| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056111 | A. Building<br>B. Wing | 04/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Griffith Park Healthcare Center | 201 Allen Ave.<br>Glendale, CA 91201 |

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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 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467<br><br>Based on interview, and record review, the facility failed to ensure one of two sampled residents (Resident 1), was appropriately transferred/discharged on [DATE] at 9 pm, in accordance with the facility ' s policy and procedure titled Discharging the Resident.<br><br>As a result, Resident 1 was inappropriately discharged to Law Enforcement and then to home with Family (FAM) 1 on 4/11/24 at 9 pm, without a physician ' s order, discharge medications, and appropriate discharge planning.<br><br>This deficient practice had resulted to Resident 1 not getting any of the prescribed and routine medications from 4/12/24 to 4/17/24 (6 days). This deficient practice may further result to medical complications due to inability to receive routine medications and the unsafe/unplanned discharge back to home.<br><br>Findings:<br><br>A review of Resident 1 ' s Admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included immunodeficiency (the decreased ability of the body to fight infections and other diseases), schizophrenia, and generalized anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness).<br><br>A review of Resident 1's Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 1/29/24, the MDS indicated, Resident 1 was cognitively intact (able to think, remember and reason) and need 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) in eating, and partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) in oral hygiene, and toilet hygiene.<br><br>A review of Resident 1 ' s Medication Administration Record (MAR) for the month of April 2024, indicated the residents had ordered medications scheduled to be administered routinely. The MAR indicated all routine including as needed medications were discontinued on 4/11/24.<br><br>-Docusate sodium 100 milligrams (mg) twice a day for bowel management.<br><br>(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 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Risperidone 1 mg tablet twice day for schizoaffective disorder.<br><br>-Vitamin D3 25 micrograms (mcg) once a day for supplement.<br><br>-Prednisone 5mg tablet once a day, for idiopathic thromobocytopenic purpura.<br><br>-Invegga Sustena 156 mg/ml, intramusculary (IM) every month on the third day, for schizophrenia.<br><br>-Levothyroxine 100 mcg capsule everyday before breakfast, for hypothyroidism.<br><br>-Liothyronine 5 mcg tablet, every day before breakfast, for hypothyroidism.<br><br>-Famotidine 20 mg tablet twice a day, for GERD.<br><br>-Desmopressin 0.1 mg tablet twice a day for bleeding disorder.<br><br>A review of Resident 1 ' s physician orders indicated an order dated 4/12/24 timed at 6:30 pm (one day after Resident 1 was discharged with law enforcement on 4/11/24) to discharge Resident 1 to home with family. The physician order did not indicate discharge medications or other follow up discharge orders for Resident 1.<br><br>A review of Resident 1 ' s Physician Discharge Summary showed a pre-typed discharge summary form signed by the attending physician (not dated) that indicated the reason why the resident ' s transfer/discharge was necessary, discharge diagnosis and prognosis. The reason indicated in the form remained blank. The discharge diagnosis and prognosis also remained blank.<br><br>A review of Resident 1 ' s Departmental Notes dated 4/12/24 at 5:27 pm, written by Licensed Vocational Nurse (LVN) 2, indicated that around 9 pm on 4/11/24, two Police Officers arrived at the facility and informed LVN 2 that Resident 1 had been reported missing for quite some time now. The Departmental Note indicated the police officers needed to take Resident 1 to the Police Station. The Departmental Notes indicated that after the police officers talked to Resident 1, the resident willingly went to the Police Station with the two police officers. The Departmental Notes indicated that LVN 2 left a message to the attending physician around 9:30 pm. The Departmental Notes indicated [NAME] Resident 1 ' s family member (FAM 1) called the facility (no time and date) to inform the LVN that Resident 1 will be coming back to the facility after being interviewed by the police.<br><br>During a telephone interview on 4/24/24 at 10:30 am with Resident 1, Resident 1 stated that on 4/11/24 at around 8:45 pm, two police officers came to the facility and talked to her. Resident 1 stated, the police officers asked her to come with them to the Police Station. Resident 1 stated that she got scared when the police officers arrived at the facility and talked to her. Resident 1 stated, the police officers later told her that her family has been waiting for her, that is why she went with the police officers to the Police Station on 4/11/24. Resident 1 stated, she did not know how long she would stay in the Police Station when she went with them on 4/11/24. Resident 1 stated, no facility staff had expressed any concern about her going to the Police Station on 4/11/24. Resident 1 stated, LVN 2 did not educate her about the importance of her medications or why she should stay in the facility, before she left the faciity on [DATE]. Resident 1 stated she did not receive any documentation regarding her diagnoses, medications, or any treatments that she needed before leaving the facility and going to the Police Station.<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/24/24 at 10:45 am with FAM 1, FAM 1 stated, he did not know what medications or treatments that Resident 1 needed when he picked her up at the Police Station. FAM 1 stated, Resident 1 did not get any prescribed medications from 4/12/24 to 4/17/24. FAM 1 stated, he had to call the general acute care hospital (GACH) and gather whatever medications that Resident 1 had prior to be missing from home. FAM 1 stated, he did not receive any call from the nursing facility to check on Resident 1 ' s safety and discharge orders. FAM 1 stated, the first time he heard from the nursing facility ' s Administrator was on 4/17/24, six days after Resident 1 left the faciity on [DATE].<br><br>During an interview on 4/24/24 at 3:24 pm with the Director of Nurses (DON), the DON stated, on 4/11/24 at nighttime, she received a telephone call from LVN 2 letting her know that police officers were at the facility. The DON stated, LVN 2 informed her that the police officers wanted to take Resident 1 to the Police Station for questioning. The DON stated the incident was so unusual that she did not know what to do. The DON stated, there was no physician ' s order to allow Resident 1 to go out of the facility on 4/11/24. The DON stated, they were police officers so they could not say no and therefore, allowed Resident 1 to go with the police officers on 4/11/24.<br><br>During an interview on 4/24/24 at 3:49 pm with the Social Service Worker (SSW), the SSW stated, before a resident can transfer to another facility, or go out with supervision, there has to be a physician ' s approval to make sure the resident is stable enough to leave the facility because the resident still needs treatments, medications and care from the facility. The SSW stated any transfer from the facility to a different facility without a physician ' s order is considered as improper (inappropriate) discharge because it is an unsafe transfer.<br><br>During an interview on 4/24/24 at 4:05 pm with LVN 2, LVN 2 stated, on 4/11/24 at around 8:45 pm, two police officers came to the facility and informed him that Resident 1 had been missing and requested to speak to the resident. LVN 2 stated that when the police officers came out of Resident 1 ' s room after talking to the resident, the police officers told LVn 2 that they were going to take Resident 1 to prison. LVN 2 stated, that around 9 pm, LVN 2 let Resident 1 go with the police officers without knowing how long Resident 1 would be out of the facility, and if Resident 1 would come back to the facility. LVN 2 stated, he called Resident 1 ' s attending physician after Resident 1 already left the faciity on [DATE]. LVN 2 stated, he did not know if Resident 1 needed any medications before letting Resident 1 go because he was not Resident 1 ' s medication nurse.<br><br>During an interview on 4/24/24 at 4:37 pm with the DON, the DON stated, the facility was responsible for Resident 1 ' s safety and make sure the resident had a safe discharge or transfer to another facility. The DON stated that the transfer/discharge to the Police Station on 4/11/24 at 9 pm was inappropriate. The DON stated, the facility could have asked the police officers to come back for questioning or bring the family to the nursing facility the next day, for a proper discharge to home. The DON stated, the incident happened so fast that they (DON and LVN 2) did not think clearly enough.<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/24/234 at 4:52 pm with the ADM, the ADM stated, he followed up with the Police Station on 4/12/24 and could not get a confirmation if Resident 1 was released safely to her family or not. The ADM stated, on 4/15/24 (4 days after Resident 1 left the facility), he got FAM 1 ' s phone numbers from the Police Station and had a brief conversation with FAM 1 to confirm Resident 1 ' s location. The ADM stated, they were responsible for the resident ' s whereabouts and safety. The ADM stated, they did not have any information for how long Resident 1 would stay in the Police Station and if she would come back to the facility, on 4/11/24. The ADM stated, they should have been more upfront with the police officers to gain more information and made better decision, on 4/11/24. The ADM confirmed that the Police Station would not be able to provide any medical care that Resident 1 needed.<br><br>A review of the facility ' s Policy and Procedure (P&P) titled Discharging the Resident, revised December 2016, indicated the following information:<br><br>-The resident should be consulted about the discharge.<br><br>-If the resident is being discharged home, ensure that resident and/or responsible party receive teaching and discharge instruction.<br><br>-If the resident is being discharged to a hospital or another facility, ensure that a transfer summary is completed, and telephone report is called to the receiving facility.<br><br>-Assess and document resident ' s condition at discharge.<br><br>A review of the facility ' s P&P titled Discharging a Resident without a Physician ' s Approval, revised October 2012, indicated the following information:<br><br>-A physician ' s order should be obtained for all discharges, unless a resident or representative is discharging himself o herself against medical advice.<br><br>-If the resident or representative (sponsor) insists upon being discharged without the approval of the Attending Physician, the resident and/or representative (sponsor) must sign a Release of Responsibility form. Should either party refuse to sign the release, such refusal must be documented in the resident ' s medical record and witnessed by two staff members. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467<br><br>Based on interview, and record review, the facility failed to ensure one of two sampled residents (Resident 1), had a developed comprehensive care plan that addressed refusal to medications, specifically the risperidone (antipsychotic medication).<br><br>This failure had a potential to result in not meeting the resident ' s needs and could lead to medical complications.<br><br>Findings:<br><br>A review of Resident 1 ' s Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included immunodeficiency (the decreased ability of the body to fight infections and other diseases), schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), and generalized anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness).<br><br>A review of Resident 1's Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 1/29/24, the MDS indicated, Resident 1 was cognitively intact (able to think, remember and reason) and need 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) in eating, and partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) in oral hygiene, and toilet hygiene.<br><br>A review of Resident 1 ' s Order Summary Report, for April 2024, indicated Resident 1 had a physician order dated 4/3/24, to administer Risperidone 1 mg tablet to be taken orally twice a day for schizoaffective disorder related to delusion resulting in persistent distress and danger to self.<br><br>A review of Resident 1 ' s Medication Administration Record for the month of April 2024, indicated Risperidone was not administered from 4/4/24 to 4/9/24 for the scheduled dose timed at 9 am, and from 4/4/24 to 4/7/24 for the scheduled dose timed at 5 pm.<br><br>A review of Resident 1 ' s care plan titled Non-compliance/Refusal dated 4/4/24, indicated REsident 1 had the potential for injury, worsening condition, related to non-compliance with wearing mask, proper hygiene/shower/grooming, and changing clothes. The care plan did not indicate that Resident 1 had concerns/problems with refusing the Risperidone medications. The care plan did not indicate interventions geared towards Resident 1 ' s refusal of the Risperidone medication.<br><br>During an interview on 4/24/24 at 10:30 am with Resident 1, Resident 1 stated, she had been refusing Risperidone because it was ordered for her when she was in the general acute care hospital prior to transferring to the facility. Resident 1 stated, she had not seen a psychiatrist yet in the facility, so she believed that she did not need the medication (Risperidone).<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/24/24 at 2:40 pm with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, he was taking care of Resident 1 since admitted d 4/3/24. LVN 1 stated, Resident 1 had been refusing her Risperidone since admission on 4/3/24. LVN 1 stated, when a resident refused their medications, they would initiate a care plan to address it. LVN 1 stated, the care plan was important because it is a guide to know how to take care of the resident and tailored to the resident ' s condition and needs.<br><br>During a concurrent interview and record review on 4/24/24 at 3:24 pm with the Director of Nurses (DON), Resident 1 ' s care plan for Non-Compliance/Refusal, dated 4/4/24 was reviewed. The DON stated, when a resident refused their medications, the facility would have to create a care plan for non-compliant with medications so that they would know to monitor the resident ' s behavior, especially with Resident 1, who was diagnosed with psychiatric disorder and refused her medication for treatment. The DON confirmed that the facility did not develop a care plan to address Resident 1 ' s non-compliance with taking the Risperidone.<br><br>A review of the facility ' s Policy and Procedure titled, Care Plans, Comprehensive Person-Centered, revised March 2022, indicated the comprehensive, person-centered care plan includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being, including: services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467<br><br>Based on interview, and record review, the facility failed to ensure one of two sampled residents (Resident 1), had behavior monitoring related to schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), in accordance with the facility ' s policy and procedure titled Behavior, Mood and Cognition.<br><br>This failure had a potential to result in a delay in physician ' s notification, interventions, and treatment of the resident ' s psychotropic medications.<br><br>Findings:<br><br>A review of Resident 1 ' s Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included immunodeficiency (the decreased ability of the body to fight infections and other diseases), schizophrenia, and generalized anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness).<br><br>A review of Resident 1's Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 1/29/24, the MDS indicated, Resident 1 was cognitively intact (able to think, remember and reason) and need 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) in eating, and partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) in oral hygiene, and toilet hygiene.<br><br>A review of Resident 1 ' s Order Summary Report, for April 2024, indicated Resident 1 had a physician order dated 4/3/24, to administer Risperidone 1 mg tablet to be taken orally twice a day for schizoaffective disorder related to delusion resulting in persistent distress and danger to self. On 4/9/24, the physician discontinued Risperidone 1 mg for schizoaffective disorder and a new order for Risperidone 1 mg tablet to be taken orally twice a day was placed on 4/9/24 for schizophrenia manifested by delusions resulting in persistent distress and danger to self. The MAR did not indicate the specific behavior manifested for the Risperidone was monitored by the facility, as indicated in the facility ' s policy and procedure.<br><br>A review of Resident 1 ' s Care Plan, dated 4/4/24, indicated Resident 1 was admitted with psychiatric diagnosis of schizophrenia related to delusions resulting in persistent distress and danger to self and periods of anxiety. The care plan indicated Resident 1 was taking Risperidone for the diagnosis of schizophrenia. The interventions included to maintain close supervision and vigilance at all possible times and to monitor and record episodes of behavior per facility ' s policy/protocol.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 4/24/24 at 2:40 pm with Licensed Vocational Nurse (LVN) 1, Resident 1 ' s Order Summary for April 2024 was reviewed. LVN 1 stated, he was taking care of Resident 1 since admission. LVN 1 stated, Resident 1 was admitted with diagnosis of schizophrenia and was supposed to be monitored for the manifested behavior (delusions resulting in persistent distress and danger to self) since admission. LVN 1 stated there was no order to monitor the resident ' s behavior from 4/3/24 to 4/8/24 and he did not know why. LVN 1 stated, it was important to monitor for psychiatric related behavior because Resident 1 had a history of delusion and danger to self.<br><br>During a concurrent interview and record review on 4/24/24 at 3:24 pm with the Director of Nurses (DON), Resident 1 ' s Medication Administration Record for April 2024 was reviewed. The DON stated, for residents admitted with psychiatric issue, it ' s their protocol that they supposed to monitor for behavior since admission. The DON stated, she reviewed the physician ' s order but forgot about behavior monitoring so the facility staff did not monitor the resident ' s behavior from 4/3/24 to 4/8/24. The DON stated, without behavior monitoring, they would not know the resident ' s behavior and could have miss any episode of delusion, which could lead to a delay in physician notification, interventions, and treatment.<br><br>A review of the facility ' s Policy and Procedure titled Behavior, Mood and Cognition, revised March 2019, indicated the following:<br><br>-The nursing staff will identify, document, and inform the physician about specific details regarding changes in an individual ' s mental status, behavior, and cognition, including:<br><br>a. onset, duration, intensity and frequency of behavioral symptoms;<br><br>b. any recent precipitating or relevant factors or environmental triggers (e.g., medication changes, infection, recent transfer from hospital); and<br><br>c. appearance and alertness of the resident and related observations.<br><br>-If the resident is being treated for altered behavior or mood, the IDT will seek and document any improvements or worsening in the individual ' s behavior, mood, and function. |