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	06/25/2026

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review , the facility failed to provide quarterly statements of the residents personal trust fund account (P&I - money that belongs to the resident but is held, safeguarded, and managed by the facility on the resident's behalf) for 3 of 3 sampled residents (Resident 2, 3, and 4), in accordance with the facility's Policy and Procedure (P&P) titled, Quarterly Accounting of Resident Funds. This deficient practice had the potential to prevent residents and / or their representatives from monitoring account balances and ensuring proper management of resident personal funds. Findings: During a review of Resident 2's admission Record (AR), the AR indicated Resident 2 was originally admitted to the facility on [DATE], with diagnosis that included toxic encephalopathy(condition in which the brain does not function normally because it has been affected by a toxic substance or imbalance), Respiratory failure(a condition in which the lungs cannot adequately oxygenate the blood and / or remove carbon dioxide) , and pulmonary disease(diseases affecting the lungs and respiratory system). During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 4/1/2026, the MDS indicated the resident had moderate cognitive (ability to reason and thought process) impairment. The MDS also indicated the resident required moderate assistance with activities of daily living (ADLs) such as oral hygiene, toileting , shower/ baths, and dressing.During a review of Resident 3's admission Record (AR), the AR indicated Resident 2 was originally admitted to the facility on [DATE], with a diagnosis that included respiratory failure (a condition which the lungs cannot provide enough oxygen to the body or cannot remove enough carbon dioxide from the blood) , contracture of left ankle (the left ankle has become stiff and cannot move normally because the tissues around the joint have tightened) , and malignant neoplasm (cancerous tumor) of right kidney. During a review of Resident 3's History and Physical (H&P) dated 2/23/2026, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool) dated 11/8/2025, the MDS indicated the resident was cognitively intact (able to think, understand, and remember, with normal thinking abilities) and requires only supervision with most activities of daily living. During a review of Resident 4's admission record (AR), the AR indicated Resident 4 was originally admitted to the facility on [DATE], with a diagnosis of fibromyalgia(the body's pain signals become overactive, causing a person to hurt all over, even when there is no injury) , Rheumatoid Arthritis(The body mistakenly attacks the joints, making them swollen, stiff, and painful) and epilepsy (the electrical signals in the brain sometimes misfire, causing shaking or jerking movements). During a review of Resident 4's History and physical (H&P) dated 4/14/2026, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 12/3/2025, the MDS indicated the resident was cognitively intact (able to thin, understand, and remember , with normal thinking abilities) and requires only set up or clean up assistance for eating, oral hygiene , toileting and dressing. During a review of a note transcript maintained by third-party representative (a person or organization appointed by the Social Security Administration (SSA) to receive and manage benefits on behalf of an individual who is unable to (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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	manage their own finances), the transcript indicated documented contacts with facility staff regarding requests for personal trust fund (P&I) ledgers and accounting information for residents of the facility. The transcript indicated entries dated 12/29/2025, 01/28/2026, 03/25/2026, and 04/16/2026 with requests for P&I ledgers. An entry dated 04/16/2026 noted that the facility's business office voicemail had not responded to prior requests and that the requested ledgers dating back to November 2025 had not been received. The document indicates repeated effort by the resident's representative to obtain personal fund accounting records from the facility. During a concurrent interview and Record review on 6/10/2026 at 10:40 AM with regional office representative, Resident 2's fund management service records were reviewed. Regional office representative stated quarterly trust account statements should be generated and provided to the resident's responsible party or representative. However, the regional office representative was unable to verify whether quarterly statements had been provided to Resident 1 and stated she did not have access to that information and had no way to verify it. The Regional office representative further stated the facility had been without a Business Office Manager for approximately five months. During an interview on 6/10/2026 at 11:07 AM with the Facilities Regional Consultant, the consultant stated quarterly statements are typically printed and mailed but could not confirm if quarterly trust account statements were provided to the resident or 3rd party representative appointed by Social Security Department (SSD).During an interview on 6/10/2026 at 11:40 AM with Resident 2's responsible party (RP), RP stated he was not involved with management of the resident's finances and identified 3rd party representative as the payee. Resident 2's RP further stated the facility has been provided with the payee's information and informed the facility that that payee was responsible for handling the resident's share of cost and personal funds. During an interview on 6/10/2026 with Resident 2, Resident 2 stated she was unaware of her personal funds and did not receive statements showing how much money was available in her account. During an interview on 6/10/2026 at 12:40PM with Director of Nursing (DON), DON stated the facility had been without a permanent Business Office Manager since February 2026, approximately 5 months . The DON sated the Assistant Business office Manager had been responsible for providing statements, however the DON was unable to explain how the facility ensured quarterly statements were being provided to residents or their representatives. DON stated the normal process required resident to sign a log acknowledging receipt of statements, or statements should be mailed, copies should be maintained, and records should be filed. The DON further stated accountability is necessary to ensure resident funds are properly handled. During an interview on 6/10/2026 at 3:28 PM with Resident 3, Resident 3 stated she was responsible and made her own healthcare decision. Resident 3 stated she had never been provided statements regarding billing or personal funds. Resident 3 stated she would like to know whether she had any money available in her account. During an interview on 6/10/2026 at 3:45 PM with Resident 4 , Resident 4 stated being self-responsible and aware that she had personal funds available through her resident allowance. However, Resident 4 stated she was not provided statements for her personal funds account and was not receiving any quarterly statements. Resident 4 stated she would like to receive statements and reported that when she wanted to know her account balance, she would ask facility staff how much money was available. During a review of the facility's policy and procedure (P&P) titled, Quarterly Accounting of Resident Funds dated April 2018, indicated that each resident with personal funds managed by the facility shall receive an individual quarterly accounting of funds. The policy further stated that the business office will prepare quarterly statements that include the resident's beginning balance, deposits, withdrawals, interest earned, ending balance, petty cash on hand, and total funds on deposit. The policy identified the Business Office Manager (BOM) and / or designee as responsible for implementation and enforcement of the policy.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide care and services consistent with the resident's condition, physician orders, and professional standards of practice for one of three sampled residents (Resident 1). The facility failed to: 1. Assess known risk factors and develop a care plan associated with Resident 1's use of anticoagulant and antiplatelet medications addressing Resident 1's anticoagulantˆrelated bleeding risks (Apixaban and Clopidogrel), despite active orders requiring monitoring for bleeding. 2. Conduct an adequate postˆfall assessment after Resident 1 slid from the bed and struck his head on [DATE], including failure to assess for possible delayed intracranial bleeding or other complications expected in an anticoagulated resident. 3. Notify the physician that Resident 1 was receiving anticoagulant and antiplatelet medications at the time of the fall, and obtain guidance on whether medications should be held, and whether diagnostic imaging was required following a head injury. Resident 1 continued to receive Apixaban and Clopidogrel from [DATE] through [DATE]. 4. Follow the facility's Fall - Clinical Protocol requiring identification of conditions that increase the risk of complications such as active anticoagulation and requiring monitoring for delayed subdural or intracranial bleeding after a head injury. This deficient practice resulted in delayed medical evaluation and intervention, during which Resident 1 developed severe head pain, headache, and loss of vision on [DATE], prompting an emergency transfer to the General Acute Care Hospital (GACH) imaging subsequently revealed a scalp hematoma, and a 7ˆmm leftward midline shift but no acute intracranial hemorrhage. Findings: During a review of Resident 1's admission Record (AR) , the AR indicated Resident 1 was originally admitted to the facility on [DATE] with diagnosis that included hemiplegia(complete paralysis on one side of the body) and hemiparesis(weakness on one side of body) following cerebral infarction (stroke caused by a blockage of blood flow to part of the brain) affecting right dominant side of body, ankylosing spondylitis(inflammatory disease that affects the spine and joints of lower back and pelvis) of lumbosacral region, and Atrial fibrillation (an abnormal heartbeat that can cause blood clots and strokes). During a review of Resident 1's Minimum Data set (MDS - a resident assessment tool) dated [DATE], the MDS indicated Resident 1 had severe impaired cognition (having difficulty with memory, understanding, decision- making, and communication, which affected his ability to perform daily activities safely and independently) and is totally dependent on staff for all activities of daily living such as personal hygiene. Resident 1 also requires maximal assistance with rolling to left or right side. During a review of Resident 1's General Acute Care Hospital (GACH 1) records, the records indicated resident was transferred to GACH 1 Emergency Department (ED) dated [DATE]. GACH 1 ED record indicated Resident 1's anticoagulation status was uncertain due to the facility's report that Resident 1 was not taking any blood thinners. The GACH records indicated Resident 1 had the following differential diagnoses: intracranial hemorrhage (a life-threatening medical emergency involving bleeding inside the skull), compression fracture (a break in vertebra [a spine bone] and it then collapses), traumatic injury (any sudden physical damage to the body caused by an external force) due to fall, and ankle fracture. The GACH records indicated Resident 1's admission to GACH was considered due to concern for intracranial hemorrhage, possible compression fracture in the setting of anticoagulation use, and Resident 1's baseline cognitive impairment. The GACH records indicated Imaging and laboratory evaluation were initiated to assess for acute injuries and clarify anticoagulation status with the facility. During a review of Resident 1's GACH Emergency Department (ED) Provider Note dated [DATE] indicated a Computed Tomography (CT, a diagnostic medical imaging test that combines a series of x-rays taken from various angles with computer processing) Head without Contrast (substances usually iodine or barium based used to enhance the visibility of tissues, blood vessels, and organs during CT scan) was performed. The results of the CT indicated findings of the brain had moderate parenchymal volume loss (atrophy, describes a moderate shrinking of brain) and 7 millimeters (mm, unit of measure) of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	leftward midline shift. The results of the CT indicated the following impressions: (1) no acute intracranial hemorrhage; (2) 7 mm of leftward midline shift of undetermined etiology, no other evidence of mass effect, and recommendation for brain Magnetic Resonance Imaging (MRI, non-invasive medical imaging test that uses powerful magnets and radio waves to create highly detailed, cross-sectional pictures of the internal organs, tissues, and bones) for further evaluation; (3) bilateral nasal bone fractures, layering hyperdense fluid in the right sphenoid sinus, possibly blood; (4) frontal scalp swelling/hematoma (abnormal, localized collection of blood outside of blood vessels, typically caused by trauma, surgery, or medical conditions); and (5) Chronic right frontal infarcts (area of tissue that has died due to lack of adequate blood supply). During a review of Resident 1's Order Summary Report, the report indicated the following physician orders: Dated [DATE], a prescribed order for Clopidogrel Bisulfate (Plavix, a prescription antiplatelet medication used to prevent serious blood clots in people who have had a recent heart attack, stroke, or severe circulation issues) Oral Tablet 75 milligram (mg, unit of measure) give 1 tablet via gastrostomy tube (g-tube, medical device inserted through the abdomen directly into the stomach) one time a day for prevention of blood clots. Dated [DATE], a prescribed order for Apixaban (Eliquis, a prescription oral anticoagulant [blood thinner] that prevents and treats harmful blood clots) Oral Tablet 5 mg give 1 tablet via g-tube two times a day for deep vein thrombosis (DVT, a serious medical condition where a blood clot [thrombus] forms in a deep vein, usually in the leg or pelvis) prophylaxis. Dated [DATE], a prescribed order to monitor for signs/symptoms of bleeding/bruising, report to Physician (MD) if noted. Dated [DATE], a prescribed order to observe closely for significant side effects of anticoagulant medication including discolored urine, black tarry stools, sudden severe headache, nausea or vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status or vital signs, shortness of breath, nose bleeds every shift. The order indicated to document the number of episodes if observed and 0 if none of the above observed, if any of the above was observed, select chart code ?other/see nurses notes' and progress notes findings. Dated [DATE], a prescribed order for Apixaban Oral Tablet 5 mg give 1 tablet via g-tube two times a day related to unspecified atrial fibrillation (common heart rhythm disorder where the heart's upper chambers beat chaotically and out of sync with the lower chambers) hold for signs/symptoms of bleeding. During a review of Resident 1's Progress Notes dated [DATE] at 10:15 AM, Certified Nurse Assistant (CNA) 1 stated when she went to check on Resident 1, Resident 1 was already observed sliding off of the bed. CNA 1 stated she attempted to catch Resident 1 from falling off of the bed, but Resident 1 lost balance and fell to the ground. CNA 1 stated she called for assistance and then placed Resident 1 back to bed with CNA1. The Progress notes indicated Resident 1 sustained a laceration to the front of the forehead, left side of the head and the posterior left wrist. The Progress Note indicated notification to the Physician and family member was done. During a review of a facility provided handwritten document titled Interview Record, dated [DATE] and signed by CNA 1, the record indicated CNA 1's witness statement. The statement indicated I [CNA 1] . was going in the room . I [CNA 1] noticed that [Resident 1] had his head off bed. I [CNA 1] immediately called for help and was running to patient [Resident 1]. DSD was nearby. DSD came to assist before she [CNA 1] can get there patient [Resident 1] fell. During a review of Resident 1's care plan developed on [DATE], the care plan indicated Resident 1 had an open area to the forehead and to the left side of the forehead. The care plan goal included wound would show signs of healing and no signs of infection would occur. The care plan did not include monitoring for nursing oversight for a resident who are taking anticoagulants which increases the risk for bleeding. During a review of Resident 1's care plan developed on [DATE] (3 days after the fall), the care plan indicated that on [DATE], Resident 1 had an actual fall witnessed fall. The care plan goal indicated Resident 1 to resume usual activities without further incident. The care plan interventions included monitoring/documenting/reporting pain, bruising, neurological checks, and pharmacy consult to evaluate medications. The care plan interventions further included providing visual checks, lighting, placing the resident on fall prevention program and rehab consult. During a (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of Resident 1's Rehabilitation (Rehab) Post Fall/Incident assessment dated [DATE] timed at 1:01 PM and authored by Physical Therapist (PT) 1, the Rehab Post Fall Assessment indicated the rehab performed a post-fall screening on [DATE] for a fall that happened on [DATE] due to Resident 1 sliding off from the bed. The Assessment indicated Resident 1 sustained skin tear/s to the left wrist and the mid left side of the forehead. The Assessment further indicated PT 1's post fall recommendations for the use of bed bolsters for proper positioning, use of call light and asking for help, and for nurses to provide supervision at all times to prevent future falls. During a review of Resident 1's Medication Administration Record (MAR) for month of [DATE], the MAR indicated Resident 1 continued to receive the anticoagulant and antiplatelet medications after the fall that happened on [DATE] at around 10 AM, on the following dates: On [DATE], Resident 1 received Apixaban 5 mg at 5 PM. On [DATE], Resident 1 received Apixaban 5 mg at 5 PM. On [DATE], Resident 1 received both Apixaban 5 mg and Clopidogrel Bisulfate 75 mg scheduled at 8 AM. During a review of Resident 1's Progress Notes dated [DATE] at 4:29AM, the Progress Note indicated Resident 1 complained of loss of vision to both eyes and complained of a headache with a 10 out 10 pain on a pain scale (a clinical tool used to measure the intensity and impact of a patient's pain- where 0 means no pain and 10 represents the worst possible pain imaginable. Progress notes indicate Physician was notified. During a review of Resident 1's Medication Administration Record (MAR) for month of [DATE], the MAR indicated Resident 1 received medication for head pain (Hydrocodone (Narcotic used to treat moderate to severe pain)- Acetaminophen (non-opioid pain reliever that helps enhance pain control) for 10 /10 pain, 10 being the highest on [DATE] at 7:10 AM. During a review of Resident 1's Progress notes dated [DATE] at 7:16 AM, the Progress Note indicated Resident 1 was transferred to GACH 1 via Ambulance for complaints of headache and head pain. During an interview on [DATE] at 1:15 PM with GACH 1 Social Worker (SW), GACH 1 SW stated Resident 1 was transferred to the GACH 1 emergency room via ambulance on [DATE] at approximately 7:08 AM for complaints of head injury and loss of vision. SW stated residents sustained a nasal fracture, front scalp hematoma and midline shift as a result of the reported fall that occurred at the facility on [DATE]. During an interview on [DATE] at 2:15 PM with the Director of Staff Development (DSD), the DSD stated Resident 1 was bedbound, required total care, could not stand, and demonstrated only minimal movement of his arms and legs. The DSD stated Resident 1 sustained a laceration to the midforehead with visible bleeding from sliding out of bed on [DATE] but was unsure if he hit his forehead on a pole or the floor. The DSD further stated a few days later ([DATE]) Resident 1 complained that resident was in pain and had blurry vision. The DSD further stated that no diagnostic imaging, including x- rays, was ordered after Resident 1 fell from the bed on [DATE]. During an interview on [DATE] at 2:30 PM with Certified Nursing Assistant (CNA), CNA 1 stated on [DATE] at approximately 10:15 AM, CNA 1 entered Resident 1's room and observed Resident 1' head sliding out of bed. CNA 1 stated Resident 1 slid off the bed headfirst and face down. CNA 1 stated Resident 1 sustained a cut to the forehead, and it was bleeding. CNA 1 stated that the DSD instructed staff to obtain an ice pack and to apply a bandage to the resident's head wound. During an interview on [DATE] at 11:41 AM with the facility's Medical Director (MD), the MD stated that he was notified that Resident 1 had sustained a fall with a head injury resulting in a forehead laceration on [DATE]. The MD stated that he instructed staff to perform routine monitoring and neurological assessments. He stated that no diagnostic testing or imaging was ordered following the fall because the injury did not appear to be serious at that time. The MD explained that he does not order an X-ray or CT scan solely because a resident has fallen. He stated that Resident 1 appeared to be fine following the fall and did not sustain a significant hematoma. The MD further stated that diagnostic imaging was not ordered because there was no indication of an obvious fracture, and an X-ray would only have been considered if a fracture had been suspected. During an interview on [DATE] at 1:34 PM with the responsible party (RP), the RP stated that the facility contacted her on [DATE] and informed her that Resident 1 was experiencing vision problems and had been transferred to the emergency department (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for evaluation. The RP stated that during this notification, facility staff did not inform her that Resident 1 had sustained a fall on [DATE]. The RP further stated that after being notified of the transfer, she contacted the GACH 1 emergency department nurse, who informed her that Resident 1 had sustained brain swelling as a result of a fall from the bed at the facility. During a concurrent interview and record review on [DATE] at 2:00 PM with Registered Nurse (RN) 1, Resident 1's Medication Administration Record (MAR) for [DATE] was reviewed. The MAR showed an active order to monitor for signs and symptoms of bleeding every shift (day, evening, and night) from [DATE] through [DATE]. The MAR documentation indicated 0 for no symptoms of bleeding during this period. RN 1 stated that any symptoms of bleeding should have been documented, as such documentation is essential to alert staff to a potential change in condition. During a concurrent interview and record review on [DATE] at 2:15 PM with Registered Nurse (RN) 1, Resident 1's active care plans were reviewed. RN1 stated there was no documented evidence that care plans were developed related to Resident 1's anticoagulant (blood thinners) and antiplatelet therapy (apixaban or plavix). RN 1 stated that a care plan should have been developed to address Resident 1's anticoagulant medications. RN1 further stated anticoagulant therapy has increased risk for bleeding, and a care plan is important to provide guidance to staff when monitoring or recognizing warning signs and symptoms of bleeding. During a concurrent interview and record review on [DATE] at 2:20 PM with RN 1, Resident 1's Progress notes documented dated [DATE] at 11:46 AM were reviewed. The progress notes indicated that the Medical Doctor (MD) and Family Member (FM1) were notified of the fall according to documentation. Further review of the record indicated no documentation indicating MD was informed of Resident 1 receiving anticoagulant therapy including Apixaban and antiplatelet at the time of fall. There was also no documented evidence that the MD was asked if the anticoagulant and antiplatelet medications should be put on hold after Resident 1's fall as part of Resident 1's post fall monitoring. RN1 stated it was important for the MD to be notified that a resident is receiving anticoagulant and antiplatelet medications because of the resident's increased risk for bleeding. RN 1 further stated this knowledge could affect the physician's decision - making, including whether to send the resident to the hospital immediately for further evaluation. During a review of the facility's policy and procedure (P&P) titled Fall- Clinical Protocol, revised [DATE], indicated that staff are responsible for assessing residents following a fall, including evaluation of recent injuries, neurological status, cognition, pain, medication associated with dizziness or lethargy, and risk factors for falls. The policy further directs staff and the physician to identify conditions that increase the risk of significant complications from falls, such as increased risk of bleeding in residents receiving anticoagulant therapy. The policy states that falls should be evaluated and residents monitored for delayed complications, including subdural hematomas or intracranial bleeding, which may occur hours, days, or several weeks following a fall.

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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 observation, interview, and record review, the facility failed to provide a safe and hazardˆfree environment for one of four sampled residents (Resident 1), who was bedbound and required total care, by failing to identify and address Resident 1's specific risks associated with the use of the Low Air Loss (LAL- an airˆpowered mattress that helps prevent skin breakdown by keeping the skin dry and reducing pressure) Mattress. The facility failed to: 1. Assess and monitor Resident 1's LAL mattress for proper functioning, appropriate settings, and the resident's tolerance to the LAL mattress in accordance with the resident's care plan. 2. Ensure staff communicated and reported significant changes in Resident 1's condition, including repeated observations on different occasions by Certified Nurse Assistant (CNA) 1 that Resident 1 would be found lying on different side positions in bed despite requiring total assistance, preventing timely reassessment and implementation of appropriate safety interventions while on the LAL mattress. 3. Complete the required Quarterly Side Rail Assessment and/or the Alternatives for Bedside Rail Utilization Assessment for [DATE] to determine Resident 1's need for side rails or alternative safety measures, in accordance with the facility's Fall Prevention Program policy, which requires identifying and implementing interventions such as environmental hazard prevention and monitoring. 4. Individualize the care plan to address risks associated with elevated head-of-bed positioning while on a LAL mattress. The facility failed to incorporate interventions to ensure Resident 1's safety while the head of bed was elevated 30 to 45 degrees while on gastrostomy tube (GT) feeding. These deficient practices resulted in Resident 1 sliding out of bed on [DATE], sustaining two open lacerations to the right frontal forehead and midˆleft hairline. On [DATE], Resident 1 developed severe head pain, headache, and loss of vision, prompting emergency transfer to the General Acute Care Hospital (GACH), where imaging revealed a scalp hematoma, 7ˆmm leftward midline shift, bilateral nasal bone fractures, and no acute intracranial hemorrhage. Findings: During a review of Resident 1's admission Record (AR) , the AR indicated Resident 1 was originally admitted to the facility on [DATE] with diagnosis that included hemiplegia (complete paralysis on one side of the body) and hemiparesis (weakness on one side of body) following cerebral infarction (stroke caused by a blockage of blood flow to part of the brain) affecting right dominant side of body, ankylosing spondylitis (inflammatory disease that affects the spine and joints of lower back and pelvis) of lumbosacral region, and atrial fibrillation (an abnormal heartbeat that can cause blood clots and strokes). During a record review of Resident 1's care plan Risk for Skin Breakdown Care Plan dated [DATE], the care plan indicated that Resident 1 may have a LAL mattress and for staff to monitor the setting, placement and functioning for skin management. During a review of Resident 1's care plan Feeding Tube dated [DATE], the care plan indicated that Resident 1's head of the bed must be elevated 30 to 45 degrees when the feeding is on. The care plan did not address resident safety while Resident 1's head of bed was elevated 30 to 45 degrees when using the LAL mattress and without siderails for bed mobility and safety. During a review of Resident 1's most current Fall Risk Evaluation dated [DATE], prior to the fall ([DATE]), the Fall Risk Evaluation indicated Resident 1's gait (a person's way of walking) has balance problems while standing/walking, jerking or unstable when making turns, decreased muscular coordination. The Fall Risk Evaluation indicated that a Score 10 or higher indicated the resident is at high risk for fall. During a review of Resident 1's care plan Fall Risk Care Plan dated [DATE], the Fall Risk Care Plan indicated, Resident 1 was at risk for falls related to gait/balance problem psychoactive drug (a chemical substance that alters brain function, directly affecting how you perceive, think, feel, or behave) use and unaware of safety needs. During a review of Resident 1's physician orders, an order dated [DATE] was reviewed for the use of low air loss mattress (LAL) and for facility staff to monitor the setting at number 3 (weight of 140 lbs. - 174 lbs., a setting used to identify the resident's weight for the proper air-filled (continued on next page)

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Griffith Park Healthcare Center	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	chamber redistribution pressure across the body surface), the placement and the functioning of the LAL for skin management. During a review of Resident 1's physician orders, an order dated [DATE] was reviewed for the use of a low air loss (LAL) mattress and for facility staff to monitor the setting at number 3 (for Micro Air 65 LAL model - this setting corresponds to a weight range of 140 to 174 pounds, used to identify the resident's weight for appropriate airˆfilled chamber pressure redistribution), as well as to monitor the placement and functioning of the LAL mattress for skin management. During a review of Resident 1's Order Summary Report for [DATE], the Order Summary Report indicated a physician order for Resident 1 to keep head of the bed elevated 30 to 45 degrees when the feeding is on. The Order Summary Report also had an order to elevate the head of the bed as tolerated while lying for breathing comfort as evidence by shortness of breath when lying flat. During a review of Resident 1's Bed Rail Entrapment Risk Assessment dated [DATE], the Assessment indicated a quarterly assessment completed resident's needs and safety in using bedrails. The Assessment indicated Resident 1 did not have any types of bedside rails. During a review of Resident 1's Minimum Data set (MDS - a resident assessment tool) dated [DATE], the MDS indicated Resident 1 had severe impaired cognition (having difficulty with memory, understanding, decision- making, and communication, which affected his ability to perform daily activities safely and independently), slurred speech, and totally dependent on staff for all activities of daily living such as personal hygiene, toilet transfer, chair-to-bed transfers, sit to lying, lying to sitting. Resident 1 also required maximal assistance with rolling to left or right side. The MDS indicated Resident 1 had impairments on both upper (shoulders. Elbows, wrists, hands) and lower extremities (hips, knees, ankles, feet) range of motion (refers to how far a joint or series of joints can move in a specific direction). During a review of Resident 1's Alternatives for Bedside Rail Utilization Assessment dated [DATE], the assessment was left blank and not completed by a licensed staff. During a review of Resident 1's bedside rail records, there was no documented evidence of a quarterly assessment for [DATE] following the Bed Rail Entrapment Risk Assessment completed on [DATE]. During a review of Resident 1's Weight Summary dated [DATE], the summary indicated Resident 1's weight was 146 pounds (lbs.). During a review of Resident 1's Progress Notes dated [DATE] at 10:15 AM, Certified Nurse Assistant (CNA) 1 stated when she went to check on Resident 1, Resident 1 was already observed sliding from the bed. CNA 1 stated she attempted to catch Resident 1 from falling off of the bed, but Resident 1 lost balance and fell to the ground. CNA 1 stated she called for assistance and then placed Resident 1 back to bed with CNA1. The Progress notes indicated Resident 1 sustained a laceration to the front of the forehead, left side of the head and the posterior left wrist. The Progress Note indicated notification to the Physician and family member was done. During a review of a facility provided document titled Interview Record, dated [DATE] and signed by CNA 1, the record indicated CNA 1's witness statement. The statement indicated I [CNA 1] . was going in the room . I [CNA 1] noticed that [Resident 1] had his head off bed. I [CNA 1] immediately called for help and was running to patient [Resident 1]. DSD was nearby. DSD came to assist before she [CNA 1] can get the patient [Resident 1] fell. During a review of a facility provided document titled Interview Record, dated [DATE], signed by Resident 2 (Resident 1's roommate), the record indicated an interview taken by the DSD. The record indicated I [Resident 2] was reading [and] seen [Resident 1] on [the] edge and seen [CNA 1] trying to hold [Resident 1] from falling out of bed. I [Resident 2] seen you [DSD] run in trying to help. During a review of a facility provided document titled Investigation Report Summary (undated), signed by the Director of Nurses (DON), the document indicated an investigation was initiated regarding Resident 1's witnessed fall on [DATE] according to CNA 1. The Investigation Summary indicated CNA 1 witnessed Resident 1 was at the edge of the bed with the resident's headfirst and sliding off the bed upon entering the room. The Investigation Summary indicated CNA called for assistance and the DSD came, however, CNA 1 and the DSD but was unable to reach Resident 1 before reaching the ground. The Investigation Summary indicated that after the resident's head to toe assessment, the mattress was also assessed with proper functioning setting on #3. The (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Investigation Summary indicated fall was unavoidable. During further record reviews from [DATE] through [DATE], the date of Resident 1's fall, there was no documented evidence that facility staff monitored the low air loss (LAL) mattress settings at level #3 or monitored the placement and functioning of the LAL mattress for skin management as ordered by the physician. During a review of Resident 1's Rehabilitation (Rehab) Post Fall/Incident assessment dated [DATE] timed at 1:01 PM and authored by Physical Therapist (PT) 1, the Rehab Post Fall Assessment indicated the rehab performed a post-fall screening on [DATE] for a fall that happened on [DATE] due to Resident 1 sliding off from the bed. The Assessment indicated Resident 1 sustained skin tear/s to the left wrist and the mid left side of the forehead. The Assessment further indicated PT 1's post fall recommendations for the use of bed bolsters for proper positioning, use of call light and asking for help, and for nurses to provide supervision at all times to prevent future falls. During a review of Resident 1's Progress Notes dated [DATE] at 4:29 AM, the Progress Note indicated Resident 1 complained of loss of vision to both eyes and complained of a headache with a 10 out 10 pain on a pain scale (a clinical tool used to measure the intensity and impact of a patient's pain- where 0 means no pain and 10 represents the worst possible pain imaginable. Progress notes indicate Physician was notified. During a review of Resident 1's Medication Administration Record (MAR) for month of [DATE], the MAR indicated Resident 1 received medication for head pain (Hydrocodone (Narcotic used to treat moderate to severe pain)- Acetaminophen (non-opioid pain reliever that helps enhance pain control) for 10 /10 pain, 10 being the highest on [DATE] at 7:10 AM. During a review of Resident 1's Progress notes dated [DATE] at 7:16 AM, the Progress Note indicated Resident 1 was transferred to GACH 1 Emergency Department (ED) via Ambulance for complaints of headache and head pain. During a review of Resident 1's GACH Emergency Department (ED) Provider Note dated [DATE] indicated a Computed Tomography (CT, a diagnostic medical imaging test that combines a series of x-rays taken from various angles with computer processing) Head without Contrast (substances usually iodine or barium based used to enhance the visibility of tissues, blood vessels, and organs during CT scan) was performed. The results of the CT indicated findings of the brain had moderate parenchymal volume loss (atrophy, describes a moderate shrinking of brain) and 7 millimeters (mm, unit of measure) of leftward midline shift. The results of the CT indicated the following impressions: (1) no acute intracranial hemorrhage; (2) 7 mm of leftward midline shift of undetermined etiology, no other evidence of mass effect, and recommendation for brain Magnetic Resonance Imaging (MRI, non-invasive medical imaging test that uses powerful magnets and radio waves to create highly detailed, cross-sectional pictures of the internal organs, tissues, and bones) for further evaluation; (3) bilateral nasal bone fractures, layering hyperdense fluid in the right sphenoid sinus, possibly blood; (4) frontal scalp swelling/hematoma (abnormal, localized collection of blood outside of blood vessels, typically caused by trauma, surgery, or medical conditions); and (5) Chronic right frontal infarcts (area of tissue that has died due to lack of adequate blood supply). During a record review of Resident 1's Rehabilitation Post-Fall/Incident Assessment dated [DATE], the Rehabilitation Post/Fall Incident Assessment indicated, Resident 1 does not have sufficient strength and correct posture while sitting. During an interview on [DATE] at 2:15 PM with the Director of Staff Development (DSD), the DSD stated Resident 1 was bedbound, required total care, could not stand, and demonstrated only minimal movement of his arms and legs. The DSD stated Resident 1 sustained a laceration to the midforehead with visible bleeding from sliding out of bed on [DATE] but was unsure if he hit his forehead on a pole or the floor. The DSD further stated a few days later ([DATE]) Resident 1 complained that resident was in pain and had blurry vision. The DSD further stated that no diagnostic imaging, including x-rays, was ordered after Resident 1 fell from the bed on [DATE]. During an interview on [DATE] at 2:30 PM with Certified Nursing Assistant (CNA) 1, CNA 1 stated on [DATE] at approximately 10:15 AM, CNA 1 entered Resident 1's room and observed Resident 1' head sliding out of bed. CNA 1 stated Resident 1 slid off the bed headfirst and face down. CNA 1 stated Resident 1 sustained a cut to the forehead, and it was bleeding. CNA 1 stated that the DSD instructed staff to obtain an ice pack and to (continued on next page)

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