

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Griffith Park Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Allen Ave. Glendale, CA 91201	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854</p> <p>Based on observation, interview, and record review, the facility failed to prevent and respond to the elopement (an act of leaving a care facility or safe area independently without notifying anyone) of one of three residents (Resident 1), who had severely impaired cognition (a condition that significantly impacts a person's ability to learn, remember, think, and communicate, making it difficult or impossible for them to live independently), by failing to implement the facility's policy and procedures by:</p> <ol style="list-style-type: none"> 1. Not assessing and identifying Resident 1 as at risk for unsafe wandering (aimlessly going to places) and elopement when the facility observed the resident wandering to other resident ' s room and front lobby as indicated in the facility ' s policy and procedure titled Wandering and Elopement. 2. Not providing adequate supervision to ensure Resident 1 who had fluctuating capacity to understand and make decisions, with diagnoses including, schizoaffective disorder (mental illness that can affect thoughts, mood, and behavior) , HIV (Human Immunodeficiency Virus), dysphagia (difficulty swallowing) and lack of coordination was properly assessed for risk of wandering and elopement as indicated in the facility ' s policy and procedure titled Nursing- Wandering and Elopement. 3. Not conducting a thorough investigation on how Resident 1 eloped and exited the facility to prevent other residents at risk of elopement from eloping in the exit areas as indicated in the facility ' s policy and procedure titled Accidents and Incidents- Investigating and Reporting. 4. Not developing a care plan to ensure Resident 1 received interventions, monitoring, and supervision to prevent elopement and wandering to other resident ' s rooms as indicated in the facility ' s policy and procedure titled Nursing- Wandering and Elopement. 5. The facility did not implement CODE [NAME] (a code called out in the facility ' s paging system [microphone announce a message] to alert staffs and visitors that a resident is missing or eloped) immediately when the resident was found missing as indicated in the facility ' s policy and procedure titled Use of Wander Guard(Wander Guard-a set of equipment, consisting of a watch-like device worn by a person and a door alarm that is set off once the watch-like device gets in close proximity to the door alarm; used for the purpose of preventing a person from exiting an area) and Nursing Wandering and Elopement. <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>As a result of these failures, on 9/16/2024 at around 1:15 PM, Resident 1 was discovered to be missing, exposing Resident 1 to extreme weather, medical complications, malnutrition (lack of sufficient nutrients in the body), and death. Resident 1 missed her daily medications, including psychoactive medication (medication to manage mental disorders) and antiviral medication (medication to manage viral diseases such as HIV). Resident 1 remained missing on 9/19/2024.</p> <p>On 9/17/2024 at 9:20 AM, the California Department of Public Health conducted an unannounced visit to the facility to investigate Resident 1 ' s elopement.</p> <p>On 9/17/2024 at 7:15 PM, while onsite at the facility, the California Department of Public Health (CDPH) identified an Immediate Jeopardy situation (IJ, a situation in which the provider ' s noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) regarding the failure to prevent and investigate how Resident 1 eloped and other residents at risk for elopement from the facility. The facility ' s Administrator (ADM) and Director of Nursing (DON) were notified of the IJ situation on 9/17/2024 at 7:15 PM.</p> <p>On 9/18/2024 at 12:13 PM, the Administrator (ADM) provided an acceptable IJ Removal Plan (a detailed plan to address the IJ findings).</p> <p>On 9/19/2024 at 5:33 PM, the IJ was removed in the presence of ADM and DON after the facility submitted an acceptable IJ Removal Plan (a plan that identifies all actions the facility will take to immediately address the noncompliance that has resulted in the IJ situation) and the surveyor verified/confirmed during onsite the facility ' s implementation of the IJ Removal Plan and the IJ situation was removed.</p> <p>The IJ Removal Plan Dated 9/19/2024, included the following:</p> <p>Immediate action(s) taken for the resident found to have been affected included:</p> <p>On 9/16/2024 the facility initiated an investigation, notified law enforcement, residents responsible party, primary physician and CDPH.</p> <p>The facility contacted hospitals in the area to inquire if they have admitted the resident.</p> <p>Multiple staff members searched in the nearby areas including, parks, stores, shopping centers as well as neighboring areas.</p> <p>The facility will continue its efforts to search for the resident on a daily basis for 3 months which would include contacting law enforcement as well as local hospitals and additionally search the local area weekly for 3 months.</p> <p>Identification of other residents having the potential to be affected was accomplished by:</p> <p>On 9/16/2024, the DON immediately initiated a review making sure that all residents are accurately reassessed, monitored, and supervised residents at risk of wandering behavior and elopement.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Residents at risk for elopement are monitored and their whereabouts always accounted for and only three residents were identified in this category of which two of them have a wander guard and one of them was on a one-on-one monitoring (one staff monitoring one resident) until a wander guard can be placed on her.</p> <p>On 9/18/2024 sliding doors in Rooms B and C were reported to be opening to a width that a person could pass through. On 9/18/2024 The maintenance supervisor immediately made appropriate adjustments by putting a stopper making sure the door does not open to a width that a person can pass through.</p> <p>On 9/18/2024 the maintenance supervisor assessed the rest of the facility and made sure that there were no possible exit doors or windows that residents with risk of elopement could exit from by making sure that the alarms that are on them are working and that if they were to be opened the staff would be alerted.</p> <p>Based on the facilities investigation it seems that the resident exited from the main lobby doors.</p> <p>Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>A scheduled 24 hour receptionist is in place to monitor the front doors.</p> <p>Additional monitoring of residents every 2 hours by the assigned nurse and reviewed by the shift charge nurse.</p> <p>Additional staff monitor implemented at the outside entrance of the facility from 7 am to 7pm and an alarm that cannot be easily removed without special tools will be activated at the facility's front door from 7pm to 7am. The Maintenance supervisor/ Designee will conduct daily audits making sure that they are working.</p> <p>On 9/16/2024 the DON/ Designee initiated in-services on:</p> <p>How to accurately assess residents for risk of wandering behavior and elopement</p> <p>How to care for residents at risk for elopement, based on the elopement assessment the plan of care will be individualized</p> <p>How to monitor and supervise residents for wandering behavior and elopement to identify risk factors for each resident such as cognitive impairment, history of wandering and/or elopement and conducting elopement risk assessment upon admission quarterly and as needed.</p> <p>Ensuring residents at risk for elopement were monitored and their whereabouts were always accounted for, and a wander guard was placed on them or other measures such as a one on one monitoring.</p> <p>Staff respond promptly by the following:</p> <p>Charge nurse should be contacted right away and immediately do the following:</p> <p>Page Code Green.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Assign staff members to search throughout the inside of the facility premises and search in the immediate outside vicinity.</p> <p>Verify whether or not the resident has gone out on pass or at an appointment.</p> <p>And immediately contact: Law enforcement, resident ' s family members, physician and CDPH (California Department of Public Health) within 2 hours.</p> <p>The maintenance supervisor was in serviced by the administrator on 9/18/2024 in regard to the importance of making sure all sliding doors are only opening enough that a person can't pass through it. The maintenance supervisor/Designee will conduct daily checks for 3 months on the sliding doors, ensuring they are only opening enough that a person can't pass through it.</p> <p>Inservice was conducted on 9/19/2024 to all supervisors in regard to properly investigating any incidents including interviewing staff, roommates, residents' family members or any other person that might be able to provide useful information.</p> <p>Monitoring of the Removal Plan include:</p> <p>Starting the week of 9/16/2024 the DON/ Designee will conduct weekly audit logs making sure that residents are being accurately assessed for the risk of wandering behavior and elopement, residents at risk for elopement are monitored and their whereabouts always accounted for every 2 hours.</p> <p>The Director of Staffing Development (DSD) will conduct weekly Audits by asking random staff on how to care for residents that have been found to be at risk for elopement and that staff are responding promptly by calling out Code green per the facilities policy and procedures. The administrator will review on a daily basis from Monday through Friday for 3 months the previous days log for the additional monitoring staff.</p> <p>The administrator will conduct weekly checks on resident room sliding doors for 3 months making sure that they are functioning properly.</p> <p>The Administrator will conduct weekly checks on the door alarms for 3 months making sure that they are working properly.</p> <p>A Quality Assurance Program Improvement- (QAPI measures set by the facility to improve delivery of care at the facility) has been initiated in regard to ensuring that there is a system in place for residents who are at risk or maybe at risk for elopement, Elopement risk assessments, and elopement management.</p> <p>The administrator will conduct a weekly review of all investigations for three months making sure that incidents are being thoroughly investigated and include Interviews of staff, roommates, residents' family members or any other person that might be able to provide useful information.</p> <p>The results will be reviewed by the QA for further evaluation and recommendation if necessary.</p> <p>Findings:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. A review of Resident 1 ' s Admission Record indicated the resident was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included lack of coordination, schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), anemia (a condition that develops when your blood produces a lower-than-normal amount of healthy red blood cells), and dysphagia (difficulty swallowing).</p> <p>A review of Resident 1 ' s History and Physical (H&P), dated 5/3/2024, indicated the resident has fluctuating capacity to understand and make decisions. The H&P also indicated Resident 1 has a diagnosis of HIV (Human immunodeficiency virus is a virus that attacks the body's immune system, specifically white blood).</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool), dated 6/17/2024, indicated the resident has severe cognitive impairment. The MDS indicated Resident 1 can walk 150 with supervision (helper provides verbal cues and/or touching assistance). The MDS also indicated Resident 1 does not use any mobility devices such as a cane, walker, or wheelchair and did not exhibit wandering behavior.</p> <p>A review of Resident 1 ' s Change in Condition Evaluation form, dated 9/16/2024, timed at 4:07 PM, conducted with the Director of Nursing (DON), indicated on 9/16/2024 at 1PM, Certified Nursing Assistant (CNA) was doing rounds and she noticed that [Resident 1] is not in her room. She looked if the resident is in the front which she always frequented but nowhere to be found.</p> <p>A review of Resident 1 ' s Order Summary Report dated 9/17/2024, included the following orders:</p> <p>-Olanzapine (medication that affects mood and behavior) tablet 15 MG (milligrams - a unit of measurement) to give 2 tablets orally (by mouth) at bedtime for Schizophrenia [manifested by] delusions [as evidenced by] believing her food has been poisoned</p> <p>-Tivacay (Dolutegravir Sodium-medication used to treat HIV virus) oral tablet 50 MG to be given one tablet by mouth one time a day for HIV.</p> <p>A review of Resident 1 ' s Progress Notes from 6/3/2024 to 9/17/2024, indicated no documented evidence that staff implemented interventions to monitor, supervise Resident 1 with wandering behavior of going into other resident ' s room.</p> <p>A review of Resident 1 ' s plan of care indicated no documented evidence that the facility developed a plan of care and implemented interventions to monitor, supervise and prevent Resident 1 from wandering or eloping from the facility after the facility observed Resident 1 wander to other resident ' s room and wanders to the front lobby near the exit door that leads to a busy street.</p> <p>During an interview on 9/17/2024 at 11:15 AM with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 usually sits in the front lobby, by the front exit. CNA 1 stated Resident 1 can walk by herself independently. CNA 1 stated the last time she saw Resident 1 was on 9/16/2024 at around 12 PM when Resident 1 was eating lunch inside of the resident ' s room.</p> <p>During an interview on 9/17/2024 at 11:32 AM with Receptionist (RP) 1, RP 1 stated Resident 1 was sitting by the front entrance in the lobby at around 11 AM to 11:30 AM on 9/16/2024 but did not notice Resident 1 leave the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/17/2024 at 11:49 AM with RP 2, RP 2 stated he last saw Resident 1 sitting in the front lobby near the facility ' s entrance door at around 11 to 11:30 AM on 9/17/2024. RP 2 stated he did not see where Resident 1 went after 11:30 AM because it became busy, and visitors started coming in.</p> <p>During an interview on 9/17/2024 at 12:08 PM with CNA 1, CNA 1 stated she noticed Resident 1 was missing at 1:15 PM because she could not find Resident 1 in her room and the front entrance. CNA 1 stated she reported to Licensed Vocational Nurse (LVN) 1 that Resident 1 was missing at around 1:20 PM.</p> <p>During an interview on 9/17/2024 at 12:10 PM, with LVN 1, LVN 1 stated she knows it was the usual routine of Resident 1 to sit on the chair by the front entrance of the facility. LVN 1 stated she was notified by CNA 1 at around 1:15 PM to 1:30 P.M on 9/16/2024 that Resident 1 was missing. LVN 1 stated she informed CNA 1, CNA 2, and CNA 3 to look for Resident 1. LVN 1 stated she immediately checked the rooms, starting from rooms in her station LVN 1 stated after checking the rooms in her station ' s rooms, she checked the rooms in 2 other stations and the front lobby. LVN 1 stated when she could not find the resident, she informed the Director of Nursing (DON) at around 2PM on 9/16/2024.</p> <p>During an interview on 9/17/2024 at 12:12 PM, LVN 1 and CNA 1 both stated they panicked and forgot to announce the Code [NAME] into the facility ' s paging system. LVN 1 stated announcing code green a code used to alert all facility staff that a resident is missing or has eloped.</p> <p>During an interview on 9/17/2024 at 1:13 PM with CNA 2, CNA 2 stated he was verbally informed by LVN 1 that Resident 1 was missing at around 1:15 PM on 9/16/2024. CNA 2 stated Resident 1 usually wanders to other resident ' s room and bathrooms, on 9/16/2024 at 1:15 PM when she looked for the resident, she did not find the resident in the facility.</p> <p>During an interview on 9/17/2024 at 1:27 PM with CNA 3, CNA 3 stated she was informed by LVN 1 that Resident 1 was missing at around 1:30 PM. CNA 3 stated Resident 1 walks around the facility without any help from the staff. CNA 3 stated Resident 1 goes to other residents ' rooms but when she looked for the resident on 9/16/2024, she did not find the resident in the facility.</p> <p>During an interview on 9/17/2024 at 12:28 PM with the DON, the DON stated LVN 1 reported to her that Resident 1 was missing at around 2PM. DON stated her initial response was to go out of the facility to look for the resident. The DON stated she and LVN 1 drove around the facility ' s area and came back at around 3PM but did not find Resident 1. DON stated when she came back into the facility, and she informed the Administrator (ADM) that Resident 1 was missing, and reported the resident was missing to the police department. DON stated, Code [NAME] was never announced on the facility ' s paging system because she and the other staffs panicked. The DON stated announcing Code [NAME] was used by the facility to help spread information to all staff that a resident has gone missing and to potentially help in preventing the resident from going out and far from the facility ' s premises.</p> <p>During an interview on 9/17/2024 at 1:58 PM with CNA 1, CNA 1 stated Resident 1 can walk without any need for assistance or devices. CNA 1 stated Resident 1 was not under any supervision or monitoring because she is quiet and just walks slowly.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/17/2024 at 1:59 PM with LVN 1, LVN 1 stated Resident 1 was not under any supervision and monitoring for wandering and elopement. LVN 1 stated Resident 1 was not one of the three residents listed in the elopement binder to be at risk for elopement in the facility. LVN 1 stated residents that are at risk for elopement are listed in the elopement binder.</p> <p>During an interview on 9/17/2024 at 2:52 PM with Registered Nurse (RN) 1, RN 1 stated the facility has an elopement binder labeled, Elopement Risk Residents which has a list of resident's names that are at risk for elopement. RN 1 stated residents are added into the list based on the assessment of the resident by the nurse using the Elopement Evaluation form. RN 1 stated if the resident was assessed to have any risk factor, then the resident must be added into the list. RN 1 stated a resident who was at risk for elopement must have interventions put in place to prevent an elopement such as monitoring the resident ' s whereabouts and supervision.</p> <p>During a concurrent interview and record review on 9/17/2024 at 3PM with RN 1, Resident 1 ' s Elopement Evaluation form, dated 6/17/2024 and 9/16/2024 were reviewed. RN 1 stated the following questions were incorrectly answered No instead of answering Yes.</p> <ul style="list-style-type: none"> -Has the resident verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door. -Does the resident wander. -Is the wandering behavior a pattern, goal-directed (an action taken with the specific intention of achieving a desired outcome). -Is the wandering behavior likely to affect the privacy of others. <p>Score value of 1 or higher indicate Risk of Elopement.</p> <p>During a follow up interview on 9/17/2024 at 3:05 PM with RN 1, RN 1 stated the questions should have been answered yes and the score should be greater than one because Resident 1 frequently stays in the front lobby, walks around the facility, and even wanders to other residents ' rooms. RN 1 stated if the form was answered correctly, Resident 1 could have been assessed as a high risk for elopement and put on the list for residents at risk for elopement. RN 1 stated Resident 1 should have been monitored to prevent elopement.</p> <p>During another concurrent interview and record review on 9/17/2024 at 3:06 PM with RN 1, Resident 1 ' s Elopement Evaluation form, dated 9/16/2024, was reviewed. RN 1 stated she did identify Resident 1 as at risk for wandering and elopement because she followed the answers in the previous Elopement Evaluation form dated 6/17/2024 that indicated Resident 1 as not at risk for wandering and elopement. RN 1 stated because she evaluated the resident as not at risk for elopement, the staffs would not know that the resident was at risk for elopement.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/18/2024 at 10:01 AM with Director of Staff Development (DSD), DSD stated residents who wander around the facility aimlessly and have psychiatric (mental, behavioral, and emotional disorders) medical diagnosis like Resident 1 are at risk for elopement. DSD added residents with psychiatric illness like Resident 1 have tendency to go out if the doors are left open which can jeopardize the safety of the resident and other residents who have behavior of wandering if they are not monitored or supervised.</p> <p>During a concurrent interview and observation on 9/18/2024 at 2:14 PM with CNA 5, Room B and Room C were checked. CNA 5 stated Room B and Room C both have sliding doors that opens wide enough for a person to walk out to and leave the facility. CNA 5 stated any resident could go out of the sliding doors that leads to the back side of the building and elope.</p> <p>During a concurrent interview and observation on 9/18/2024 at 2:30 PM with DON, Room B and Room C were checked. DON stated Room B was next to Resident 1 ' s room and Resident 1 could have eloped through the sliding doors. DON stated there were no alarms after a resident has passed through the sliding doors that could have alerted staff that a resident was eloping. DON stated there are no locks to the gate outside the sliding doors that could prevent any resident from leaving the facility. DON stated the sliding doors of Room B and Room C were not supposed to open wide enough for a person to be able to walk out.</p> <p>During an interview on 9/18/2024 at 2:40 PM with Maintenance Supervisor (MS), MS stated the area outside the sliding doors of Room C and Room D do not have any alarms, sensors, or cameras that could notify staff if a resident was outside. MS stated the facility does not lock the gate outside of the sliding doors.</p> <p>A review of Resident 2 ' s Admission Record indicated the resident was originally admitted on [DATE], readmitted on [DATE], with diagnoses that included spondylosis (abnormal wear on the cartilage [flexible tissue that lines joints] and bones of the back) and dysphagia.</p> <p>A review of Resident 2 ' s H&P, dated 10/25/2023, indicated Resident 2 has the capacity to understand and make decisions.</p> <p>A review of Resident 2 ' s MDS, dated [DATE], indicated Resident 2 had no cognitive impairment.</p> <p>During an interview on 9/18/2024 at 3:20 PM, Resident 2 stated Resident 1 mentioned to her that Resident 1 was anxious to go home. Resident 2 stated no one has asked her regarding Resident 1 who was missing.</p> <p>A review of Resident 3 ' s Admission Record indicated the resident was originally admitted on [DATE], readmitted on [DATE], with diagnoses that included fibromyalgia (a chronic condition that causes widespread pain and tenderness in the muscles and soft tissues of the body) and epilepsy (a chronic brain disorder that causes recurrent seizures, which are episodes of involuntary brain activity).</p> <p>A review of Resident 3 ' s H&P, dated 5/6/2024, indicated Resident 3 has the capacity to understand and make decisions.</p> <p>A review of Resident 3 ' s MDS, dated [DATE], indicated Resident 2 has no cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/18/2024 at 3:23 PM, Resident 3 was interviewed. Resident 3 stated no one has interviewed her regarding Resident 1. Resident 3 stated she sees the resident wander around the facility.</p> <p>During a concurrent interview and record review on 9/19/2024 at 9:52 AM with ADM, ADM 's written statement and the facility 's investigation report were reviewed. ADM stated he and the DON did not interview residents to verify if Resident 1 had wandering behavior or if the resident verbalized wanting to leave the facility during the facility 's investigation about Resident 1 's elopement. ADM stated residents should have been interviewed because they can be witnesses that could provide valuable information and it is basic to interview residents. ADM stated he and DON leads the investigation to Resident 1 's elopement. ADM added the investigation was not thorough because no resident interviews were conducted and he does not know the possible area where Resident 1 exited from the facility on the day the resident eloped because the doors that were possible exit doors were not checked until the surveyor informed him about the sliding doors that could be opened and used as exit.</p> <p>During an interview on 9/19/2024 at 10:01 AM with Social Services Director (SSD), SSD stated she was not instructed to interview any residents about Resident 1 's elopement. SSD stated she did not interview Resident 2 and other residents regarding Resident 1 's elopement.</p> <p>During a phone interview on 9/19/2024 at 11:05 AM with Medical Doctor (MD), MD stated the facility never contacted him to provide a physician orders to prevent Resident 1 from eloping. MD stated the facility did not consider Resident 1 as at risk for elopement.</p> <p>During an interview on 9/19/2024 at 12:54 PM with SSD, Resident 2 was interviewed concurrently with SSD. During the interview, Resident 2 stated Resident 1 has been verbalizing of wanting to go home.</p> <p>During an interview on 9/19/2024 at 2:39 PM with DON, DON stated Resident 1 's cognitive ability was not reliable because of her medical diagnoses of schizophrenia. DON stated it was risky that Resident 1 was walking around the facility without any supervision or monitoring. DON also stated the facility should have contacted the police right away for assistance when they could not find the resident in the facility, instead of driving outside before calling the police. DON added it was her booboo or mistake on instructing staff to copy the Resident 1 's previous elopement evaluation onto a new elopement evaluation form.</p> <p>During a concurrent interview and record review on 9/19/2024 at 2:39 PM with DON, Resident 1 's entire medical records were reviewed. DON stated there was no care plan developed for Resident 1 to prevent the resident from elopement. DON stated there was no documented evidence that staff monitored or intervened to prevent Resident 1 from eloping. DON stated Resident 1 's Elopement Evaluation, dated 6/17/2024, was not answered correctly. DON stated Resident 1 should have been one of the residents in the facility 's elopement list. DON stated she admits the facility was at fault of Resident 1 's elopement because of not accurately assessing and identifying Resident 1 as at risk of elopement and not implementing any interventions to prevent Resident 1 from eloping. DON stated the facility could have used a Wander guard to prevent Resident 1 from eloping. DON stated Resident 1 's medical condition could worsen because Resident 1 has not received the scheduled medications while out in the facility since 9/16/2024 and the resident had not been found.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Griffith Park Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Allen Ave. Glendale, CA 91201	
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of the facility ' s Elopement Risk Residents binder conducted with the DON on 9/19/2024 at 2:39 PM did not include Resident 1 on the list.</p> <p>During a concurrent interview and record review on 9/19/2024 at 5:12 PM with ADM, the facility ' s policy and procedure (P&P) titled, Accidents and Incidents- Investigating and Reporting, revised 7/2017, was reviewed. ADM stated the investigation should include witnesses and their accounts of the accident or incident. ADM stated residents are witnesses that could provide valuable information to the investigation.</p> <p>A review of the facility ' s job description for Director of Nursing Services undated, indicated it is the DON ' s responsibility to promote a safe environment within the facility, which includes fire and accident prevention. The job description also indicated the DON assumes responsibility for investigations of alleged abuse or unusual occurrence.</p> <p>A review of the facility ' s P&P titled, Use of Wander guard, dated 7/23/2021, indicated when a resident is wearing a Wander guard or wristband that transmitter attempts to exit a monitored doorway, an audible alarm sounds. The P&P indicated Wander guard may be used for residents who has impaired cognition & decision-making skills yet verbalizes of wanting to leave the facility without supervision. The P&P also indicated if a resident is noted missing, the nurse will call Code [NAME] and organize a search immediately.</p> <p>A review or the facility ' s P&P titled, Nursing- Wandering and Elopement, released 6/2018, indicated residents who are deemed to be high risk for elopement or wandering will have a photograph maintained in their medical record. The P&P indicated the facility will develop a plan of care considering the individual risk factors of the resident.</p> <p>A review of the facility ' s P&P titled, Safety and Supervision of Residents, revised 7/2017, indicated the facility shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. The P&P indicated resident supervision is a core component to safety. The P&P indicated risk factors include wandering.</p> <p>A review of the facility ' s P&P titled, Elopements, revised 12/2007, indicated if an employee discovers a resident is missing, he/she shall initiate an extensive search of the surrounding area. The P&P also indicated if the resident is not located in the facility ' s building(s) and premises, he/she shall notify law enforcement.</p> <p>A review of the facility ' s P&P titled, Wandering and Elopements, revised 3/2019, indicated the facility will identify residents who are at risk for unsafe wandering and elopement, the resident ' s care plan will include strategies and interventions to maintain resident ' s safety. The P&P also indicated if a resident is missing, initiate a search of the building(s) and premises; and if the resident is not located, notify the administrator and director of nursing services, the resident ' s legal representative, the attending physician, law enforcement officials.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854</p> <p>Based on interview and record review, the facility failed to ensure three of three facility staffs had appropriate competencies and skills sets necessary to provide nursing related services related to residents with wandering behavior (walking or going to places aimlessly) and at risk for elopement (running away or leaving the facility without proper permission) as indicated in the facility's policy and procedure titled Staffing, Sufficient and Competent Nursing.</p> <p>The facility failed to ensure:</p> <ol style="list-style-type: none"> Licensed Vocational Nurse (LVN) 1 attended in-services for elopement and Code [NAME] (the code used to alert all facility staff that a resident is missing or has eloped). Director of Staffing Development (DSD) evaluate the competencies of staff after in-services and when Resident 1 eloped. DSD did not have specific clear instructions in the in-services provided about Code Green. Registered Nurse (RN) 1 to completed Resident 1's Elopement Evaluation (EE) and not copying the previous form which was incorrect and indicated Resident 1 was not at risk for elopement. Care plan was developed to by the licensed nurse responsible with Resident 1 to ensure interventions were implemented to prevent the resident from wandering and eloping. <p>As a result of these deficient practices, Resident 1 eloped and remained missing as of 9/19/2024 which put the resident at risk for harm from extreme weather, car accidents and other accidents resulting in injuries or even death.</p> <p>Cross reference to F689</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record indicated the resident was originally admitted on [DATE], readmitted on [DATE], with diagnoses that included lack of coordination, schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), anemia (a condition that develops when your blood produces a lower-than-normal amount of healthy red blood cells), and dysphagia (difficulty swallowing).</p> <p>A review of Resident 1's History and Physical (H&P), dated 5/3/2024, indicated the resident has fluctuating capacity to understand and make decisions. The H&P also indicated Resident 1 has a diagnosis of HIV.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 1's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool), dated 6/17/2024, indicated the resident has severe cognitive impairment. The MDS indicated Resident 1 was able to walk 150 with supervision (helper provides verbal cues and/or touching assistance). The MDS also indicated Resident 1 does not use any mobility devices such as a cane, walker, or wheelchair.</p> <p>A review of Resident 1's Elopement Evaluation form, dated 6/17/2024, times at 9:09 AM, and on 9/16/2024, timed at 5:32 PM was answered no to the following questions indicating resident was not at risk of elopement instead of Yes due to Resident 1 ' s behavior or wandering to other resident's room and verbalized wanting to go home.</p> <p>a. Resident verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door.</p> <p>b. Does the Resident wander.</p> <p>c. Is the wandering behavior a pattern, goal directed.</p> <p>d. Wandering behavior likely to affect the privacy of others.</p> <p>A review of Resident 1's Change in Condition Evaluation form, dated 9/16/2024, timed at 4:07 PM, signed by DON, indicated at 1PM, CNA stated she was doing rounds, and she noticed that [Resident 1] was not in her room. She looked if the resident was in the front lobby which she always frequented but the resident was nowhere to be found.</p> <p>A review of Resident 1's entire Progress Notes from 6/3/2024 to 9/17/2024, did not have documented evidence that staff implemented interventions to prevent Resident 1 from eloping from the facility prior to elopement on 9/16/2024.</p> <p>A review of Resident 1's clinical record indicated no Care Plans were developed that addressed interventions to prevent Resident 1 from elopement and who was at risk for elopement.</p> <p>During an interview on 9/17/2024 at 12:08 PM with CNA 1, CNA 1 stated she noticed Resident 1 was missing and was not in her room or the front entrance at 1:15 PM which she reported her discovery to LVN 1 at 1:20 PM.</p> <p>During an interview on 9/17/2024 at 12:10 PM with LVN 1, LVN 1 stated she knows it is the usual routine of Resident 1 to sit on the chair by the front entrance of the facility. LVN 1 stated she was notified by CNA 1 at around 1:15 PM to 1:30 P.M. LVN 1 stated she informed CNA 1, CNA 2, and CNA 3 to look for Resident 1. LVN 1 stated she checked the rooms, starting from rooms in her station. LVN 1 stated after checking her station ' s rooms, she checked the rooms in the 2 other stations and the front lobby. LVN 1 stated when she could not find the resident, she informed the DON at around 2PM (40 minutes after the resident was discovered missing).</p> <p>During an interview on 9/17/2024 at 12:12 PM with LVN 1 and CNA 1, both LVN 1 and CNA 1 stated they panicked and forgot to announce Code [NAME] into the facility ' s paging system. LVN 1 stated announcing Code [NAME] is the code used to alert all facility staff that a resident is missing or has eloped.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/17/2024 at 12:28 PM with DON, DON stated LVN 1 reported to her that Resident 1 was missing at around 2PM. DON stated Code [NAME] was never announced because she and other staff panicked. DON stated announcing Code [NAME] is used to help spread information to all staff that a resident has gone missing and to potentially help in preventing the resident from going out and far from the facility ' s premises.</p> <p>During a phone interview on 9/17/2024 at 4:05 PM with DSD, DSD stated staff must announce Code green into the facility ' s speaker system when a resident has been discovered missing. DSD stated he has provided education to staff regarding the facility ' s procedure when an elopement is suspected. DSD stated he randomly tests staff regarding the study materials. DSD stated there is no checklist or paper system to track who has been tested . DSD stated when staff attend the in-service, they attest that they attended the in-service by signing on the attendance roster.</p> <p>During an interview on 9/17/2024 at 4:42 PM with LVN 1, LVN 1 stated she does not remember if she attended an in-service for elopement for the year 2024. LVN 1 stated if she attended, she would have signed in the attendance roster. LVN 1 stated if she did not sign the attendance roster, it means she did not attend the in-service.</p> <p>During an interview o 9/18/2024 at 9:40 AM with CNA 3, CNA 3 stated when Code [NAME] is announced, she will go to the front lobby to see what happened. CNA 3 stated she is not sure what the other CNA ' s will do, but [she] will go to the front and ask the charge nurse what happened.</p> <p>During a concurrent interview and record review on 9/18/2024 at 10:33 AM with DSD, DSD ' s written statement was reviewed and in-services were reviewed. DSD stated he forgot to write that someone will page ' Code [NAME] ' as well. DSD stated someone must announce Code [NAME] via the facility ' s speaker system to broadcast to the entire facility for the purpose of letting all staff aware of a missing resident. During a review of the in-services titled, Elopement, dated 2/9/2024 to 2/12/2024, and Dementia (Elopement & Wandering), dated 8/1/2024 to 8/3/2024, DSD stated there are no clear instructions on how to announce, Code Green. DSD further stated he does not test all staff if they have understood the in-service.</p> <p>During an interview on 9/19/2024 at 10:01 AM with Social Services Director (SSD), SSD stated when she was notified that Resident 1 was missing, she went on a search outside of the facility for about one hour. SSD stated she called the police department only after searching for Resident 1 outside of the facility.</p> <p>During a concurrent interview and record review on 9/19/2024 at 12:04 with DSD, the in-services titled, Elopement, dated 2/9/2024 to 2/12/2024, and Dementia (Elopement & Wandering), dated 8/1/2024 to 8/3/2024, were reviewed. DSD stated LVN 1 did not have signatures in the attendance roster for the in-services. DSD stated LVN 1 must not have attended the in-services. DSD stated if LVN 1 had attended the in-services, LVN 1 would have known what to do when Resident 1 was discovered missing such as to announce Code [NAME] using the facility ' s speaker system. DSD stated it is his responsibility to make sure all staff receive the in-service.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/19/2024 at 2:39 PM with DON, DON stated the facility should have contacted the police right away for assistance when they couldn't find the resident in the facility, instead of driving around outside before calling the police. DON added it was her booboo or mistake on instructing staff to copy the Resident 1's previous elopement evaluation onto a new elopement evaluation form.</p> <p>A review of the facility's in-services titled, Elopement, dated 2/9/2024 to 2/12/2024, and Dementia (Elopement & Wandering), dated 8/1/2024 to 8/3/2024, did not include LVN 1 attended the in-service. The in-services also did not include instructions on announcing Code Green.</p> <p>During an interview on 9/19/2024 at 5:12 PM with Administrator (ADM), ADM stated DSD will provide in-services to staff that includes clear instructions for staff to follow in the event of a resident elopement.</p> <p>A review of the facility's in-service titled, Elopement Risk & Prevention, dated 9/19/2024, provided by DSD, indicated in the vent of an elopement, staff respond promptly by informing the charge nurse or LVN. The in-service indicated the charge nurse should page ' Code [NAME] ' and immediately assign staff members to:</p> <p>Search throughout the inside of the facility premises.</p> <p>Search in the immediate outside vicinity.</p> <p>Verify whether or not the resident has gone out on pass or at an appointment.</p> <p>Immediately contact Law Enforcement.</p> <p>Contact residents family members.</p> <p>Notify Physician.</p> <p>Contact [the California Department of Public Health] within 2 hours.</p> <p>A review of the facility's job description for Director of Staff Development, undated, indicated the Director of Staff Development (DSD) is responsible for planning, implementation, and evaluation of the facility's educational programs for all employees. The job description indicated the DSD coordinates and conducts an effective on-going in-service plan to all employees. It also indicated the DSD is to monitor, support, teach, and supervise the nursing staff on established procedures.</p> <p>A review of the facility's job description for Director of Nursing Services, undated, indicated it is the responsibility of the Director of Nursing (DON) to assure that an adequate orientation and in-service training program is provided for all nursing personnel. The job description also indicates the DON assumes ultimate responsibility for coordinating plans for the total care of each resident.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility ' s Policy and Procedure (P&P) titled, Elopements, revised 12/2007, indicated if an employee discovers a resident is missing, he/she shall initiate an extensive search of the surrounding area. The P&P also indicated if the resident is not located in the facility ' s building(s) and premises, he/she shall notify law enforcement.</p> <p>A review of the facility ' s P&P titled, Wandering and Elopements, revised 3/2019, indicated if a resident is missing, initiate a search of the building(s) and premises; and if the resident is not located, notify the administrator and director of nursing services, the resident ' s legal representative, the attending physician, law enforcement officials.</p> <p>A review of the facility ' s P&P titled, Staffing, Sufficient and Competent Nursing, revised 8/2022, indicated the facility provides nursing staff with appropriate skills and competency necessary to provide nursing and related care and services for all residents. The P&P indicated ' Competency ' is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that in individual needs to perform work roles or occupational functions successfully. The P&P also indicated competency requirements and training for nursing staff are established and monitored to ensure that tracking or other mechanisms are in place to evaluate effectiveness of training.</p>		