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	02/12/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) who had a behavioral problem were assessed, monitored, supervised and provided necessary care since admission to the facility on 1/26/2026. This deficient practice resulted in Resident 1 hitting another resident (Resident 2) on 1/29/2026.Findings: During a review of General Acute Care Hospital (GACH) Psychiatry evaluation (assessment conducted by mental health professionals to diagnose mental health, behavioral, or learning disorders) dated 1/18/2026, the Evaluation indicated Resident 1 had a history of depression, anxiety, frustration, irritability, agitation, and lack of motivation. Resident 1 reported having dark thoughts and thoughts of (suicide the act of intentionally causing one's own death). Resident 1 was having difficulty resisting urges to self-harm. Resident 1 was unpredictable with a lack of coping skills and frustration. Resident 1 was reluctant to share details of why he was admitted , Resident reported he cannot quite understand. The Evaluation indicated Resident 1 appeared to be disheveled, guarded, and poor eye contact with psychomotor agitation. Mood and affect were labile, with thoughts of suicidal plan to overdose. The Evaluation indicated Resident 1's insight, judgement and impulse control were impaired. During a review of GACH History and Physical, dated 1/19/2026, Resident 1 was admitted for increased agitation and anxiety for two days. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety (a feeling of fear, dread, and uneasiness), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 1's Social Service History and Initial Assessment, dated 1/27/2026, timed 8:52 AM, the Assessment indicated blank check marks on the following boxes has no check marks for Resident 1's psychosocial (relating to the interrelation of social factors and individual thought and behavior) adjustment factors.Distressed moodHistory of depressionHistory of suicidal ideation/gesturesAnxiety/uneasinessInsomnia (trouble falling asleep or staying asleepUse of psychotropic medicationsHistory of drug/alcohol abuseDisruptive behaviorDifficulty controlling behaviorAgitation, aggressionResistant to care During a review of Resident 1's Interdisciplinary Team (IDT, a collaborative group of health professionals and direct care staff responsible for developing, implementing, and reviewing a resident's comprehensive care plan) conference record, dated 1/27/2026, timed 10:30 AM, the IDT indicated Resident 1 and Resident 1's responsible agent participated in the IDT meeting. The IDT indicated the team looked closer on several considerations and deemed to admit Resident 1 to psych services under nursing. For it will be more beneficial to Resident 1, to prevent further decline with the treatment for diagnosis of schizophrenia, anxiety, depression and bipolar. The IDT indicated Resident 1 will be on close daily monitoring for medication regimen, treatment, compliance of the plan of care. The IDT indicated Resident 1's responsible agent stated Resident 1 has history of (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychiatric hospitalization. During a review of Resident 1's Order Summary Report dated from 1/26/2026 to 2/9/2026, the Report indicated the following orders:Monitor anxiety manifested by repetitive anxious complaints, ordered on 1/26/2026.Monitor schizophrenia manifested by paranoia, ordered on 1/26/2026.Monitor insomnia manifested by inability to sleep, ordered on 1/26/2026. During a review of Resident 1's Care Plan (CP) focusing on psychosocial wellbeing (actual or potential) related to anxiety, dependent behavior, disease process. Distractibility/inability to concentrate, inability to meet role expectations, ineffective coping, lack of acceptance to current condition. Lack of motivation, initiated on 1/28/2026, the Care Plan interventions included the following:Consult with social servicesMonitor/document Resident 1's usual response to problemsMonitor behavior every shift and recordPsychiatric (a medical practitioner specializing in the diagnosis and treatment of mental illness) consultWhen conflict arises, remove Resident 1 to a calm safe environment and allow to vent/share feelings. During a review of Resident 1's Change of Condition (COC) Evaluation, dated 1/29/2026, timed 8:46 AM, the COC indicated Resident 1 has alleged physical abused of slap another resident. The COC evaluation also indicated Resident 1 was observed by staff slapping another resident on the right upper back. Resident 1 stated he do not know why he did it. During an interview on 2/11/2026 at 11:31 AM, with Payroll, Payroll stated she witnessed Resident 1 walking in the hallway, then out of nowhere, Resident 1 stopped behind Resident 2, and with Resident 1's right hand's open palm, Resident 1 hit Resident 2. Payroll stated the action looks like a harder than a tap, like a hard smack, with a sound. After Resident 1 hit Resident 2, Resident 1 continued to walk down the hallway away from Resident 2. During an interview on 2/11/2026 at 12:02 PM, with central supply staff (CSS), CSS stated he witnessed on 1/29/2026, morning before resident's smoke break (8 AM - 9 AM), CSS stated he was with Payroll in the front lobby with Resident 2 who is sitting in a wheelchair, CSS observed Resident 1 walking up and down the hallway, then suddenly, Resident 1 hit Resident 2's back area. CSS stated the hit was like a slap from the sound of it. CSS stated Resident 1 walked away after hitting Resident 2. During an interview on 2/11/2026 at 2:18 PM with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated that on 1/29/2026, Resident 1 rushed to eat breakfast and left the room for smoke break. CNA 1 stated the incident of Resident 1 hitting Resident 2 happened before the smoke break. CNA 1 stated Resident 1 was just walking up and down the hallway while waiting for the staff and other residents to go out to smoke. During a concurrent interview and record review on 2/12/2026 at 8:20 AM with Social Service Director (SSD), Resident 1's Social Service History and Initial Assessment, dated 1/27/2026, and admission IDT dated 1/27/2026 were reviewed. SSD stated the Social Service History and Initial Assessment and IDT meeting was conducted on 1/27/2026, the day after Resident 1 was admitted to the facility. SSD stated she had not reviewed Resident 1's hospital records prior to admission to the facility. SSD stated that she was not aware of Resident 1's behavior of increased agitation and having dark thoughts and thoughts of suicide. SSD verified the Social Service assessment and IDT did not and should have indicated Resident 1's past behaviors that was documented in the GACH records. SSD stated Resident 1's past behaviors were not and should have been discussed during IDT, and plan of care, such as to conduct one to one (1:1, staff continually stay with resident) monitoring since admission until psychiatrist evaluated and checked if medications are enough and if care is appropriate. During a concurrent record review and interview on 2/12/2026 at 8:56 AM with Licensed Nurse 1 (LN 1), Resident 1's medical records were reviewed. LN 1 stated she admitted Resident 1 in the facility on 1/26/2026. LN 1 stated she received the report from GACH that Resident 1 had increased aggressive behavior. LN 1 admitted she did not ask and should have asked GACH staff which specific aggressive behavior Resident 1 manifested and if psychiatrist evaluation was conducted in GACH. LN 1 stated she (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not review the hospital records that came along with Resident 1 on 1/26/2026. LN 1 stated the following orders were made on 1/26/2026 based on what she observed with Resident 1:Monitor anxiety manifested by repetitive anxious complaints.Monitor schizophrenia manifested by paranoia.LN 1 stated Resident 1 was observed on 1/26/2026 to be a little anxious and kept asking what is this place again?, What time is smoking again?, repetitively. LN 1 stated these behaviors was care planned on 1/29/2026, after Resident 1 slapped another resident. LN 1 stated Resident 1's past behaviors should have been known to the facility, and plan of care should have been initiated. Resident 1's past behaviors should have been considered, and 1:1 monitoring should have been ordered until Resident 1 was seen by the Psychiatrist. LN 1 verified the Psychiatrist consult was ordered on 1/28/2026, and the Psychologist (a person who specializes in the study of mind and behavior) consult was ordered on 1/29/2026. LN 1 stated Resident 1 was not evaluated in the facility by the Psychiatrist before 1/29/2026 incident of slapping another resident. LN 1 stated a Psychiatrist consult order upon admission should have been ordered. LN 1 stated Resident 1's GACH records and behaviors should have been discussed during IDT on 1/27/2026. LN 1 stated all licensed staff can initiate and develop a care plan. During a concurrent interview and record review and interview on 2/12/2026 at 10:30 AM with LN 2, Resident 1's medical records were reviewed. LN 2 stated she was not aware of Resident 1's specific past psychiatric behaviors. LN 2 stated an IDT meeting was conducted on 1/27/2026 with Resident 1 and Resident 1's responsible agent, and specific behaviors were not discussed. LN 2 stated she had not and should have reviewed Resident 1's GACH medical records, and that Resident 1's GACH records should have been reviewed, and it should have been discussed during the IDT meeting on 1/27/2026. LN 2 stated Resident 1's baseline care plan was completed on 1/26/2026, indicating the use of psychotropic medications, but mental health needs and behavioral concerns remained blank and unanswered. LN 2 stated Resident 1's past behavior should have been assessed properly to determine appropriate care for Resident 1's safety and other residents. LN verified Resident 1 did not have a care plan to manage behaviors prior to 1/29/2026, where Resident 1 hit another resident. LN 2 further stated a Psychiatrist consult order should have been ordered upon admission on [DATE] since Resident 1 was taking psychotropic medication, and to determine the care to be rendered to Resident 1. During a review of facility's Policy and Procedures (P&P) titled Behavioral Assessment, Intervention and Monitoring, revised in March 2019, indicated the IDT will thoroughly evaluate new or changing behavioral symptoms in order to identify underlying causes and address any modifiable factors that may have contributed to the resident's change in condition, including depression, anxiety, alteration in routines and change in caregivers. The P&P also indicated the interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the residents and others from harm. During a review of facility's P&P titled Care Plans - Baseline, revised in December 2016, indicated a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within 48 hours of admission.