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	06/09/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the resident ' s rights to be free from physical and verbal abuse for one of three sampled residents (Resident 2) by failing to protect Resident 2 from Resident 1, after Residents 1 and 2 had a prior physical altercation on 5/29/2025 at around 8 AM and 10 AM. This deficient practice resulted in Resident 2 experiencing physical and verbal abuse from Resideht 1 on 5/29/2025 and had the potential to result to physical injury and/or affect Resident 2 psychosocially. Findings: During a review of Resident 1 ' s admission Record (AR), the AR indicated a readmission to the facility on 4/9/2025 with diagnoses including schizoaffective disorder (a mental health condition including schizophrenia [a serious mental health condition that affects how people think, feel and behave] and mood disorder symptoms), hemiplegia (severe or complete loss of strength leading to paralysis on one side of the body) and hemiparesis (one-sided muscle weakness) following cerebral infarction (when the blood supply to part of the brain is blocked or reduced) affecting right dominant side, and dysphagia (difficulty swallowing). During a review of Resident 1 ' s History and Physical Assessment (H&P) dated 11/16/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set (MDS, an assessment and screen tool) dated 4/9/2025, the MDS indicated Resident 1 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding through thought, experience and the senses). During a review of Resident 1 ' s Progress Notes dated 5/29/2025 timed at 8:03 AM, the notes indicated Resident 1 was moved to another room. During a review of Resident 1 ' s Progress Notes dated 5/29/2025 timed at 10:33 AM, the notes indicated Resident 1 ' s attending physician was notified of Resident 1 ' s physical altercation with another resident and was ordered to transfer to the acute hospital for medical and psychiatric evaluation. (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

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	06/09/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Progress Notes dated 5/29/2025 timed at 12 noon, Resident 1 refused medications due and the physician was made aware. The notes indicated Resident1 was picked up by ambulance due to elevated blood pressure. During a review of Resident 2 ' s AR, the AR indicated an admission to the facility on 5/8/2025 with diagnoses including radiculopathy lumbar region (disorder that causes pain in the lower back and hip), polyneuropathies (condition in which a person ' s peripheral nerves are damaged), and osteoarthritis (degenerative joint disease, in which the tissues in the joint break down overtime). During a review of Resident 2 ' s H&P dated 5/9/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2 ' s MDS dated [DATE], the MDS indicated Resident 2 ' s cognition was intact. During a review of Resident 2 ' s SBAR Communication Form dated 5/29/2025 timed at 8 AM, the form indicated At approximately 7:40 AM, Resident 2 was having a verbal disagreement about his curtain and whether or not it should be closed. Victim (Resident 2) requested for it to be closed, which led to Aggressor (Resident 1) to get agitated and strike at Victim (Resident 2). Staff immediately responded and separated both residents. Took aggressor (Resident 1) to a different room and a head-to-toe assessment was done on Victim (Resident 2). Police and physician notified. Resident continuing to be monitored. During an interview on 6/6/2025 at 12:18 PM, the Social Services Director (SSD) stated on 5/29/2025 before 8 AM (around breakfast time), Resident 1 hit Resident 2. The SSD stated Resident 2 asked Certified Nursing Assistant (CNA) 1 to close the curtain between Resident 1 and 2 ' s beds. The SSD stated Resident 1 opened the curtains and hit Resident 2. The SSD stated both residents were separated and the police came to the facility. The SSD stated after that first incident, Resident 1 went back to his room to use the bathroom and turned on the tv, then told Resident 2 I ' m going get you. The SSD stated Resident 2 told Resident 1 I ' m ready for you to come at me. SSD staff were able to get Resident 1 out of the room. The SSD stated Resident 2 told her to call the police again and wanted Resident 1 to be arrested (around 10 AM). The police came back around 10 AM. During an interview on 6/6/2025 at 1:05 PM, Registered Nurse Supervisor (RNS) 1 stated after Resident 1 hit Resident 2 on 5/29/2025 (before 8 AM), Resident 1 was moved to another room. RNS 1 stated CNA 2 saw Resident 1 return back to his original room with Resident 2. RNS 1 stated she did not know how Resident 1 was able to go back to his original room after being moved to another room and should have been supervised. RNS 1 stated I don ' t know what happened, maybe lack of communication. During an interview on 6/6/2025 at 1:29 PM, CNA 2 stated that on 5/29/2025, she saw Resident 1 go back to the room and saw him turn on/off the television. CNA 2 stated she did not go and follow Resident 1 to the original room to stop Resident 1 from going back. (continued on next page)

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	06/09/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/6/2025 at 1:52 PM, Resident 2 stated that on 5/29/2025, he did not want to eat his breakfast and wanted CNA 1 to close the curtain to sleep. Resident 2 stated Resident 1 did not want the curtain closed and started hitting me. Resident 2 stated he had his pillow as defense and staff came to separate the 2 residents. Resident 2 stated he had no problems with Resident 1 before, they never spoke to each other. Resident 2 stated Resident 1 was not a pleasant person so he never spoke to him. Resident 2 stated after Resident 1 hit him, staff moved Resident 1 to another room. Resident 2 could not recall the time and heard someone in the bathroom and then turned the television on. Resident 2 stated Resident 1 said to him I ' m gonna get you. Resident 2 stated he told Resident 1 come at me then. Resident 2 stated staff took Resident 1 out of the room. Resident 2 stated he told the SSD to call the police again, because Resident 2 wanted to file charges against Resident 1. Resident 2 stated he did not feel safe while at the facility that time when Resident 1 keeps coming back and threatening him. During a telephone interview on 6/6/2025 at 2:10 PM, Activities Aide (AA) 1 stated he was watching Resident 1 and brought him to the Dining/Activity Room on 5/29/2025 after the altercation. AA 1 stated AA 2 covered for him when he went to lunch. During an interview on 6/6/2025 at 2:15 PM, AA 2 stated on 5/29/2025 in the morning, AA 1 brought Resident 1 to the activity room after the altercation with Resident 2 and another resident asked for coffee. AA 2 stated AA 1 left the room to get coffee for the other resident. AA 2 stated she did not notice Resident 1 leave the activity room. AA 2 stated she noticed Resident 1 was gone when AA 1 returned from getting the other resident ' s coffee. During a concurrent interview and record review of Resident 1 ' s progress notes, RNS 1 stated We didn ' t do another progress note because we thought it was the same, no one thought after the second incident happened, that they had to do another one. RNS 1 stated the second incident should have been included and should be in the progress notes. RNS 1 stated it was missed because they were so focused working on Resident 1 ' s transfer. RNS 1 stated Resident 1 should have been supervised the whole time, because he was the aggressor and went back to the room. RNS 1 stated it was important for residents to be separated for resident safety. During an interview on 6/6/2025 at 3:02 PM, the Director of Nursing (DON) stated she expects staff to document and notify the physician. The DON stated it was important to include documentation of the 2ndincident to make sure it was included in the resident ' s record. The DON stated the physician would be notified and interventions would be in place in care plan for resident. The DON stated the residents should have been completely separated to ensure the safety of residents. The DON stated if there was proper supervision, the 2nd incident between Resident 1 and 2 would not have happened. A review of the facility ' s undated policy and procedure (P&P) titled Abuse Prevention/Prohibition, indicated the facility does not condone any form of resident abuse, neglect, misappropriation of resident property, exploitation and/or mistreatment, and develops policies, procedures, training programs and systems in order to promote an environment free from abuse and mistreatment.