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	06/18/2025

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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to provide treatment and services to attain the highest practicable mental and psychosocial well- being for Resident 1 who was diagnosed with major depressive disorder, anxiety and schizophrenia (a mental illness that affect how person think, feel, behave, mixed symptoms such as hallucination, delusion, disorganized thinking and who was identified as having behavioral issues and verbalization of wanting to go to the hospital on 6/16/2025 at 8:15 PM to 11 PM, in one of two sampled residents reviewed for behaviors (Resident 1), by failing to: 1. Ensure 1:1 sitter (provide one to one nursing or observation care to an individual patient for a period of time) intervention was put in place for Resident 1 whose behaviors were escalating on 6/16/2025. 2. Inform Resident 1 ' s physician of Resident 1 ' s complaint of pain or chest pain and fall on 6/16/2025 and request to go to the acute hospital. Follow up with Resident 1 ' s physician for any new order when Resident 1 ' s physician did not give any instructions or orders on 6/16/2025 at 8:58 PM, upon Licensed Vocational Nurse (LVN) 1 ' s notification that Resident 1 had been readmitted back to the facility, in accordance with the facility ' s P&P on Change in a Resident's Condition or Status 3. Ensure additional follow up and intervention was developed for Resident 1 to ensure Resident 1 ' s safety and prevent injury and harm to self or to others after resident ' s behavior was observed to be escalating and not managed as reported by CNAs 1 and 2 to LVNs 1, 2 and 3, in accordance with the facility ' s P&P on Behavioral Assessment, Intervention and Monitoring. 4. Ensure the facility meet Resident 1 ' s mental health needs when LVNs 1, 2, and 3 did not address Resident 1 ' s request to go to the hospital and threatening behavior of putting her self on the floor, in accordance with the facility ' s P&P on Behavioral Assessment, Intervention and Monitoring. 5. Provide a safe environment by ensuring Resident 1 was supervised/monitor adequately to prevent accidents/hazards that may put Resident 1 or others in danger, in accordance with the facility ' s P&P on Behavioral Assessment, Intervention and Monitoring. (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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficient practice resulted in the facility violating its policy and escalating Resident ' s1 behavior resulting in the resident smashing a glass window and obtaining a sharp object (broken glass), which she was actively brandishing (wave or flourish something or a weapon, as a threat or in anger or excitement) and holding toward her neck, in an attempt to leave the facility and be transferred to the acute hospital. This failure has the potential to cause physical injury to Resident 1. Resident 1 was transferred to the General Acute Care Hospital (GACH) 1 on 6/17/2025 via 911 emergency services for Suicide Attempt. Findings: During a review of Resident 1 ' s admission Records (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnosis that included major depressive disorder, anxiety disorder and schizophrenia (a mental illness that affect how person think , feel, behave , mixed symptoms such as hallucination, delusion , disorganized thinking). During a review of Resident 1 ' s Hospital Progress Note provided by the facility from General Acute Care Hospital (GACH) 1, with date of service of 6/12/2025, the Note indicated Resident 1 has extensive During a review of Resident 1 ' s Hospital Progress Note provided by the facility from General Acute Care Hospital (GACH) 1, with date of service of 6/13/2025, the Hospital Progress Note indicated Resident 1 was recently admitted to GACH 1 Emergency Department (ED) on 5/30/25 for seizure activity. The GACH 1 record indicated the resident was discharged back to the facility on 6/16/2025. During a review of Resident 1 ' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 5/30/2025, the MDS indicated the resident was moderately impaired in cognition (problems with a person ' s ability to think, learn, remember, use judgement, and make decisions). During a review of Resident 1 ' s Change of Condition (COC), dated 6/16/2025 timed at 8:15 PM documented by LVN 1 indicated Resident admitted at 7:45 PM. At 8:15 Resident 1 was lying on the floor on her back next to bed. During a review of a facility provided text message obtained on the facility ' s physician communication phone, between Physician 1 and LVN 1, on 6/16/2025 at 8:57 PM, the text message indicated LVN 1 texted Physician 1 and reported Resident 1 requested to go back to the hospital and was found on the floor. The text message further indicated LVN 1 informing Physician 1 that [Resident 1] was not happy. On 6/16/2025 at 8:58 PM, Physician 2 responded via text message asking if Resident 1 was sent back to the facility. On 6/16/2025 at 8:58 PM, LVN 1 responded via text yes. On 6/16/2025 at 8:58 PM, Physician 1 asked via text message, Where is she [Resident 1]? On 6/16/2025 at 9:55 PM, LVN 1 responded via text message At the facility. During a review of Resident 1 ' s Nurse Note dated, 6/16/2025 timed at 10:39 PM documented by LVN 1, the Note indicated Resident 1 was observed moving herself off the bed onto the floor two times, lying and screaming for no apparent reason stating, I am going back on the floor. The Note indicated Risks and benefits explained to the resident moving herself to the floor is unsafe. Frequent visual checks rendered. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Nurse Note dated 6/17/2025 timed at 12:50 AM documented by LVN 3 indicated, the Note indicated A behavioral emergency (Code Orange) was in progress, involving a newly readmitted resident. The Note indicated that [LVN 1] stated that [Resident 1] shattered her room window using an unknown object and is armed with a large shard of glass. The Note indicated LVN 3 observed Resident 1 obtained a sharp jagged piece of glass approximately 2 feet in length and several inches wide, which she [Resident 1] was actively brandishing and holding toward her neck. The Note indicated Resident 1 was stating loudly and repeatedly, to send her back to the hospital, and demanding her nitroglycerin (medication to provide relief of chest pain). The Note indicated Resident 1 ' s Tone was threatening and unstable, subjective of acute psychological distress. The Note further indicated It was later discovered that the glass shard had been concealed under her [Resident 1] bedsheet immediately after breaking the window, indication intent to avoid detection and possible premeditation. The Note indicated 911 EMS was contacted, and a staff was assigned maintain line of sight observation. The Note indicated that at 1 AM, law enforcement and 911 EMS arrived at the facility and transferred Resident 1 back to GACH 1 for psychiatric evaluation. During a review of the Police Report dated 06/17/2025 timed at 12:56 AM, the Report indicated, on 06/17/25 at approximately 1 AM, the police officer arrived at the facility and upon arrival, medical (facility) staff informed the police officer that Resident 1 smashed the window by her bed and used the (broken) glass to threaten to take her own life. The Police Report further indicated that facility staff also stated that the resident was not ambulatory, however the resident (Resident 1) was in her bed, holding the piece of glass to her own neck. The Police Report indicated that after making contact with Resident 1 it was apparent that the resident was now holding the large piece of glass on her chest and a smaller piece in her right hand. The Police Report indicated when Resident 1 was asked why she was holding the glass; Resident 1 stated the facility staff mistreated her because they refused to give her medication. The Police Report indicated Resident 1 decided to threaten to take her own life. The Police Report indicated, after talking to Resident 1, she agreed to put down the glass as she wanted to transport her to the hospital. The Police Report indicated Resident 1 stated she had to act this way to get the appropriate attention so she could get her medication. The Police Report indicated the police officer spoke with [LVN 1] who stated Resident 1 arrived at 7:30 PM that evening (6/16/25) and had been complaining about treatment since her arrival, stating that she [Resident 1] needed medication. The Police Report indicated [LVN 1] also stated she found that the resident got herself out of bed and positioned herself on the floor multiple times. The Police Report indicated [LVN 1] stated that due to the fact that they refused to give Resident 1 medication, Resident 1 broke the glass and threatened to take her own life, at which point the staff called the police department and Resident 1 was transported to the hospital. During a review of the Transfer Form dated, 6/17/2025 timed at 1:36 AM, documented by LVN 3, the Form indicated Resident 1 was transferred to GACH 1 for suicide attempt. During an interview on 6/18/2025 at 10:25 AM with the ADON, the ADON stated on 6/17/2025 at around 1 AM, Resident 1 broke her room ' s window glass and placed the glass next to her neck. The ADON stated Resident 1 was transferred to the hospital for attempted suicide. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/18/2025 at 10:48 AM with the Administrator, the Administrator stated on 6/17/2025 around 1:30 AM, he was informed by LVN 3 that Resident 1 broke the window in her room and held the glass next to her neck. The Administrator stated he arrived at the facility on 6/17/2025 at around 2 AM but Resident 1 was already transferred to GACH 1 and observed that Resident 1 ' s window glass inside the room was broken. The Administrator stated it was not usual for the facility to have a resident break the glass and attempt suicide During an interview on 6/18/2025 at 12:03 PM with LVN 1, LVN 1 stated she was working on 6/16/2025 from 3 PM to 6/16/2025 at 11 PM, however LVN 1 stayed longer due to the incident that happened that night with Resident 1. LVN 1 stated Resident 1 was admitted to the facility on [DATE] at around 7:45 PM. LVN 1 stated that on 6/16/2025 at around 8:15 PM, LVN 1 was informed by CNA 1 that Resident 1 was on the floor. LVN 1 stated Resident 1 was agitated and screaming that she does not want to stay at the facility. LVN 1 stated she sent a text message to Physician 1 that Resident 1 does not want to stay at the facility. LVN 1 stated Physician 1 asked where Resident 1 is but did not give any instructions or orders. LVN 1 stated she did not follow up or call Physician 1 to clarify any orders. LVN 1 stated about 30 minutes later, after Physician 1 ' s text message, Resident 1 started screaming for no reason and try to get out of the bed and asked to send her to the hospital. During the same interview on 6/18/2025 at 12:03 PM with LVN 1, LVN 1 stated she asked CNA 1 to do frequent rounds and check on Resident 1 to prevent her from getting out of bed and fall. LVN 1 stated Resident 1 behavior (yelling and screaming) was escalating through the night, and it was not manageable try to talk to her [Resident 1] and redirect, but Resident 1 did not want to stay at the facility. LVN 1 stated on the same night at around 11:39 PM, Resident 1 was found again on the floor and screaming and agitated demanding to go back to hospital. LVN 1 stated Resident 1 was assisted back to bed but at around 12:30 AM to 1 AM (12/17/25), the facility staff heard a noise and observed Resident 1 inside her room with a broken glass in her hand and holding it close to her neck and saying she has chest pain and wants to go to the hospital. LVN 1 stated Resident 1 was not redirectable and behavior was not managed. LVN 1 stated she was scared for the safety of Resident 1 and other residents, and staff. LVN 1 stated she did not follow up or called Physician 1 that Resident 1 ' s behavior was escalating and behavior is not being managed in the facility. LVN 1 stated she did not document a change in condition [COC] form for Resident 1 ' s behavior. During an interview on 6/18/2025 at 12:55 PM with LVN 3, LVN 3 stated he was at the facility on 6/16/2025 from 3 PM to 11 PM, however stayed longer due to the incident that happen. LVN 3 stated on 6/16/2025 at around 10:30 PM, LVN 1 informed her that Resident 1 was on the floor, and she need help to transfer Resident 1 back to bed. LVN 3 stated he delegated to CNA 1 to help LVN 1. LVN3 stated he asked CNA 2 around 11 PM to do frequent rounds on Resident 1 and stay with her, however CNA 2 would come to the Nursing Station and informed LVN 3 that Resident 1 ' s behavior (getting out of bed) was not manageable. LVN 3 stated he reinstructed CNA 2 to stay with Resident 1. LVN 3 stated he was informed by LVN 1 around 1 AM that Resident 1 broke the window glass. LVN 3 stated he went to Resident 1 ' s room and observed Resident 1 holding a big glass next to her neck. LVN 3 stated he called 911 EMS. LVN 3 stated if a resident ' s behavior is not managed and escalating (screaming and demanding to go back to hospital), staff should call and notify the physician and if the physician is not available, staff should call 911. LVN 3 stated he did not call 911 right away, since LVN 2 was already on duty and assigned to Resident 1. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/18/2025 at 1:28 PM with LVN 2, LVN 2 stated he was working on 6/16/2025 from 11 PM to 6/17/2025 at 7 AM and was assigned to Resident 1. LVN 2 stated around 11 PM to 11:30 PM Resident 1 reported to him that she has pain, and she was screaming and yelling that she wants to go to hospital, and no one was helping her. LVN 2 stated he asked where the pain was but Resident 1 could not tell her where the pain is, she was screaming, and she was not responding to redirection. LVN 2 stated he ask CNA 2 to do frequent check to Resident 1 since LVN 2 had to attend another resident. LVN 2 stated Resident 1 ' s behavior was not managed. LVN 2 stated he does not know how he could he managed the behavior of yelling and screaming and trying to get out of bed. LVN 2 stated he did not call the physician to notify the physician of Resident 1 ' s pain and escalating behavior. During an interview on 6/18/2025 at 1:52 PM with CNA 1, CNA 1 stated he was working on 6/16/2025 from 3 PM to 11 PM and was assigned to Resident 1. CNA 1 stated on 6/16/2025 at around 8:15 PM, he found Resident 1 on the floor and reported it to LVN 1. CNA 1 stated Resident 1 was demanding to go to the hospital and does not want to stay in the facility. CNA 1 stated he heard that Resident 1 reported to LVN1 that she wants to go to the hospital, but LVN 1 reported to her that she has to ask the physician. CNA 1 stated Resident 1 constantly asking from 8:15 PM to 11 PM, on 6/16/2025 to send her to the hospital. CNA 1 stated she reported the behavior to LVN 1 and LVN 3 and they were aware. During an interview on 6/18/2025 at 2:02 PM with CNA 2 , CNA 2 stated he was working on 6/16/2025 from 11 PM to 6/17/2025 at 7 AM and was assigned to Resident 1.CNA 2 stated from the beginning of his shift on 6/16/2025 at 11 PM , Resident 1 was asking to go to the hospital and telling LVN 2 that she has a chest pain and requesting Nitroglycerin. CNA 2 stated LVN 2 left Resident 1 ' s room and did not come back. CNA 2 stated Resident 1 was yelling and agitated from 11 PM until the incident happened. CNA 2 stated he stayed the room with Resident 1 and try to calm her down, but she was not redirectable. CNA 2 stated around 12:50 AM, CNA2 observed Resident 1 breaking the window of her room and holding on to a glass in her hand very close to her neck and demanding to go to the hospital. CNA 2 stated LVN 2 did not attend to care for Resident 1, until Resident 1 broke the glass. During an interview and record review of Resident 1 medical records from 6/16/2025 to 6/17/2025, on 6/18/2025 at 2:08 PM with the ADON, the ADON stated if a resident ' s mental or physical condition change such as Resident 1 ' s report of pain or chest pain, the staff should do a complete assessment, inform the physician, and document in the COC form. The ADON stated if Resident 1 refuse assessment, staff should document in the nurses note that resident refused. If Resident behavior is not managed and agitated and staff was unable to assess Resident 1 and unable to redirect, the staff should inform the physician. The ADON stated if the physician was not available and behavior not managed, staff should call 911 EMS. The ADON stated Resident 1 ' s behavior was not managed in this incident and could have been prevented if staff would have assigned one on one supervision and call 911 for the report of chest pain if staff cannot assess properly such as check blood pressure or heart rate. The ADON stated since Resident 1 was a new admit, there was no comprehensive care plan initiated yet. The ADON stated there is no documentation that Resident 1 had pain, chest pain, or the behavior (screaming yelling) was present. The ADON stated there is no documentation what intervention was provided to manage her behavior. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility P&P titled Behavioral Assessment, Intervention and Monitoring revised March 2019, the P&P indicated The facility will provide, and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental ,and psychosocial well being in accordance with the comprehensive assessment and plan of care. Behavioral health services will be provided by qualified staff who have the competencies and skills necessary to provide appropriate services to Residents. Residents will have minimal complication associated with management of altered or impaired behavior. Behavior is the response ofan individual to a wide variety of factors. These factors may include [NAME].) physical, functional, psychosocial, emotional, psychiatric, or environmental causes. a. Behavior is regulated by the brain and is influenced by past experiences, personality traits, environment, and interactions with other people. b. Behavior can be a way for an individual in distress to communicate unmet needs, indicate discomfort, or express thoughts that cannot be articulated. As part of the comprehensive assessment, staff will evaluate, based on input from the resident, family and caregivers, review of medical record and general observations: The resident's usual patterns of cognition, mood and behavior; b The Resident's usual method of communicating things like pain, hunger, thirst, and other physical discomforts . The resident's typical or past responses to stress, fatigue, fear, anxiety, frustration and other triggers; The resident's previous patterns of coping with stress, anxiety, and depression. 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: a. Onset, duration, intensity and frequency of behavioral symptoms; b. Any recent precipitation or relevant factors or environmental triggers (e.g., medication changes , infection , recent transfer from hospital) Appearance and alertness of the resident and related observations. New onset or changes in behavior will be documented regardless of the degree of risk to the resident or others. The Resident or /and resident surrogate will have a right to refuse treatment . Innervations will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand , prevent or relive the resident distress or loss of ability. During a review of facility P&P titled Change in a Resident's Condition or Status revised May 2017, the P&P indicated Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). The nurse will notify the resident's Attending Physician or physician on call when there has been a(an) significant change in the resident's physical/emotional/mental condition; need to alter the resident's medical treatment significantly; refusal of treatment or medications two (2) or more consecutive times); need to transfer the resident to a hospital/treatment center; specific instruction to notify the Physician of changes in the resident's condition. Asignificant change of condition is a major decline or improvement in the resident's status that: Will not normally resolve itself without intervention by staff or by implementing standard disease- related clinical interventions (is not self-limiting); Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.