD regarding CNA1). The IDT record indicated that the Administrator (ADM) told FM 1 that no report was made to CDPH because Resident 1 was alert and oriented and she had never complained of any staff or reported any unusual occurrence. The IDT indicated ADM asked Resident 1 if she had experienced any issues while in the facility, the Record indicated Resident 1 felt mistreated by CNA 1. The recordindicated that Resident 1 felt rushed by CNA1 during a bed transfer, and that juice spilled all over Resident 1. The IDT indicated Resident 1 made false allegations against CNA1, however, the Record did not indicate why Resident 1 made the false allegations. During a review of Resident 1 ' s Psychology Intake Note (PIN) dated 9/6/2024, indicated Resident 1 was evaluated since Resident 1 reported to the police department regarding CNA 1 carrying a gun while in the facility. The PIN indicated Resident 1 was feeling down and was sad and felt lonely. During an interview on 10/2/2024 at 9:31AM with Resident 1, Resident 1 stated CNA 1 had mistreated her by cursing at me and not giving me care. Resident 1 stated she had called the police and that the police did nothing to punish CNA1. Resident 1 stated the mistreatment from CNA 1 began in February, but she did not want to report it in fear of retaliation, so Resident 1 waited until 9/4/24, when she spoke with the police. Resident 1 stated that the staff would gossip about her stating that she had feelings for CNA 1 and that she was jealous because CNA 1 gave more attention to other female residents and not enough to Resident 1. Resident 1 stated that CNA 1 had feelings for her since CNA1 gave a valentine ' s day chocolate on Valentine ' s Day which indicated I LUV YOU. Resident 1 stated that after she had called the police on CNA 1, and ADM changed her room and only allowed female CNAs to care for Resident 1. Resident 1 stated feeling discriminated against that only female CNA care for her and no more male CNA. During an interview on 10/2/2024 at 11:48AM with SSD, SSD stated that Resident 1 requested transportation on 9/4/2024 and went to the police department. SSD stated two PO came to the facility to investigate Resident 1 ' s allegation that CNA 1 had a gun in his possession while working at the facility. SSD stated an IDT was conducted on 9/5/2024 with FM 1. SSD stated that Resident 1 had withdrew the false allegation she made with the police Regarding CNA1 carrying a gun while at work. SSD stated since Resident 1 ' s allegation, the IDT ' s intervention included for Resident 1 to be only taken care of by female CNA ' s. SSD stated the incident of Resident 1 going to the police department and reporting CNA1 was in possession of a gun, and then retracting her statement was not reported to California Department of Public Health. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/2/2024 at 12:09PM with the Director of Nurses (DON), DON stated that Resident 1 filed a report to the PD to punish CNA1. The DON stated Resident 1 reporting the false allegation to the PD, and the PO coming to the facility was an unusual occurrence. The DON stated the facility had not reported the incident of unusual occurrence to CDPH. During an interview on 10/2/2024 at 3:15PM with CNA 1, CNA 1 stating caring for Resident 1 on more than one occasion. CNA1 stated care provided to Resident 1 took more time than other residents, since Resident 1 was very demanding. CNA1 denied any inappropriate behavior towards Resident 1, however could not state why Resident 1 reported to the PD alleging CNA1 had a gun in the facility. During a phone interview on 10/2/2024 at 3:36PM with FM 1, FM 1 stated Resident 1 had complained about CNA1 being rough. FM 1 stated that the facility should have reported the incident of Resident 1 making false allegations to the PD about CNA1 to CDPH and that the facility should have done a better job on investigating the incident between Resident 1 and CNA1. During a review of the facility ' s P&P titled Abuse Investigation & Reporting dated 4/22/2024, the P&P indicated all allegations of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (Abuse) shall be promptly reported to the appropriate local, state and/or federal agencies (as defined by current regulations) and thoroughly investigated by Company management. Findings of abuse investigations will also be reported to local law enforcement and the Office of Ombudsman. The P&P indicated if an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual. The P&P indicated all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the Company Administrator, or his/her designee, to the following persons or agencies: The State licensing/certification agency responsible for surveying/licensing the facility; the local/State Ombudsman. The P&P indicated an alleged violation of abuse, neglect, exploitation, or mistreatment (Including Injuries of unknown source and misappropriation of resident property) will be reported Immediately, but not later than: Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or Twenty-four (24) hours If the alleged violation does not Involve abuse AND has not resulted in serious bodily injury

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(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 - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 44429 Based on interview and record review, the facility failed to develop a resident- centered care plan for one of three sampled residents. This deficient practice had the potential to delay care and services provided to Resident 1 according to Resident 1 ' s specific needs. Findings: During a review of Resident 1 ' s Admission Record (AR), the AR indicated the facility admitted the resident on 11/14/2022, with a diagnosis of major depressive disorder (a persistent feeling of sadness and loss of interest) and paraplegia (loss of muscle function that affects the legs). During a review of Resident 1 ' s History and Physical Examination (HPE, a comprehensive physician ' s note regarding the assessment of the resident ' s health status) signed by the attending physician on 9/25/2024, the HPE indicated that Resident 1 had the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set (MDS, a federally mandated assessment tool) dated 9/12/2024, indicated the resident ' s cognition (thought process) was intact. During a review of Resident 1 ' s Situation, Background, Assessment, Recommendation (SBAR) Communication Form and Narrative Note dated 9/4/2024 at 10:52PM, indicated two police officers (PO) came to the facility and stated that Resident 1 reported that she was mistreated by certified nurse assistant (CNA) 1. The SBAR indicated the PO reported to the facility that CNA 1 pointed his fingers, like a gun, to Resident 1, and that Resident 1 stated feeling threatened. The SBAR indicated PO spoke to Family Member (FM) 1 and the facility notified the Medical Director (MD)1. During a review of Resident 1 ' s Investigation Summary (IS) dated 9/5/2024, the IS indicated that Resident 1 called for transportation and went to the police department (PD) on 9/4/2024. The IS indicated that Resident 1 reported to the PD that she did not feel safe because Resident 1 alleged CNA1 was carrying a gun in the facility. The IS indicated CNA1 gave Resident 1 a candy for Valentine ' s Day on 2/14/24, and Resident 1 felt special. The IS indicated a misunderstanding between Resident 1 and CNA 1 ' s reasoning for giving Resident 1 a candy. The IS indicated Resident 1 wanted to punish CNA1 therefore, made a false report to the PD, since Resident 1 ' s expectation between her and CNA 1 was not met. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Interdisciplinary Team (IDT) Conference Record dated 9/6/2024, indicated that Resident 1 ' s FM 1 asked the facility if any report was made to the California Department of Public Health (CDPH) regarding the unusual occurrence (Resident 1 making a false allegation to the PD regarding CNA1). The IDT record indicated that the Administrator (ADM) told FM 1 that no report was made to CDPH because Resident 1 was alert and oriented and she had never complained of any staff or reported any unusual occurrence. The IDT indicated ADM asked Resident 1 if she had experienced any issues while in the facility, the Record indicated Resident 1 felt mistreated by CNA 1. The recordindicated that Resident 1 felt rushed by CNA1 during a bed transfer, and that juice spilled all over Resident 1. The IDT indicated Resident 1 made false allegations against CNA1, however, the Record did not indicate why Resident 1 made the false allegations. During a review of Resident 1 ' s Psychology Intake Note (PIN) dated 9/6/2024, indicated Resident 1 was evaluated since Resident 1 reported to the police department regarding CNA 1 carrying a gun while in the facility. The PIN indicated Resident 1 was feeling down and was sad and felt lonely. During a review of Resident 1 ' s Care Plan titled Mood State initiated on 9/12/2024, the care plan indicated the following information: Resident 1 has feelings toward male CNA, she believes she fell in love. The care plan goal was to identify the underlying cause of mood disorder. The care plan approach was to encourage family/friend ' s visits. During a review of Resident 1 ' s medical records on 10/2/24, there was no care plans indicating the specific incident of Resident 1 reporting to the police that CNA1 had a gun, or any indication of Resident 1 ' s incident of false allegation about CNA1. During an interview on 10/2/2024 at 12:09PM with the Director of Nursing (DON), DON stated that that Resident 1 had feelings for CNA 1 and then she contacted the police, filed a false report to punish CNA 1 because she was jealous that CNA 1 was giving more attention to female staff and residents. The DON stated a care plan should have been initiated regarding the incident of false allegation against CNA1 from Resident 1. The DON stated care plans were important to address residents ' specific needs and goals for treatment. During a review of the facility ' s P&P titled Comprehensive Plan of Care dated 10/23/2023, indicated that each resident will have a comprehensive care plan developed that includes goals, measurable objectives, and timetables to meet their medical, nursing, mental, and psychosocial needs identified during the comprehensive assessment. The P&P indicated the comprehensive care plan must describe services that are provided to the resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.