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	12/15/2025

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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its policies and procedures titled Abuse Prevention/Prohibition and Abuse Reporting and Investigation for two of two sampled residents (Residents 45 and 46) by failing to protect, prevent, report, and investigate an alleged physical abuse incident that occurred between Residents 45 and 46 on 07/13/2025. Specifically, the facility failed to: 1. Identify the physical altercation between Residents 45 and 46 as a form of abuse, which was reported by Licensed Vocational Nurses (LVNs) 2 and 7 to the Administrator on 07/13/2025, and which resulted in a mark on Resident 45's upper left forehead. 2. Protect Resident 45 and prevent further physical abuse when licensed nurses did not develop a care plan after LVNs 2 and 7 were made aware of the allegation of physical abuse by Resident 46 toward Resident 45. 3. Report Resident 45's allegation of physical abuse by Resident 46 to the Department of Public Health (State Survey Agency), local law enforcement, the Ombudsman (state agency that advocates for residents), and Adult Protective Services (agency that protects adults and the elderly) on 07/13/2025. 4. Investigate and document the investigation to determine whether abuse had occurred and to protect Resident 45 from further physical abuse by Resident 46. These deficient practices placed Residents 45 and 46, as well as other residents in the facility, at risk for further abuse, feelings of intimidation, and neglect. Findings: During an interview on 12/15/2025 from 11 AM to 1 PM with the Staff Coordinator (SC) 1, SC 1 stated on 7/13/2025 SC 1 started her shift at 5 AM. SC 1 stated she was in Station 1 when she heard a noise coming from the Resident 45 and 46's room. SC 1 stated she responded to the noise and saw Resident 45 and 46 looked like they just had an argument, SC 1 stated the incident was reported to LN 7 and LN 7 went to the resident's room. SC1 stated Resident 45 alleged that Resident 46 hit Resident 45 to the head that had left a mark. SC 1 showed surveyor the photo she held in her phone, stated she kept the photo just to assist staff with their investigation. During a concurrent review of the photo, the photo was taken from the anterior left angle of Resident 45's face and showed a peach-colored mark, size of approximately one inch in diameter, located on upper left portion of the resident's forehead. SC 1 further stated that later the ADM came to the facility and informed SC 1, LN 2, and LN 7 that he would take care of the alleged incident between Residents 45 and 46 and told them not to report the incident to anyone. 1. During a review of Resident 45's admission Record (AR) indicated that the facility admitted Resident 45 on 4/24/2025 with diagnoses including, bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), cognitive communication deficits (difficulty communicating because of injury to the brain that controls the ability to think.) During a review of Resident 45's History and Physical (H&P) dated 4/25/2025, the H&P indicated that Resident 45 did not have the capacity to understand and make decisions. During a review of Resident 45's Minimum Data Set (MDS- a resident assessment tool) dated 7/17/2025, the MDS indicated Resident 45 was severely cognitively impaired (rarely/never made decisions). The MDS indicated that Resident 45 had verbal behavior symptoms directed toward others. During a review of Resident 45's Change in Condition Evaluation (COC) dated 7/13/2025, the COC indicated Resident 45 had behavioral symptoms with no further documentation describing Resident 45's behaviors, and indicated a change in skin color or condition. The COC indicated a blank where the provider notification should be notified. The COC also indicated a blank where Resident 45's responsible party should be notified. During a review of Resident 45's Progress Notes dated 7/1/2025 to 7/18/2025, the Note did not indicate any documentation of any unknown injury for Resident 45. During a review of Resident 45's Care Plans, there was no documented evidence indicating a care plan was developed related to the alleged incident on 7/13/25. During a review of Resident 46's admission Record (AR), the AR indicated that the facility originally admitted Resident 46 on 11/13/2015 and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), and anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms.) During a review of Resident 46's MDS dated [DATE], the MDS indicated Resident 45 was severely cognitively impaired (rarely/never made decisions). The MDS also indicated that Resident 46 required partial/moderate assistance (Helper does less than half the effort) on rolling left-and-right, sit to lying, and lying-to-sitting on side of bed. During a review of Resident 46's Progress Notes dated from 7/1/2025 to 7/31/2025, there was no documented evidence related to any altercation with Resident 45. During a review of Resident 46's Care Plans, there was no documented evidence indicating a care plan was developed related to the alleged

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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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an alleged resident to resident altercation within 24 hours for two of two sampled residents (Resident 45 and Resident 46) to the California Department of Public Health (CDPH) in accordance with the facility's Policy and Procedure (P&P) titled, Abuse Reporting and Investigation. This deficient practice resulted in the facility underreporting allegations of abuse and Resident 45 sustaining a red mark in between the left frontal and temporal area (upper left portion of the forehead). Findings: 1.During a review of Resident 45's admission Record (AR), the AR indicated that Resident 45 was admitted to the facility on [DATE] with diagnoses including, bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), cognitive communication deficits (difficulty communicating because of injury to the brain that controls the ability to think.) During a review of Resident 45's History and Physical (H&P) dated 4/25/2025, the H&P indicated that Resident 45 did not have the capacity to understand and make decisions. During a review of Resident 45's History and Physical (H&P) dated 4/25/2025, the H&P indicated that Resident 45 did not have the capacity to understand and make decisions. During a review of Resident 45's Minimum Data Set (MDS- a resident assessment tool) dated 7/17/2025, the MDS indicated Resident 45 was severely cognitively impaired (rarely/never made decisions). The MDS indicated that Resident 45 had verbal behavior symptoms directed toward others. During a review of Resident 45's Change in Condition Evaluation (COC) dated 7/13/2025, the COC indicated Resident 45 had behavioral symptoms with no further documentation describing Resident 45's behaviors, and indicated a change in skin color or condition. The COC indicated a blank where the provider notification should be notified. The COC also indicated a blank where Resident 45's responsible party should be notified. During a review of Resident 45's Progress Notes dated from 7/1/2025 to 7/18/2025, there was no documented evidence related to any unknown injury. 2. During a review of Resident 46's admission Record (AR), the AR indicated that the facility originally admitted Resident 46 on 11/13/2015 and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), and anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms.) During a review of Resident 46's MDS dated [DATE], the MDS indicated Resident 46 was severely cognitively impaired (rarely/never made decisions). The MDS also indicated that Resident 46 required partial/moderate assistance (Helper does less than half the effort) on rolling left-and-right, sit to lying, and lying-to-sitting on side of bed. During a review of Resident 46's Progress Notes dated from 7/1/2025 to 7/31/2025, there was no documented evidence related to any incident involving Resident 46 and Resident 45. During a review of Resident 46's Change in Condition Evaluation from 7/1/2025 to 7/31/2025, there was no documented evidence related to any resident-to-resident altercation between Residents 45 and 46. During an interview on 12/15/2025 at 11:39 AM with the Staff Coordinator (SC) 1, SC 1 stated on 7/13/2025 SC 1 started her shift at 5 AM. SC 1 stated she was in Station 1 when she heard a noise coming from the Resident 45 and 46's room. SC 1 stated she responded to the noise and saw Resident 45 and 46 looked like they just had an argument, SC 1 stated the incident was reported to LN 7 and LN 7 went to the resident's room. SC1 stated Resident 45 alleged that Resident 46 hit Resident 45 to the head that had left a mark. SC 1 showed surveyor the photo she held in her phone, stated she kept the photo just to assist staff with their investigation. During a concurrent review of the photo, the photo was taken from the anterior left angle of Resident 45's face and showed a peach-colored mark, size of approximately one inch in diameter, located on upper left portion of the resident's forehead. SC 1 further stated that later the ADM came to the facility and informed SC 1, LN 2, and LN 7 that he would take care of the alleged incident between Residents 45 and 46 and told them not to report the incident to anyone. During an interview on 12/15/2025 at 12:59 PM with Licensed Nurse (LN) 2, LN 2 stated that on 7/13/2025 between 5 AM to 6 AM, LN 2 recalled there was an incident which occurred in Resident 45's room. LN 2 stated that together with LN 7, they heard a commotion coming from Resident 45's room. LN 2 stated, LN 2 and LN 7 responded to the noise and saw that Resident 45 and Resident 46 looked upset. Resident 46 informed LN 2 that Resident 45 hit her first. LN 2 stated Resident 45 and Resident 46 were separated immediately, and Resident 46 was temporarily moved to another room. LN 2 stated that the administrator (ADM) came in early that morning and LN 2 reported this incident to the ADM, who said that he will take care of everything. LN 2 stated this incident occurred close to the morning shift change on 7/13/2025. LN 2 stated since ADM said he would take care of

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to ensure that Resident 34 received appropriate pain management for open wounds on the right and left temporal areas by failing to: 1. Monitor and document Resident 34's pain before, during, and after wound treatments on 5/5/2025, 5/26/2025, 7/24/2025, 8/23/2025, and from 12/1/2025 to 12/13/2025, in accordance with physician orders and the resident's care plan. 2. Reevaluate Resident 34's pain management and notify Physician 1 (Attending Physician) of the resident's refusal of wound care treatments due to pain and sensitivity in the right and left temporal wounds, as required by the facility's policy and procedure (P&P) titled Pain - Clinical Protocol and care plan for refusal of treatments. 3 Monitor and document the probable causes of each pain episode, including pain characteristics and relieving factors, every shift and as needed. The facility also failed to monitor, record, and report any signs and symptoms of non-verbal pain indicators, as outlined in the resident's pain care plan. These failures resulted in Resident 34 exhibiting both verbal and non-verbal signs of pain during activities of daily living (ADL) care and wound treatments. Consequently, Resident 34 experienced unnecessary pain, which negatively impacted his quality of life and overall well-being. Findings: During a review of Resident 34's admission Record (AR), the facility admitted Resident 34 on 12/2/2023 and readmitted on [DATE] with diagnoses that included open wound of right cheek and temporomandibular (area connecting jawbone to skull in front of the ears) area and squamous cell carcinoma of skin (skin cancer) of other parts of face. During a review of Resident 34's care plan (CP), dated 2/20/2025, the CP indicated Resident 34 experienced acute (short term) pain and chronic (long term) pain. The CP's interventions included to establish a pain management treatment plan, evaluate the effectiveness of non-pharmacological and pharmacological treatments, evaluate for pain, and evaluate for non-verbal indicators of pain. During a review of Resident 34's Order Recap Report, with an order date of 3/1/2025 and discontinued date 11/22/2025, the order indicated to administer Acetaminophen Oral Tablet 325 milligrams (mg, unit of weight), two tablets by mouth every six hours as needed for moderate to severe pain (4-10) on the numerical number scale (0/10 indicated no pain to 10/10 indicated the worse pain ever felt). During a review of Resident 34's Order Recap Report, with an order date 5/9/2025 and discontinued date 8/3/2025, the order indicated to monitor Resident 34's pain levels before, during and after treatment as needed and every evening shift. During a review of Resident 34's Order Recap Report, with an order date 5/3/2025 and discontinued date 6/3/2025, the order indicated Resident 34's right temporal wound care included to clean the right temporal open wound with normal saline solution, pat dry, apply betadine 10% solution and leave open to air every evening shift for 30 days and as needed for 30 days. During a review of Resident 34's Order Recap Report, with an order date 5/3/2025 and discontinued date 6/3/2025, the order indicated Resident 34's left temporal wound care included to apply Vitamin A and D ointment to the left temporal scab and leave open to air for 30 days and as needed for 30 days. During a review of Physician 3 (Dermatology)'s Visit Note, dated 5/16/2025, Physician 3 indicated Resident 34 had skin lesions (any area of skin that looks different from the surrounding skin), located on the left lateral forehead and the right lateral forehead. Physician 3 indicated these growths were asymmetric, bleeding, draining, growing, not healing, oozing, scaley, spreading, and tender and moderate in severity. Physician 3 indicated that Resident 34's skin lesions were interfering with grooming and catching on his clothing, and these skin lesions were red, swelling, and itchy. During a review of Resident 3's Dermatopathology Report, reported on 5/21/2025, the report indicated Resident 34 had a left and right lateral forehead shaved biopsy that indicated squamous cell carcinoma with adnexal extensions. The report indicated these lesions extended to both peripheral margins and to deep margin. During a review of Resident 34's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for the month of May 2025, on the dates 5/5/2025 and 5/26/2025, was reviewed. The TAR, on 5/5/2025 to monitor pain level before, during, and after treatment, was left blank. The MAR, on 5/26/2025 for pain monitoring every shift, was blank. There was no documented evidence Resident 34 was premedicated or offered pain medications prior to the left and right open temporal wound treatment. During a review of Resident 34's CP, revised 6/26/2025, the CP indicated Resident 34 was at risk for pain related to right temporal wound. The CP's interventions included to monitor and document probable causes of each pain episode, to monitor/record the pain characteristics such as quality, severity, location, duration, aggravating factors, and relieving factors every shift and as needed, and to monitor/record/report any signs and

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure continuous communication and collaboration for Resident 34's overall medical management between Physician 1 (Attending Physician), Physician 2 (Wound Care Specialist, physician who specializes in Wound Care and management), Physician 3 (Dermatologist, physician who specializes in skin care and management), and Physician 4 (Oncologist, physician who specializes in cancer and cancer management). This failure resulted in the breakdown of communication and collaboration between Resident 34's physicians which led to the lack of direction for Resident 34's overall medical care and management. Cross Reference F697 Findings: During a review of Resident 34's admission Record (AR), the facility admitted Resident 34 on 12/2/2023 and readmitted Resident 34 on 11/22/2025 with diagnoses that include squamous cell carcinoma (skin cancer) of skin of other parts of face, open wound of right cheek and temporomandibular (area connecting jawbone to skull in front of the ears) and dementia (a progressive state of decline in mental abilities). The AR indicated Resident 34's responsible part was the Bioethics Committee (committee within the facility composed of the interdisciplinary team (IDT) including the Medical Director, Attending Physician, Nursing Services, Social Services, and other ancillary staff). During a review of Resident 34's Wound Assessment Report written by Treatment Nurse (TXN) 3, dated 12/2/2023, TXN 3 indicated Resident 34 had a right temple hematoma (a collection of blood outside of a blood vessel caused by a broken blood vessel) sized 3 centimeters (cm) by 3 cm that was raised and dark colored. During a review of Resident 34's Minimum Data Set (MDS, a resident's assessment tool), dated 12/7/2023, the MDS indicated Resident 34's cognition (a residents thought process) was moderately impaired. The MDS indicated Resident 34 required moderate assistance (helper does less than half the effort) for activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily) and required moderate assistance when transferring from a sitting to standing position and repositioning self in bed. The MDS indicated Resident 34 was not receiving a pain management regimen and denied pain. The MDS indicated the staff assessment for pain was blank and Resident 34's indicators for pain such as non-verbal sounds (such as groaning, gasping, or crying), vocal complaints (such as ouch or stop), facial expressions (such as grimacing, wincing, or clenched teeth or jaw), or protective body movements (such as guarding, bracing, or tensing a body part). The MDS did not indicate Resident 34 had any open lesions (an area of abnormal or damaged tissue caused by injury, infection, or disease). During a review of Physician 2's (Wound Care Specialist, physician who specializes in Wound Care and management) Surgical Notes, dated 4/9/2024, 4/16/2024, 4/23/2024, 4/30/2024, 5/7/2024, 5/14/2024, and 5/21/2024 Resident 34 had a left and right temporal wound. Physician 2 indicated Resident 34's left temporal wound was sized 3 cm by 3 cm with scant amount of serosanguineous (fluid mixed with blood and serum) drainage, unstable peri-wound (skin around the wound) and erythematous (inflamed and red) wound edge. Physician 2 indicated Resident 34's right temporal wound had increased in size from 7 cm by 7 cm to 8 cm by 8 cm with mild to scant amounts of serosanguineous drainage, unstable peri-wound, and friable (easily crumbled) wound edge on 5/21/2024. Physician 2 indicated that the recommended dressing was Betadine (antiseptic) solution cleanse and dry dressing. Physician 2 did not indicate in her 5/21/2024 Surgical Note the reason she stopped Resident 34's wound care consultation after 5/21/2024. During a review of Physician 3 (Dermatology)'s Visit Note, dated 5/16/2025, Physician 3 indicated Resident 34 had skin lesions (any area of skin that looks different from the surrounding skin), located on the left lateral forehead and the right lateral forehead. Physician 3 indicated these growths were asymmetric, bleeding, draining, growing, not healing, oozing, scaley, spreading, and tender and moderate in severity. Physician 3 indicated that Resident 34's skin lesions were interfering with grooming and catching on his clothing, and these skin lesions were red, swelling, and itchy. Physician 3 indicated Resident 34's plan of care was to refer Resident 34 to Physician 5 (Specialized Dermatologist who surgically removes skin cancer). During a review of Resident 3's Dermatopathology Report, reported on 5/21/2025, the report indicated Resident 34 had a left and right lateral forehead shaved biopsy that indicated squamous cell carcinoma with adnexal extensions. The report indicated these lesions extended to both peripheral margins and to deep margin. During a review of Resident 34's Nursing Progress Notes (PN), dated 6/17/2024 timed at 12:32 PM, the PN indicated Physician 3 recommended Resident 34 to be referred to Physician 4 (Oncologist physician who specializes in cancer care and management). During a review of Physician 4's New Visit note, dated 6/27/2024, Physician 4 indicated Resident 34 had high risk squamous