STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056111	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Griffith Park Healthcare Center	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)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854 Based on interview and record review, the facility failed to implement their policy and procedure for abuse prevention and reporting when Resident 1 had a verbal altercation with Licensed Vocational Nurse (LVN) 1. The facility failed to: 1. Investigate the allegation of abuse between LVN 1 and Resident 1 on 2/11/2025. 2. Suspend LVN 1 on 2/11/2025, pending the results of the facility's investigation, as indicated in the facility's policy and procedure (P&P). 3. Prevent further contact between LVN 1 and Resident 1, following the incident of verbal altercation on 2/11/2025. This deficient practice placed Resident 1 and other residents at risk for potential abuse from LVN 1, which could cause physical, mental, and emotional harm. Findings: A review of Resident 1's Admission Record indicated the resident was admitted on [DATE] with diagnoses that included lack of coordination, muscle wasting (loss of muscle mass and strength), and depression. A review of Resident 1's History and Physical (H&P), dated 11/6/2024, indicated the resident have the capacity to understand and make decisions. A review of Resident 1's Psychiatric Progress Notes, dated 11/13/2024, indicated the resident was assessed to not having delusions (false beliefs that are firmly held despite overwhelming evidence to the contrary) or hallucinations (sensory experiences that occur in the absence of an external stimulus). A review of Resident 1 's Minimum Data Set (MDS - a resident assessment tool), dated 2/12/2025, indicated the resident had intact cognition (ability to process thoughts). The MDS also indicated the resident requires moderate assistance (helper does less than half the effort) for self-care activities such as bathing and personal hygiene. The MDS also indicated the resident requires moderate assistance for mobility such as rolling in bed, standing from a sitting position, and sitting from a lying position. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's nursing progress notes, dated 2/11/2025, timed at 11:33 PM, entered by Registered Nurse (RN) 1, indicated the resident called police at 7:20 PM complaining what happen this morning. Police asked the behavior of resident and left card in the RN book. A review of Resident 1's Nursing Progress Notes, from 2/11/2025 to 3/11/2025, did not indicate documented evidence that the facility staff interviewed Resident 1 regarding reason why he called the Police. The Progress Notes did not indicate any documented evidence that an allegation of abuse was investigated involving Resident 1 and any staff, including LVN 1. A review of Resident 1's social worker Progress Notes, from 12/11/2024 to 3/11/2025, did not indicate documented evidence that the social worker interviewed Resident 1 regarding why he called the Police. A review of Resident 2's Admission Record indicated Resident 2 was admitted on [DATE], with diagnoses that included lack of coordination, hypertension (high blood pressure), and diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). A review of Resident 2's H&P, dated 7/22/2024, indicated Resident 2 has fluctuating capacity to understand and make decisions. A review of Resident 2's MDS, dated [DATE], indicated Resident 2 has intact cognition. During an interview on 3/19/2025 at 2:59 PM with Resident 2 (Resident 1's roommate), Resident 2 stated he heard a verbal argument between Resident 1 and a male staff (LVN 1). Resident 2 stated no one has interviewed him regarding that incident. During a phone interview on 3/19/2025 at 3:19 PM with the Police Office (PO), the PO stated he went to the facility in response to Resident 1's call to the Police. The PO stated Resident 1 stated he had a verbal argument with a male staff, LVN 1. The PO stated he conducted a phone interview with LVN 1 regarding the allegation. During an interview on 3/19/2025 at 3:25 PM, LVN 1 stated on 2/11/2025 at around 2:30 PM, he heard Resident 1 yelling at CNA 1 on the hallway. LVN 1 stated he went to grab Resident 1's wheelchair to take Resident 1 to the patio to calm him down. LVN 1 added that Resident 1 got up from his wheelchair, started yelling at him, and threw a baseball cap towards him. LVN 1 stated the PO called him on his phone the night of 2/11/2025 and interviewed him regarding the allegation that he threatened Resident 1 by allegedly telling Resident 1 that he will bring 2 guys to hurt [Resident 1]. LVN 1 stated he did not report the allegation to the DON or the ADM. During another interview on 3/19/2025 at 3:37 PM, LVN 1 stated he was not suspended by the facility because of the altercation between him and Resident 1. LVN 1 added he spoke to Resident 1 again, two days after the altercation. During an interview on 3/19/2025 at 3:48 PM, RN 1 stated she remembered that a police officer visited the facility to interview Resident 1. RN 1 stated she attempted to interview Resident 1 one time, but Resident 1 did not want to talk about the incident. RN 1 stated she did not report to the DON or ADM that the police was called into the facility by Resident 1 or to ask for help in interviewing Resident 1 to find out the why the resident called the police. (continued on next page)

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/19/2025 at 4:40 PM, the DON stated she was never informed that the PO was called to the facility to investigate an allegation of abuse by Resident 1 against LVN 1. The DON stated LVN 1 never reported to her that he was interviewed by the PO. The DON stated that facility staff should have reported the incident to her or the ADM to investigate the alleged incident and protect the residents from further abuse. The DON stated if allegations of abuse are not addressed, residents could suffer harm such as physical harm and emotional distress. The DON added LVN 1 should have been suspended immediately to prevent further contact with Resident 1 and other residents. During a concurrent interview and record review on 3/19/2025 at 4:43 PM, Resident 1's entire medical records were reviewed with the DON. The DON stated there is no evidence that the allegation of abuse was investigated. During a follow up interview on 3/20/2025 at 9:19 AM, the DON stated LVN 1 has been suspended due to the allegation of resident abuse. The DON stated LVN 1 should have been suspended right away on 3/11/25 after the alleged incident wiith Resident 1, until the investigation was conducted to prevent possible abuse to Resident 1 and other residents. The DON also stated LVN 1 should not have made contact again with Resident 1 after the allegation on 3/11/25. During an interview on 3/20/2025 at 9:44 AM, CNA 1 stated Resident 1 was yelling at her on the hallway because Resident 1 wanted a different CNA to care for him. CNA 1 stated LVN 1 approached Resident 1 and grabbed Resident 1's wheelchair. CNA 1 added Resident 1 stood up and started yelling at LVN 1. CNA 1 stated LVN 1 told Resident 1 to Respect the CNAs. CNA 1 stated she was never interviewed regarding the incident between LVN 1 and Resident 1. During an interview on 3/20/2025 at 10:49 AM, the ADM stated verbal altercations are reportable because it could be ruled as a verbal abuse. The ADM stated if he is not in the facility, such as at night, a nurse could initiate the investigation of an incident involving a potential abuse allegation. During another interview on 3/20/2025 at 11:10 AM, the ADM stated CNA 1 and LVN 1 should have reported the incident to him, because all staff are mandated reporters of abuse. The ADM added RN 1 should have also reported that the Police was in the facility so that he could instruct the staff to investigate, and he could further investigated the reason for the police officer's visit to the facility. The ADM stated the verbal altercation with Resident 1 was a reportable incident for possible abuse. The ADM stated all allegations and incidents of abuse should be investigated because it is part of taking care of residents and to prevent abuse from reoccurring. A review of Resident 1's Behavioral Symptoms care plan, initiated on 2/12/2025, indicated the resident has behavioral symptom or yelling/screaming and cursing, threatening staff . A review of the care plan did not include to take the resident to the patio, as an intervention for the behavior. The care plan included interventions for staff to: 1. Honor resident's rights at all times. 2. Identify times/approaches/staff that result in least resistance. 3. When behavior occurs, remind resident of potential risks. Coax but do not force compliance. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's job description for a Registered Nurse (RN), undated, indicated it is a job function of an RN to comply with abuse prevention and reporting policies and procedures. A review of the facility's job description for a Licensed Vocational Nurse (LVN), undated, indicated it is a job function of an LVN to comply with abuse prevention and reporting policies and procedures. A review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating , revised 9/2022, indicated: 1. All reports of resident abuse . are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. 2. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. 3. Investigations may be assigned to an individual trained in reviewing, investigation, and reporting such allegations. 4. The individual conducting the investigation as a minimum: a. Interviews the person(s) reporting the incident. b. Interviews any witnesses to the incident. A review of the facility's policy and procedure (P&P) titled, Abuse Prevention Program , revised 12/2016, indicated 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 indicated that the admin will identify and assess all possible incidents of abuse. The P&P further indicated to investigate and report any allegations of abuse within timeframes as required by federal requirements.

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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	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** 48854 Based on interview and record review, the facility failed to notify the State Srvey Agency (SA) immediately or within two hours of an allegation involving abuse for one of two sampled residents (Resident 1) Resident 1 made an allegation of verbal abuse against Licensed Vocational Nurse (LVN) 1 by calling a Police Officer on 3/11/25 and arrived at the facility at 7:20 PM, as indicated in Registered Nurse (RN) 1's notes. RN 1 and LVN 1 did not notify the facility's Abuse Coordinator and/or the State Survey Agency (SA) within two hours after having knowledge of Resident 1's allegation of verbal abuse against LVN 1 on 3/11/25. This deficient practice had the potential for facility staff to under report all types of abuse allegations and placed Resident 1 at risk for further abuse and caused the facility to fail to address Resident 1's complaints of abuse. Findings: A review of Resident 1's Admission Record indicated the resident was admitted on [DATE] with diagnoses that included lack of coordination, muscle wasting (loss of muscle mass and strength), and depression. A review of Resident 1's History and Physical (H&P), dated 11/6/2024, indicated the resident does have the capacity to understand and make decisions. A review of Resident 1's Psychiatric Progress Notes, dated 11/13/2024, indicated the resident was assessed to not having delusions (false beliefs that are firmly held despite overwhelming evidence to the contrary) or hallucinations (sensory experiences that occur in the absence of an external stimulus). A review of Resident 1 's Minimum Data Set (MDS - a resident assessment tool), dated 2/12/2025, indicated the resident has intact cognition (ability to process thoughts). The MDS also indicated the resident requires moderate assistance (helper does less than half the effort) for self-care activities such as bathing and personal hygiene. The MDS also indicated the resident requires moderate assistance for mobility such as rolling in bed, standing from a sitting position, and sitting from a lying position. A review of Resident 1's Nursing Progress Notes, dated 2/11/2025, timed at 11:33 PM, entered by Registered Nurse (RN) 1, indicated the resident called police at 7:20 PM complaining what happen this morning. Police asked the behavior of resident and left card in the RN book. A review of Resident 1's Nursing Progress Notes, from 2/11/2025 to 3/11/2025, did not indicate documented evidence that the facility staff interviewed Resident 1 regarding reason why he called the police. (continued on next page)

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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	A review of Resident 1's social worker Progress Notes, from 12/11/2024 to 3/11/2025, did not indicate documented evidence that the social worker interviewed Resident 1 regarding why he called the police. A review of Resident 2's Admission Record indicated Resident 2 was admitted on [DATE], with diagnoses that included lack of coordination, hypertension (high blood pressure), and diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). A review of Resident 2's H&P, dated 7/22/2024, indicated Resident 2 has fluctuating capacity to understand and make decisions. A review of Resident 2's MDS, dated [DATE], indicated Resident 2 has intact cognition. During an interview on 3/19/2025 at 2:59 PM with Resident 1's roommate, Resident 2, Resident 2 stated he heard a verbal argument between Resident 1 and a male staff. Resident 2 stated no one has talked to him regarding that incident. During a phone interview on 3/19/2025 at 3:19 PM with Police Office (PO), the PO stated he went to the facility in response to Resident 1's call to the police. The PO stated Resident 1 stated he had a verbal argument with a male staff, LVN 1. The PO stated he conducted a phone interview with LVN 1 regarding the allegation. During an interview on 3/19/2025 at 3:25 PM, LVN 1 stated on 2/11/2025 at around 2:30 PM, he heard Resident 1 yelling at CNA 1 on the hallway. LVN 1 stated he went to grab Resident 1's wheelchair to take Resident 1 to the patio to calm him down. LVN 1 added that Resident 1 got up from his wheelchair, started yelling at him, and threw a baseball cap towards him. LVN 1 stated the PO called him on his phone on the night of 2/11/2025 and interviewed him regarding the allegation that he threatened Resident 1 by allegedly telling Resident 1 that he will bring 2 guys to hurt [Resident 1]. LVN 1 stated he did not report the allegation to the DON or the ADM. During an interview 3/19/2025 at 3:48 PM, RN 1 stated she remembers that a police officer visited the facility to interview Resident 1. RN 1 stated Resident 1 did not want to talk about the incident when she attempted to interview Resident 1. RN 1 stated she did not report to DON or ADM or the SA, that the police was called into the facility by Resident 1. During an interview on 3/19/2025 at 4:40 PM, the DON stated she was never informed that PO was called to the facility to investigate an allegation of abuse by Resident 1 against LVN 1. The DON stated LVN 1 never reported to her that he was interviewed by PO. The DON stated staff should have reported the incident to her or ADM for them to investigate the incident and protect the residents from further abuse. The DON stated if allegations of abuse are not addressed, residents could suffer harm such as physical harm and emotional distress. During an interview on 3/20/2025 at 9:44 AM, CNA 1 stated Resident 1 was yelling at her on the hallway because Resident 1 wanted a different CNA to care for him. CNA 1 stated LVN 1 approached Resident 1 and grabbed Resident 1's wheelchair. CNA 1 added Resident 1 stood up and started yelling at LVN 1. CNA 1 stated LVN 1 told Resident 1 to respect the CNA's. CNA 1 stated she did not report what she saw or heard to the DON or ADM or the SA. (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 3/20/2025 at 11:10 AM, the ADM stated CNA 1 and LVN 1 should have reported the incident to him, because all facility staff are mandated reporters of abuse. The ADM added RN 1 should have also reported that the police was in the facility so that he could have further investigated the reason for the police officer's visit to the facility. The ADM stated the verbal altercation with Resident 1 was a reportable incident for possible abuse. The ADM stated all allegations and incidents of abuse should be reported and investigated because it is part of taking care of residents and to prevent abuse from reoccurring. A review of Resident 1's Behavioral Symptoms care plan, initiated on 2/12/2025, indicated the resident has behavioral symptom or yelling/screaming and cursing, threatening staff . A review of the care plan did not include to take the resident to the patio, as an intervention for the behavior. The care plan included interventions for staff to: Honor resident's rights at all times. Identify times/approaches/staff that result in least resistance. When behavior occurs, remind resident of potential risks. Coax but do not force compliance. A review of the facility's job description for a Registered Nurse (RN), undated, indicated it is a job function of an RN to comply with abuse prevention and reporting policies and procedures. A review of the facility's job description for a Licensed Vocational Nurse (LVN), undated, indicated it is a job function of an LVN to comply with abuse prevention and reporting policies and procedures. A review of the facility's job description for a Certified Nursing Assistant (CNA), undated, indicated it is a job function of a CNA to report all accidents and incidents [they] observe on the shift that they occur. The job description also indicated that a CNA is to report all allegations of resident abuse. A review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating , revised 9/2022, indicated: If resident abuse is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 'Immediately' is defined as within two hours of an allegation involving abuse . All reports of resident abuse . are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. A review of the facility's policy and procedure (P&P) titled, Abuse Prevention Program , revised 12/2016, indicated 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 indicated that the admin will identify and assess all possible incidents of abuse. The P&P further indicated to investigate and report any allegations of abuse within timeframes as required by federal requirements.