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	02/26/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 1) was free from physical abuse in accordance with the facility's Policy and Procedure, titled Abuse and Neglect Clinical Protocol, by failing to: 1.Identify physical abuse after Physical therapist (PT) 1 slapped Resident 1 on the right thigh on 2/23/2026. 2. Implement abuse protocols by not immediately reporting the incident to the Administrator (ADM). 3. Monitor Resident 1 immediately after the incident occurred on 2/23/2026. 4. Protect Resident 1 from PT 1 after PT 2 witnessed PT 1 slap Resident 1 on the right thigh and PT 2 continued to provide physical therapy services to Resident 1while PT 1 remained in the therapy room. These failures resulted in Resident 1 being slapped on the right thigh by PT 1 and verbalized feelings of being shocked and upset, and for Resident 1 to not be immediately protected by the facility from PT 1. During a review of Resident 1's admission Record (AR) , the AR indicated the facility admitted the resident to the facility on [DATE], with a diagnosis including Hemiplegia (complete paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a cerebral infarction (a blood clot or blocked blood vessel stops oxygen from reaching part of the brain, causing brain cells to die) affecting left side of his body. During a review of Resident 1's History and Physical (H&P) dated 02/05/2026, the H&P indicated Resident 1 has the capacity to understand and make decisions. During a review of Resident 1's Progress Notes dated 2/24/2026 at 2:55 PM, the note indicated Resident 1 had reported to the nurse at approximately 3 PM that PT 1 had made physical contact towards Resident 1, and used an open hand to the resident's right leg in anger. Resident 1 reported that the incident had happened the day before [2/23/2026] but did not want to get anyone in trouble. The note indicated Resident 1 thought this nurse should know. The note indicated that Resident 1 was able to visually identify the therapist he is reporting. When asked to explain what happened, Resident 1 stated, I thumped [hit/strike]therapist [PT 1] in back of head, and he turned in anger and smacked my leg with his hand. The note indicated PT 1 tapped his [Resident 1] right leg. During a review of Physical Therapist Employee Record (PT1) dated 3/25/2025, indicated PT 1 was suspended previously for potential physical and verbal altercation and disrespectful behavior towards another employee . Investigation concluded that allegation of verbal altercation was substantiated and PT 1 would return to work after completion of eight trainings. During an interview on 2/26/2026 at 9:35 AM with the Administrator (ADM), the ADM stated that Resident 1 attended physical therapy on 2/23/2026, where two physical therapists were present in the therapy room. PT2 was cleaning and organizing the area while PT1 was documenting on the computer. According to the ADM, Resident 1 attempted to get PT1's attention by flicking (to move, hit, or remove something with a quick, light, and sudden jerk) the back of PT1's head. PT1 then turned toward Resident 1 and struck Resident 1 once with the palm of his hand. ADM stated when she spoke to PT1, PT 1 stated he had only slapped the resident's hand and told him not to do that again; (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	however, both the resident and PT 2 reported that PT1 slapped the resident on the right thigh. ADM stated Resident 1 stated that PT 2 then yelled at him and asked, You want to beat me? Resident 1 reported feeling shocked and upset by the incident. The ADM stated that therapy continued after the incident. The ADM stated PT 2 asked Resident 1 if he was okay, and Resident 1 continued with therapy. PT 2 reported that she did not notify anyone about the incident on 2/23/2026 because Resident 1 had asked PT 2 not to report it. The incident was reported the following day to the Director of Rehabilitation (DOR) after it was learned that PT 1 had not reported the event (physical abuse). During an interview on 02/26/2026 at 10:26 AM with PT 2, PT 2, stated Resident 1 entered the therapy room and approached PT 1 who was seated at a computer with his back to the room. Resident 1 flicked PT 1 once on the back of the head to get his attention. PT 1 then rotated his chair approximately 180 degrees towards Resident 1 and struck Resident 1 once on the right thigh with an open hand. PT 2 stated the slap was very loud and sounded like someone slamming their hands down on a desk. PT 2 stated as the therapist struck the resident, Resident 1 yelled no, you can't do that. Resident 1 appeared shocked and upset and said, you beat me. PT 2 stated it appeared that PT 1 was often annoyed with Resident 1 and, on multiple occasions, she had heard PT 1 speaking loudly to the resident stating you need to be quiet, you talk too much, which was directed toward Resident 1. PT 2 stated Resident 1 did not appear to have visible injury and therapy continued with both therapists remaining in the room. PT 2 stated she did not report the incident of PT 1 slapping Resident 1's right thigh immediately on 2/23/2026, because she believed there was a 24-hour reporting window and wanted to give PT 1 an opportunity to report the incident himself. PT 2 stated she reported the incident the following day, on 2/24/2026 to the Director of Rehabilitation (DOR) after learning PT 1 had not reported the incident. During an interview on 2/26/2026 at 11:55AM with Resident 1, Resident 1 stated on 2/23/2026, Resident 1 entered the therapy room and approached PT 1 to get his attention and touched the back of PT 1's head. Resident 1 stated PT 1 quickly turned around and slapped Resident 1 on the right leg. Resident 1 stated PT 1 appeared very angry and mean and that the slap inflicted by PT 1 stung his leg. Resident 1 stated he felt angry and felt assaulted and went on to say he had previously considered PT 1 a friend and someone he could talk to and did not expect this kind of behavior. Resident 1 stated he did not want to complain, since he considered himself a strong person. Resident 1 stated he continued with physical therapy with PT 2 afterward while PT 1 remained in the room. Resident 1 further stated no one asked him how he was or whether he was okay following the incident. During an interview on 2/26/2026 at 1:10 PM with the Director of Nursing (DON), DON stated she was surprised by the incident and stated PT 1 should have never touched Resident 1. DON stated PT 1 was suspended the same day the facility became aware of the incident on 2/24/2026. DON stated the incident constituted physical abuse and should have been reported immediately. During an interview on 2/26/2026 at 1:32PM with the DOR, DOR stated not being present at the time of the incident on 2/23/2026 regarding Resident 1 and PT 1 but reported to the ADM after being informed of the event on 2/24/2026 by PT 2. DOR stated the incident constituted physical abuse and expressed concern about the situation, continuing to say Resident 1 is generally pleasant, friendly, and positive. During an interview on 2/26/2026 at 1:40PM with a PT 1, PT 1 stated on the morning of the incident on 2/23/2026 he was seated at a computer completing paperwork in the therapy room when Resident 1 approached him. PT 1 stated he did not initially notice Resident 1 in the room and reported that Resident 1 touched or slapped the back of his head trying to get his attention, which startled PT 1. PT1 stated he immediately turned around and told Resident 1 to stop and slapped Resident 1 on his hand. PT 1 stated he spoke to the resident in a low voice and told him to stop. PT 1 stated to Resident 1 hey stop it, this is not right. PT 1 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	continued to say that sometimes residents can make staff upset and acknowledge he is a healthcare worker. PT 1 stated not reporting the incident between him and Resident 1 since because when PT reported things, nothing happens During a review of the facility's policy and procedure (P&P) titled, Abuse Prevention Program dated 05/12/2025, the P&P indicated, Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse. The P&P further indicated as part of the resident abuse prevention, the administration will protect residents from abuse by anyone including, but not necessarily limited to facility staff, protecting resident during abuse ingestions. The P&P indicated administration would protect residents from abuse by anyone and would implement P&P's to aid the facility in preventing abuse, neglect, or mistreatment

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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** Based on observations, interviews and record reviews, the facility failed to immediately report physical abuse by Physical therapist (PT) 1 towards Resident 1 to the Administrator (ADM) within two (2) hours for one of five sampled residents, in accordance with the facility's policy and procedure (P&P) titled, Abuse Prevention Program. On 2/23/2026 while Resident 1 was beginning physical therapy, Resident 1 entered the rehabilitation (rehab) room and touched PT 1 on the back of the head. PT 1 reacted by slapping Resident 1 on the right thigh. PT 2 was also in the room. Neither PT 1 or PT 2 reported this incident on 2/23/2026 to the ADM. This deficient practice resulted in the facility not immediately reporting a witnessed physical abuse to the Administrator and delayed the investigation and protection for Resident 1 from further abuse. During a review of Resident 1's admission Record (AR) , the AR indicated the facility admitted the resident to the facility on [DATE], with a diagnosis including Hemiplegia (complete paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a cerebral infarction (a blood clot or blocked blood vessel stops oxygen from reaching part of the brain , causing brain cells to die) affecting left side of his body. During a review of Resident 1's History and Physical (H&P) dated 02/05/2026, the H&P indicated Resident 1 has the capacity to understand and make decisions. During an interview on 02/26/2026 at 9:35 AM with the Administrator (ADM), ADM stated that PT 2 reported the incident on 2/24/2026 between Resident 1 and PT 1 one day later on 2/24/26. ADM stated PT 2 reported the incident to the Director of Rehabilitation (DOR). During an interview on 02/26/2026 at 10:26 AM with PT 2, PT 2, stated Resident 1 entered the therapy room and approached PT 1 who was seated at a computer with his back to the room. Resident 1 flicked[to move, hit, or remove something with a quick, light, and sudden jerk] PT 1 once on the back of the head to get his attention. PT 1 then rotated his chair approximately 180 degrees towards Resident 1 and struck Resident 1 once on the right thigh with an open hand. PT 2 stated the slap was very loud and sounded like someone slamming their hands down on a desk. PT 2 stated as the therapist struck the resident, Resident 1 yelled no, you can't do that. Resident 1 appeared shocked and upset and said, you beat me. PT 2 stated it appeared that PT 1 was often annoyed with Resident 1 and, on multiple occasions, she had heard PT 1 speaking loudly to the resident stating you need to be quiet, you talk too much, which was directed toward Resident 1. PT 2 stated Resident 1 did not appear to have visible injury and therapy continued with both therapists remaining in the room. PT 2 stated she did not report the incident of PT 1 slapping Resident 1's right thigh on immediately on 2/23/2026, because she believed there was a 24-hour reporting window and wanted to give PT 1 an opportunity to report the incident himself. PT 2 stated she reported the incident the following day, on 2/24/2026 to the Director of Rehabilitation (DOR) after learning the therapist PT 1 had not reported the incident. During an interview on 2/26/2026 at 11:55AM with Resident 1, Resident 1 stated on 2/23/2026, Resident 1 entered the therapy room and approached PT 1 to get his attention and touched the back of PT 1's head. Resident 1 stated PT 1 quickly turned around and slapped Resident 1 on the right leg. Resident 1 stated PT 1 appeared very angry and mean and that the slap inflicted by PT 1 stung Resident 1's leg. Resident 1 stated he felt angry and felt assaulted and went on to say he had previously considered PT 1 a friend and someone he could talk to and did not expect this kind of behavior. Resident 1 stated he did not want to complain, since he considered himself a strong person. Resident 1 stated he continued with physical therapy with PT 2 afterward while PT 1 remained in the room. Resident 1 further stated no one asked him how he was or whether he was okay following the incident. During an interview on 02/26/2026 at 1:10 PM with the Director of Nursing (DON), DON stated the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident between Resident 1 and PT 1 was considered physical abuse and should have been reported immediately to facility administration in accordance with facility policy and abuse reporting requirements. During an interview on 02/26/2026 at 1:40 PM with PT 1, PT 1 stated he did not notify the Administrator (ADM) or Director of Rehabilitation (DOR) because in his experience when he reports concerns, no action was taken. During a review of the facility's policy and procedure (P&P) titled Abuse investigation & Reporting, undated, the P&P indicated All allegation or resident abuse, neglect, exploitation, misappropriation or resident property, mistreatment and/ or injuries of unknown source (Abuse) shall be promptly reported to appropriate local, state and / or federal agencies (as defined by current regulation) 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 further indicated an alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately. During a review of the facility's P&P titled Abuse Prevention Program, undated, the P&P indicated the facility would investigate and report any allegations of abuse within timeframes as required by federal requirements. During a review of the facility's P&P titled, Abuse and Neglect Clinical Protocol, undated, indicated the facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect. The P&P indicated management and staff will address situations of suspected or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations.