

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/15/2025
NAME OF PROVIDER OR SUPPLIER Griffith Park Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to provide care in a manner that maintained or enhanced residents' dignity and respect in full recognition of their individuality for three (3) of six sampled residents (Residents 32, 69, and 81) by failing to: 1. Ensure Occupational Therapist (OT 1) was seated at eye level while assisting Resident 32 with the use of an adaptive utensil during meals. 2. Ensure Staff were at eye level while assisting with feeding; specifically, certified nurse assistant (CNA) 1 was observed standing over Resident 69 while feeding her. 3. Ensure Staff provided assistance with attention to safety, comfort, and dignity; specifically, CNA 2 was observed removing Resident 81 from the dining room without assisting with personal hygiene or cleaning noticeable phlegm (mucus produced by the cells lining the upper airways and lungs) after Resident 81 coughed. This failure did not support a respectful, person-centered approach to care and had the potential to negatively impact Residents 32, 69, and 81's psychosocial well-being and feelings of self-worth. Findings: 1. During a review of Resident 32's admission Record (AR), the facility admitted Resident 32 on 2/10/2025 and readmitted Resident 32 on 11/17/2025 with diagnoses that included dysphagia (difficulty swallowing) and lack of coordination. During a review of Resident 32's History and Physical (H&P), dated 11/29/2025, the HP indicated Resident 32 did not have the capacity to understand and make decisions. During a review of Resident 32's Minimum Data Set (MDS, a resident's assessment), dated 11/21/2025, the MDS indicated Resident 32's cognitive (a resident's thought process) skills for daily decision making were severely impaired. The MDS indicated Resident 32 required substantial assistance (helper does more than half the effort) when eating, which includes the ability to use suitable utensils to bring food or liquid to her mouth. During an observation on 12/10/2025 at 12:35 PM in the activities room, Resident 32 was sitting in her wheelchair with her lunch tray on the table in front of her. OT 1 was standing over Resident 32 on her right side and assisted Resident 32 with gripping the spoon to scoop some pureed food onto the spoon. OT 1 continued to stand over Resident 32 as she assisted Resident 32 using the adaptive utensil to scoop up her pureed lunch. During an interview on 12/10/2025 at 12:52 PM with OT 1, OT 1 stated she was standing next to Resident 32 as she assisted Resident 32 use the adaptive utensil. OT 1 stated, she was trying to assess Resident 32's ability to use the adaptive utensil to feed herself. OT 1 stated, she forgot to sit down next to Resident 32 during this evaluation and while feeding because my main concern was 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 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. **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, scaly, 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 (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that the TXN would tell the LN that Resident 34 was requesting pain medication, and it was the LN's responsibility to provide medication to Resident 34. LN 6 stated, Resident 34 was not pre-medicated prior to Physician 2 (Wound Care Specialist) performing wound care treatment. LN 6 stated, if she had pre-medicated Resident 34, then Resident 34 probably would not have refused Physician 2's wound care treatment. During a concurrent interview and record review on 12/11/2025 at 1:15 PM with LN 6, Resident 34's CoC evaluations were reviewed. LN 6 stated, there was no documented evidence Physician 1 was notified of Resident 34's refusal of temporal wound treatments. LN 6 stated, if Resident 34 refused wound treatments three (3) times, a CoC should be initiated. During an interview on 12/12/2025 at 10:31 AM with Certified Nurse Assistant (CNA) 3, CNA 3 stated, Resident 34 was very sensitive to the right side of his head and face being touched. CNA 3 stated, on shower days, Resident 34 did not want the water to touch his hair and face. CNA 3 stated, Resident 34 would only allow me to clean the left side of his face. CNA 3 stated, when she would clean the left side of Resident 34's face, Resident 34's body was relaxed and resident would let me clean the left side of his face from his forehead to his chin. CNA 3 stated, when she tried to clean the right side of Resident 34's face, Resident 34's body and face would be more alert and more guarded. CNA 3 stated, she would explain to Resident 34 she was cleaning the right side of his face, and Resident 34 would be more alert, defensive, and on guard, the closer she cleaned to his upper right cheek area. CNA 3 stated, when she was too close to his upper right cheek area, Resident 34 would scream and say ouch!. CNA 3 stated she reported Resident 34's pain to the charge nurse. During an interview on 12/12/2025 at 1:45 PM with Physician 1 (Attending Physician), Physician 1 stated that Resident 34 would refuse [wound care] treatment, and it was difficult to care for [Resident 34]. Physician 1 stated, he does not know when he was first notified of Resident 34's refusal for wound care treatment, but stated, I clearly know about [Resident 34's] refusal of care. During an interview on 12/12/2025 at 2:35 PM with LN 4, LN 4 stated Resident 34 would get upset and more agitated when someone tries to touch his face. LN 4 stated, Resident would push your hand away and would say no, no, no and leave me alone when staff gets close to [Resident 34's] face. LN 4 stated that Resident 34 does not ask for any pain management, but he will say something when someone touches his face. During an observation on 12/15/2025 at 11:10 AM in Resident 34's room with TXN 2 present, Resident 34 was observed lying on his left side with a blanket covering his face. TXN 2 stood on the right side of the bed, slightly outside Resident 34's line of sight, and asked if she could perform his wound care treatment while pointing to the wound on the right side of his face. TXN 2 explained to Resident 34 the importance of wound care, offered Resident 34 pain medication, and offered to come back and check again around 1:30 PM. TXN 2 asked Resident 34 why he kept refusing his treatments, and Resident 34 leaned his neck back slightly, turned the right side of his face away from TXN 2's hand, and stated, No thank you. Go away. During a concurrent interview and record review on 12/15/2025 at 11:20 AM with TXN 2, Resident 34's TAR was reviewed. TXN 2 stated, Resident 34's pain assessments before, during, and after treatment were missing from the TAR from 12/1/2025 to 12/13/2025. TXN 2 stated, it was important to assess Resident 34's pain before and after treatment to evaluate and re-evaluate if Resident 34's current pain management was effective or needed to be re-evaluated. During a concurrent interview and record review on 12/15/2025 at 11:55 AM with LN 6, Resident 34's MAR and TAR for December 2025 was reviewed. LN 6 stated that there was no documented evidence of pain management from December 1 to December 9, 2025. LN 6 stated, there was no documented evidence Resident 34 was premedicated prior to temporal wound treatments. LN 6 stated, it was important to assess Resident 34's pain levels before, during, and after treatment. LN 6 stated, it was important to assess Resident 34's pain prior to treatment and premedicating is important prior to treatment because treatments hurt. LN 6 stated, it was important to reassess Resident 34's pain after treatment to determine if the pain management was effective. During a concurrent interview and record review on 12/15/2025 at 4:41 PM with the Director of Nursing (DON), Resident 34's MAR and TAR for December 2025 was reviewed. The DON stated, there was no (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented evidence Resident 34's pain was assessed before, during, and after temporal wound care treatments. The DON stated there was no documented evidence Resident 34 was premedicated prior to starting wound treatments. The DON stated, pain assessment included assessing the pain level, type of pain, location of pain, frequency of pain, description of pain, what aggravates the pain, and what relieves the pain. The DON stated that it was important to reassess pain after Resident 34's wound treatments to evaluate whether the current pain management was effective. During the same concurrent interview and record review on 12/15/2025 at 4:50 PM with the DON, Resident 34's CoC documentations were reviewed. The DON stated that there was no documented evidence of Resident 34's refusal for treatments. The DON stated that a CoC needed to be created if the resident refused treatment three times because the physician needed to be notified of the resident's refusal. The DON stated she could not recall if the facility's IDT had discussed Resident 34's pain issues and wound treatment refusals during the facility's IDT meetings. During a review of the facility's P&P titled Pain - Clinical Protocol, dated March 2018, the P&P indicated that the physician and staff will identify individuals who have pain or who are at risk for having pain which included a review of any treatments that the resident currently is receiving for pain including complementary and non-pharmacological interventions. The P&P further indicated that the nursing staff will assess each resident when there is onset of new pain or worsening of existing pain. The P&P indicated that staff and physician will identify the characteristics of pain such as location, intensity, frequency, pattern, and severity. The P&P indicated the nursing staff will identify any situation or interventions where an increase in the resident's pain may be anticipated such as wound care. The P&P further indicated the physician will help identify causes of pain and help identify the extent of the underlying cause of pain. During a review of the same policy, Pain - Clinical Protocol, dated March 2018, the P&P indicated, the physician and staff will establish goals of pain treatment, and will reassess the resident's pain and related consequences at regular intervals. The P&P indicated that if the resident's pain is complex and not responding to standard interventions, the attending physician may consider additional consultative support. During a review of the facility's P&P titled Requesting, Reusing, and/or Discontinuing Care or Treatment, dated 5/2017, the P&P indicated that if a resident requests, discontinues, or refuses care or treatment, the unit manager, charge nurse or director of nursing services will meet with the resident to: determine why the resident is requesting, refusing, or discontinuing care or treatment. The P&P indicated that the healthcare practitioner must be notified of refusal of treatment.		

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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. **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, scaly, 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, (continued on next page)		

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 cell carcinoma with multiple lesions on the left and right forehead and hands and arms which were large at 6 cm and 8 millimeters (mm, unit of measure) deep. Physician 4's plan of care indicated Resident 34 needed systemic treatment and would like to proceed with Cemiplimab (Immunotherapy treatment used to help increase the body's defense against cancer cells) 300 milligrams (mg, unit of weight) intravenous (medication delivered directly into the vein via a small catheter) every 3 weeks until Resident 34's intolerance or up to 24 months. During a review of Physician 4's Follow-up notes, dated 7/17/2024, 9/18/2024, 3/26/2025, 4/16/2025, 5/14/2025, 6/4/2025, 6/25/2025, 7/30/2025, and 12/3/2025, Physician 4 indicated Resident 34's CT (imaging) scan on 7/11/2024 indicated a right temporal scalp mass with the size 9.5 cm by 1cm and the right greater than left maxillary sinus (hollow space in the bones around the nose) polypoid (growth) lesions. Physician 4 indicated Resident 34's right forehead lesion was worsening, tumor was growing. During a review of Resident 34's Order Recap Report, order dated 10/4/2024 and discontinued in 2/25/2025, the order indicated Resident 34 had a Wound Consult and Follow up visit by Physician 2. During a review of Resident 34's MDS, dated [DATE], the MDS indicated Resident 34's cognition as severely impaired. The MDS indicated Resident 34 required maximal assistance (helper does most of the effort) with ADL cares and required supervision when transferring from lying to sitting position or from bed to chair. The MDS indicated Resident 34 was not receiving a schedule pain medication regimen, Resident 34 denied pain, and the staff assessment for Resident 34's indicators of pain was blank. The MDS did not indicate Resident 34 had any open lesions. During a review of Physician 4's Follow up note, dated 11/19/2025, Physician 4 indicated Resident 34 had a Stage 3 high risk squamous cell carcinoma of the skin. Physician 4 indicated Resident 34 had multiple lesions on the left and right forehead and the arms and legs. Physician 4 indicated to transfer Resident 34 to the emergency department for altered mental status, locally advances skin cancer mixed with infection, hypotension (low blood pressure), and tachycardia (increased heart rate). Physician 4 indicated her recommendations to the emergency department including a blood culture, wound culture, wound care consult, infectious disease consult, and broad-spectrum IV antibiotics. During a review of Resident Acute Care Hospital (GACH) 1 records, Physician 6's (Plastic Surgery, physician specializes in the reconstruction of defects affecting appearance or function) Consultation Note, dated 11/20/2025 was reviewed. Physician 6 indicated Resident 34 had signification ulcerative (open sore)/erosive (an aggressive breakdown and destruction of deeper tissue) squamous cell carcinoma to the face with a cancerous wound to the scalp and right eye. Physician 6 recommended to keep the wound clean and dry, and may be covered with xeroform dressing if the wound is draining, otherwise leave open to air. During an observation on 12/10/2025 at 10:09 AM in Resident 34's room, Resident 34 was observed lying on his back in bed with his face exposed. The right side of Resident 34's face had dried scabbing extending from the hairline on the right side of the forehead across the right temple, over the right eyelid, and towards the area before the right ear. Dried blood streaks were also noted across the bridge of the nose, down the right side of the face to the chin, and on Resident 34's top linen sheets. During an interview on 12/10/2025 at 3:30 PM with Licensed Nurse (LN) 4, LN 4 stated Resident 34 was admitted in 2023 with a small hematoma (a collection of blood outside of the blood vessel caused by a broken blood vessel) on the right side of his face/ LN 4 stated, Resident 34 was under the care (continued on next page)		

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of a Dermatologist in early 2024 but then Physician 4 (Oncologist) took over Resident 34's care in mid-2024. LN 4 stated, Physician 2 managed Resident 34's wound care on the right side of his face. During an interview on 12/11/2025 at 12: 03 PM with Physician 2 (Wound Care Specialist), Physician 2 stated she managed Resident 34 wound care at the beginning of 2024, and it was small in size but it was scabbed. Physician 2 stated, once she knew Resident 34 had a biopsy (medical procedure to remove a piece of tissue and be tested in a laboratory) and was under the care of a Dermatologist, I pulled myself off the case to prevent conflicting orders between herself and the Dermatologist. Physician 2 stated that Resident 34 has not been under her care since 2024. Physician 2 stated, that today (12/11/2025) was her first time providing care for Resident 34 since 2024, and stated, I saw him because I think he stopped his chemotherapy. During the same interview on 12/11/2025 at 12:10 PM with Physician 2, Physician 2 stated, Resident 34 refused treatment and measuring today (12/11/2025). Physician 2 stated, Resident 34's right temple and forehead wound does not look infected, just necrotic and friable (easily crumbled). Physician 2 stated, she would like to cauterize (seal) the friable edges to stop the bleeding. During the same interview on 12/11/2025 at 12:15 PM with Physician 2, Physician 2 stated that she would like to get a better idea from the Oncologist of what Resident 34's goal of care was. Physician 2 stated, in her experience, the cancer growth was like an iceberg. If it looks bad on the outside, it looks worst on the inside. Physician 2 stated, one of the complications of this type of cancer was Resident 34's [cancerous] growth will eventually cover the whole face. Physician 2 stated another complication was the possibility of the cancerous growth inside the body may grow large enough to push against the brain. During a concurrent interview and record review on 12/11/2025 at 12:30 PM with Physician 2, Resident 34's Order Recap Report from 2023 to 2025 was reviewed. Physician 2 stated, Resident 34's wound care treatments to cleanse the right and left temporal open wound with normal saline solution, pat dry, apply xeroform dressing and cover with abdominal pad and secure the bandage with an elastic bandage were not her physician orders. Physician 2 stated, it was in her experience and understanding Resident 34's right forehead/temple wound cannot heal with topical treatment. During an interview on 12/12/2025 at 2:00 PM with Physician 1, Physician 1 stated he was the Medical Director and Resident 34's Attending Physician. Physician 1 stated, Resident 34 was under the care of an Oncologist and not a Dermatologist because Resident 34 does not have a wound. He has cancer. Physician 1 stated, Resident 34 was under the care of an Oncologist, who monitored Resident 34's radiation therapy, chemotherapy, and wound care therapy. Physician 1 stated, Resident 34 does not have an open wound. He just has facial cancer. During the same interview on 12/12/2025 at 2:15 PM with Physician 1, Physician 1 stated Resident 34 was being seen by the Wound Care Specialist who does wound coverage under contract with the facility. Physician 1 stated, Resident 34 had a wound consult back in February 2025 but there was not much for the consult to do but clean and dress Resident 34's right forehead/temple wound. Physician 1 stated, Resident 34 was seen by the wound care team, and he (Physician 1) ordered the standard wound care for Resident 34 to keep the area clean and dry and covered as Resident 34 would allow. During an interview on 12/12/2025 at 2:20 PM with LN 4, LN 4 stated Resident 34 was referred to the Dermatologist in 2024 when his right forehead/temple area became an open wound, and LN 4 stated it was a wound because there was an opening between the skin and some drainage. LN 4 stated, she was not aware Physician 2 had pulled herself off [Resident 34's] case until yesterday [12/11/2025]. LN 4 stated that Physician 2 had told LN 4 that Physician 2 thought Resident 34 was under management of a Dermatologist since 2024. LN 4 stated, she had assumed Resident 34's skin and wound care management was under Physician 2 since 2024. During an interview on 12/12/2025 at 3 PM with LN 4, LN 4 stated, Resident 34 was under the facility's Bioethics Committee because he does not have any family members and was not capable of making decisions. LN 4 stated, the Bioethics Committee consisted of the DON, Social Services Director (SSD), the Attending Physician, and the Medical Director. LN 4 stated, the Bioethics Committee coordinated and managed all of Resident 34's medical care while in the facility. LN 4 stated, she (continued on next page)		

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	would consider Resident 34's overall medical management as the lack of communication and collaboration between the Physician 1, Physician 2, and Physician 4. During an interview on 12/15/2025 at 11:38 AM with LN 6, LN 6 stated, she was not aware Physician 2 was not overseeing Resident 34's right forehead/temple wound. LN 6 stated, I thought [Physician 2] was overseeing Resident 34 because she would see the TXN round with Physician 2 around the facility and Resident 34 had a wound. During a concurrent interview and record review on 12/15/2025 at 12:15 PM with LN 6, Physician 2's Surgical Notes dated from 4/9/2024 to 5/21/2024 and Resident 34's Order Recap Report from 2023 to 2025 were reviewed. LN 6 stated, Resident 34 had a wound care consult ordered on 10/4/2024 and 2/28/2025. LN 6 stated, Physician 2's documented were from 4/9/2024 to 5/21/2024. LN 6 stated, Resident 34 did not have a Wound Care Consult from 5/21/2024 to 12/11/2025, because Physician 2 was here 4 days ago [12/11/2025] for Resident 34's newest Wound Care Consult order. LN 6 stated, a wound was defined as an opening in the skin with drainage. During a concurrent interview and record review on 12/15/2025 at 12:30 PM with LN 6, Physician 4's Follow-up notes dated 7/17/2024, 9/18/2024, 3/26/2025, 4/16/2025, 5/14/2025, 6/4/2025, 6/25/2025, 7/30/2025, and 12/3/2025 were reviewed. LN 6 stated, Physician 4 managed Resident 34's chemotherapy and oncology management, but Physician 4 did not indicate Resident 34's wound care management or pain management. During an interview on 12/15/2025 at 4:15 PM with the Director of Nursing (DON), the DON stated, Resident 34 had skin cancer and was under the care of the Oncologist. The DON stated, Physician 1 indicated Resident 34 does not have a wound, and stated do not expect it to be treated like a wound because Resident 34 has facial cancer. The DON stated, Physician 2 stated that Resident 34's right forehead/temple area was a wound because there was a break in the skin and draining. The DON stated that the facility's nursing staff had assumed Physician 2 was providing Resident 34 with wound care management because of the state of Resident 34's right forehead/temple wound. During a review of the facility's P&P titled Physician Services, dated 4/2013, the P&P indicated that the resident's attending physician participates in the resident's assessment and care planning, monitoring changes in the resident's medical status, providing consultation or treatment when called by the facility, and overseeing a relevant plan of care for the resident.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide sufficient number of staff to provide quality care that meets the individualized needs of the resident population, in accordance with the facility's policy and procedures (P&P) titled Staffing, dated August 2022 and as outlined in its Facility Assessment, revised dated 9/8/2025, by failing to: 1.Provide adequate Certified Nursing Assistants (CNA) coverage for the 7:00 AM-3:00 PM, 3:00 PM-11:00 PM, and 11:00 PM-7:00 AM shifts for multiple days in September and December 2025. 2.Assign a Treatment Nurse (TXN) for two days in September 2025 and two days in October 2025, as required in accordance with the Facility assessment dated [DATE]. These deficient practices resulted in inadequate staffing to respond to residents' requests for assistance with Activities of Daily Living (ADLs) and nursing care in a timely manner for three of three sampled residents (Residents 80, 69, and 34). This failure had the potential to negatively impact other residents' quality of life and feelings of self-worth. Cross Reference with F697 and F838 Findings: During a review of the facility's P&P titled Staffing, dated August 2022, the P&P indicated that the facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents. During a review of the facility's P&P titled Staffing, dated August 2022, the P&P indicated that the staffing numbers and skill required of direct care staff are determined by the needs of the residents based on each resident's plan of care, the resident assessment, and the facility assessment. 1. During a review of Resident 80 admission Record (AR), the facility admitted Resident 80 on 11/24/2025 with diagnoses that included paraplegia (loss of movement and/or sensation, to some degree, of the legs) and osteomyelitis (infection of the bone) of vertebra, sacral and sacrococcygeal region (lowest part of the back, tailbone area). During a review of Resident 80's Minimum Data Set (MDS, a resident assessment tool), dated 11/30/2025, Resident 80's cognitive (a resident's thought process) skills were moderately impaired. The MDS indicated Resident 80 was dependent (helper does all the effort) with ADLs such as toileting and bathing. The MDS indicated Resident 80 needed substantial assistance (helper does more than half the effort) when transferring from a lying to sitting position in bed and needed moderate assistance (helper does less than half the effort) when repositioning self in bed. The MDS indicated Resident 80 had an ostomy bag (a collection bag outside the body that collects urine or stool). 2.During a review of Resident 69's AR, the facility admitted Resident 69 on 1/16/2025 with diagnoses that included Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement) with dyskinesia (involuntary movement) and heart failure (the body cannot pump enough blood to meet the body's needs). During a review of Resident 69's MDS, dated [DATE], the MDS indicated Resident 69's cognitive skills were severely impaired. The MDS indicated Resident was dependent on staff for ADLs such as toileting, showering, and dressing herself. The MDS indicated Resident 39 was dependent on staff for transferring from a lying position to sitting position and required substantial assistance when repositioning herself in bed. The MDS indicated Resident 69 had urine and stool incontinence (loss of control of bladder and bowels). 3. During a review of Resident 34's AR, the facility admitted Resident 34 on 12/2/2023 and readmitted Resident 34 on 11/22/2025 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 MDS, dated [DATE], the MDS indicated Resident 34's cognitive skills were severely impaired. The MDS indicated Resident 34 required substantial assistance with ADLs such as toileting, showering, and dressing. The MDS indicated Resident 34 needed substantial assistance when repositioning himself in bed and transferring from a lying to sitting position at the side of the bed. The MDS indicated Resident 34 had urine and stool (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/15/2025
NAME OF PROVIDER OR SUPPLIER Griffith Park Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Allen Ave. Glendale, CA 91201	
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incontinence. During an interview on 12/9/2025 at 11:05 AM in Resident 80's room with Resident 80, Resident 80 stated, it took the staff a long time to answer my call-light (a button or touch pad device used to notify the nursing staff for assistance). Resident 80 stated there were times he had to wait almost 45 minutes for a CNA to respond to his call light. Resident 80 stated, it makes me worried because what if I am calling for an emergency? It should not take them that long. During an interview on 12/9/2025 at 12:15 PM with Family Member (FM) 1 of Resident 69, FM 1 stated, Resident 69 developed a rash that broke down her skin because the CNAs took too long to respond to her call lights and change Resident 69's adult briefs. During a review on 12/12/2025 at 3:47 PM with the Director of Staff Development (DSD), the Nursing Staff Assessment and Sign in Sheet for September, October, and December 2025 were reviewed. The DSD stated the following: - On 9/6/2025 on the 11 PM to 7 AM shift, there were six (6) CNAs scheduled, but five (5) CNAs worked that night. The CNA resident assignment was split among five (5) CNAs. - On 9/6/2025 for the 7 AM to 3PM shift, 3 PM to 11 PM shift, and the 11 PM to 7 AM shift, there were no TXN this day. - On 9/7/2025 for the 7 AM to 3 PM shift, there were eleven (11) CNAs scheduled, but ten (10) CNAs worked this shift. The CNA assignment was split among four (4) of the CNAs. - On 9/28/2025 for the 3 PM to 11 PM shift, there were seven (7) CNAs scheduled, but six (6) CNAs worked this shift. The CNA assignment was split between two (2) of the CNAs, and the CNA Team Lead had an assignment. - On 10/28/2025 and 10/29/2025 for all three shifts, there was no TXN who worked these days. - On 12/1/2025 for the 7 AM to 3 PM shift, there were eleven (11) CNAs scheduled, but 10 CNAs worked this shift. The CNA assignment was split among four (4) CNAs. - On 12/1/2025 for the 11 PM to 7 AM shift, there were six (6) CNAs scheduled, but five (5) CNAs worked this shift. The CNA assignment was split among five (5) CNAs. - On 12/4/2025 for the 11 PM to 7 AM shift, there were six (6) CNAs scheduled, but five (5) CNAs worked this shift. The CNA assignment was split among five (5) CNAs. - On 12/5/2025 for the 11 PM to 7 AM shift, there were six (6) CNAs scheduled, but four (4) CNAs worked this shift. The CNA assignment was split among four (4) CNAs. - On 12/6/2025 for the 11 PM to 7 AM shift, there were six (6) CNAs scheduled, but five (5) CNAs worked this shift. The CNA assignment was split among five (5) CNAs. - On 12/7/2025 for the 11 PM to 7 AM shift, there were six (6) CNAs scheduled, but five (5) CNAs worked this shift. The CNA assignment was split among five (5) CNAs. - On 12/9/2025 for the 11 PM to 7 AM shift, there were six (6) CNAs scheduled, but four (4) CNAs worked this shift. The CNA assignment was split among four (4) CNAs. - On 12/10/2025 for the 11 PM to 7 AM shift, there were six (6) CNAs scheduled, but five (5) CNAs worked this shift. The CNA assignment was split among five (5) CNAs. During a concurrent record review and interview on 12/12/2025 at 4:08 PM with the DSD, the Facility Assessment, dated 9/8/2025, was reviewed. The DSD stated the Facility Assessment, dated 9/8/2025, indicated there should be 1 TXN, 11 CNAs for the 7 AM to 3 PM shift, 9 CNAs for the 3 PM to 11PM shift, and 6 CNAs for the 11 PM to 7 AM shift. During the same interview on 12/12/2025 at 4:30 PM with the DSD, the DSD stated, if the facility did not have enough CNAs for each shift, the facility would handle it internally by asking part-time or per diem CNAs to work; if those CNAs do not pick up the shift, the department heads such as the Infection Preventionist (IP) or the DSD would fill-in for short staffing. The DSD stated that there was no contingency plan in place for short staffing on the dates mentioned in September and December 2025. During an interview on 12/12/2025 at 4:45 PM with the Director of Nursing (DON), the DON stated if the facility was short staff, the coverage for CNAs or Licensed Nurses (LN) were handled internally. The DON stated that the facility would ask the part-time or per diem nursing staff first to work. The DON stated, if the part-time or per diem nursing staff did not want to work, the facility will stagger the CNA and LN shifts. The DON stated that she would ask the CNAs or the LNs of the off-going shift to work an additional two (2) to four (4) hours into the following shift to help the nurses of that shift. The DON stated she could not speak of the reason why the facility was short staffed on the dates mentioned in September and December 2025 because she just started working at the facility on 12/1/2025. During the same interview on 12/12/2025 at 4:55 PM with the DON, the (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DON stated, the complications of CNA short staffing may result in not answering call lights and responding to the resident's needs within a timely manner. The DON stated that the complications of LN short staffing may result in late medications and late responses to an emergency. During a concurrent record review and interview on 12/12/2025 at 5:00 PM with the DON, the Facility Assessment, dated 12/10/2025, was reviewed. The DON stated, the Facility Assessment, dated 12/10/2025, was the current assessment the facility was following. The DON stated, this Facility Assessment did not indicate the CNA or TXN direct nursing care per shift or per unit. The DON stated that it was missed. During an interview on 12/15/2025 at 3:10 PM with CNA 6, CNA 6 stated that she could not recall specific dates, however, she did receive extra assignments on two days. CNA 6 stated, there were days where she could not finish her tasks within the eight (8) hour shift and needed to stay past her eight (8) hour shift to complete all her tasks. CNA 6 stated, she heard from other staff about having a higher workload because one (1) or two (2) staff members did not come to work. During an interview on 12/15/2025 at 3:50 PM with CNA 7, CNA 7 stated that his assignment may range from 14 to 21 residents a shift. CNA 7 stated, he could not complete all his tasks within the eight (8) hour shift and needed to stay past his eight (8) hours to complete all his tasks. CNA 7 stated, this was a frequent occurrence that happens about one (1) to three (3) times a week. During a concurrent interview and record review on 12/15/2025 at 4 PM with the DSD, Resident 34's Treatment Administration Record (TAR) and Nursing Staffing and Sign in Sheet for October 2025 were reviewed. The DSD stated, per the Nursing Staffing and Sign in Sheet for 10/28/2025 and 10/29/2025, there was no TXN coverage. The DSD stated, per Resident 34's TAR, there was no documented evidence Resident 34 received his wound care treatment on 10/28/2025 and 10/29/2025 because there was no TXN coverage to perform the wound/skin treatments to residents and the Licensed Nurses (LN) did not document the treatment was administered.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to implement the facility's policies and procedures, titled storage of Food and Supplies, Procedures for Refrigerated Storage, professional standards of practice on food storage, food service safety, sanitation and handling practices to prevent the outbreak of foodborne illness (food poisoning) by failing to ensure: 1. Labeled and stored food indicated the use-by-date or expiration date, including: one-gallon bottle of liquid oil, one-gallon of barbecue sauce, four opened cans and a dozen of unopened soup base stock powders, and one bulk container in the dry storage room filled with white powder labeled as Food thickener. 2. Followed appropriate hygiene and sanitary procedures and did not leave ice scooper uncovered to prevent contamination. 3. Frozen foods were stored properly, and raw meat were not stored over vegetables. These deficient practices had the potential to result in food contamination (transfer of harmful bacteria or other germs to food, surfaces, or utensils) that placed residents at risk for foodborne illness and lead to other serious medical complications and hospitalization. Findings: During an initial kitchen tour and a concurrent interview on 12/9/2025 from 8:30 AM to 9 AM with the Dietary Service Supervisor (DSS), the following were observed: 1. Ice scoop was placed on top of a smaller container that did not fit on a cart of juice and coffee machine. Another ice scooper with attached-lid and broken handle was found underneath the bigger scoop. 2. In the freezer: (a) A freezer bag of five (5) pieces of tilapia fish filet was stored on top of four (4) packages of frozen spinach. 3. The following were observed in dry storage room: (a) A bulk container filled with powders labeled Food Thickener with no open-date use-by date. (b) An one-gallon bottle of barbecue sauce with no expiration date. (c) A one-gallon bottle of yellow liquid with no label of product name and expiration date. (d) A dozen in an unopened box and four loose cans of soup base powder with no expiration date. 4. On the shelf over the food preparation counter: (a) One opened can of chicken-flavored and one opened can of beef-flavored soup base powder with no use-by date or expiration date. During a concurrent interview on 12/9/2025 at 9:15 AM, the DSS stated the yellow liquid was corn oil however should have been labeled clearly to prevent confusion. The DSS stated that dry stored, frozen foods without label or lacking expiration or use-by-date were considered unsafe for resident's consumption, and storing fish over vegetables in the freezer was inappropriate and unsafe practice according to Food Code. The DSS stated according to facility policy, the kitchen staff are required to label and date foods when storing food, and supply be stored properly and in a safe manner. The DSS stated ice was treated as food and kitchen staff was supposed to follow safe and sanitary practice and find a clean holder for the ice scoop instead of leaving it on top of the broken-handle scoop which surface might have been contaminated. During a review of the facility's Policy and Procedures (P&P) titled Storage of Food and Supplies dated in 2023, the P&P indicated the procedures for dry storage: 1. Dry bulk foods (flour, sugar, dry beans, food thickener, spices, etc) should be stored in seamless metal or plastic containers with tight covers, or in bins which are easily sanitized. Bins/ containers are to be labeled, covered, and dated. 2. Food stores should be arranged in food groups to facilitate storing, locating, and taking inventories. Labels should be visible, and the arrangement should permit rotation of supplies so that oldest items will be used first. All food will be dated- month, day, year. No food will be kept longer than the expiration date on the product. 3. Dry food items which have been opened, such as pudding, gelatin, biscuit mix, pancake mix, dry cereal, spices, coffee, noodles, etc., will be tightly closed, labeled, and dated. During a review of the facility's P&P titled Procedures for Freezer Storage dated in 2023, the P&P indicated that raw meat must be stored below ready-to-eat foods like vegetables (whether fresh or frozen) to prevent cross-contamination from dripping juices. During a review of the facility's P&P titled Ice Procedures dated 2023, the P&P indicated that ice is to be handled properly to prevent infection, and a covered plastic or stainless steel container will be used to hold the scoop.		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Facility Assessment tool, dated 12/10/2025, was updated by failing to indicate the specific staffing needs such as the Certified Nurse Assistants (CNA) and Treatment Nurse (TXN) for each resident unit in the facility and each shift. This deficient practice had the potential for the residents not to receive care and treatment services as needed due to inadequate staffing. Cross Reference with F725 Findings: During a review of the facility's policy and procedure titled Facility Assessment, dated October 2018, the P&P indicated that the facility assessment is conducted annually to determine and update our capacity to meet the needs of and competently care for our residents during day-to-day operations. During a record review of the facility's Facility Assessment, dated 12/10/2025, the Facility Assessment indicated the following: - For the 7 AM to 3 PM shift, 1 Registered Nurse (RN)/Desk nurse to 3 Charge Nurses - For the 3 PM to 11 PM shift, 1 RN/Desk Nurse to 3 Charge Nurses - For the 11 PM to 7 AM shift, 1 RN/Desk Nurse to 2 Charge nurses During a record review of the facility's Facility Assessment, dated 12/10/2025, the Facility Assessment did not indicate the facility's Staffing Plan for the number of Certified Nurse Assistants (CNAs) for the 7AM to 3PM, 3 PM to 11 PM, and the 11 PM to 7 AM shifts. During a concurrent record review and interview on 12/12/2025 at 12:00 PM, with the Administrator (ADM), the Administrator provided the Facility assessment dated [DATE]. The ADM stated that the Facility Assessment provided on Entrance, dated 9/8/2025, was out of date. The ADM stated, the Facility Assessment, dated 12/10/2025, was the most current and comprehensive Facility Assessment up to date. During a concurrent record review and interview on 12/12/2025 at 4:08 PM with the Director of Staff Development (DSD), the previous Facility Assessment, dated 9/8/2025, was reviewed. The DSD stated the Facility Assessment, dated 9/8/2025, indicated there should be one (1) TXN, 11 CNAs for the 7 AM to 3 PM shift, 9 CNAs for the 3 PM to 11 PM shift, and 6 CNAs for the 11 PM to 7 AM shift. During a concurrent record review and interview on 12/12/2025 at 4:20 PM with the DSD, the Facility Assessment, dated 12/10/2025, was reviewed. The DSD stated that the Facility Assessment, dated 12/10/2025, did not indicate the number of CNAs per shift nor did it indicate the number of TXN for the facility. During a concurrent record review and interview on 12/12/2025 at 5:00 PM with the Director of Nursing (DON), the Facility Assessment, dated 12/10/2025, was reviewed. The DON stated, the Facility Assessment, dated 12/10/2025, was the current assessment the facility was following. The DON stated, this Facility Assessment did not indicate the CNA or TXN direct nursing care per shift or per unit. The DON stated that it was missed.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the pneumococcal vaccine (PCV2) as required and appropriate for three of five residents sampled for immunizations (Resident 68, Resident 42, and Resident 66) when: 1. Resident 68 was not consented for the PCV20 vaccine five days after admission into the facility as per the facility's policy and procedure (P&P). 2. Resident 42 was consented for the PCV20 vaccine but not administered the vaccine within 30 days of admission into the facility as per the facility's P&P. 3. Resident 66 was consented for PCV20 vaccine but was not administered the vaccine within 30 days of admission into the facility as per the facility's P&P. This deficient practice had the potential to result in Resident 68, Resident 42, and Resident 66 contracting, transmitting, and experiencing complications related to pneumococcal diseases such as pneumonia (an infection in the lungs), meningitis (inflammation of brain and spinal cord membranes), and sepsis (a life-threatening blood infection). Findings: 1. During a review of Resident 68's admission Record, the record indicated that Resident 68 was admitted to the facility on [DATE] with diagnoses including emphysema (a chronic lung disease in which the air sacs in the lungs are damaged, causing difficulty in breathing and reduced oxygen exchange) and diabetes mellitus (DM: a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 68's undated Vaccine Consent Form, the consent form indicated Resident 68 or her responsible party had not been consented for PCV20. During a review of Resident 68's California Immunization Registry 2 (CAIR2: a secure, statewide registry that stores vaccination records and helps healthcare providers track and report immunizations), the CAIR2 indicated Resident 68 had not been administered the PCV20 vaccine. 2. During a review of Resident 42's admission record, the record indicated Resident 42 was admitted to the facility on [DATE] with diagnoses including hypertension (HTN: high blood pressure) and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 42's Vaccine Consent Form dated 12/5/2025, the consent form indicated Resident 68 consented to receive the PCV20 vaccine. During a review of Resident 42's CAIR2, the CAIR2 indicated Resident 42 had not been administered the PCV20 vaccine. 3. During a review of Resident 66's admission Record, the record indicated Resident 66 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities) and kidney failure. During a review of Resident 66's Vaccine Consent Form dated 12/5/2025, the consent form indicated Resident 66 was consented to receive the PCV20 vaccine. During a review of Resident 66's CAIR2, the CAIR2 indicated Resident 66 had not been administered the PCV20 vaccine. During an interview with the Infection Preventionist (IP) on 12/11/2025 at 2:59 PM, the IP stated she was newly hired into the facility with no proper endorsement of immunization surveillance and tracking from the previous IP, therefore she had to start a new log for tracking. The IP further stated that residents who are admitted to the facility should be assessed for vaccine eligibility, consented, and administered the vaccine per the facility's policy. The IP further stated that it was important to properly track the residents' vaccination status because residents who did not receive their vaccines were at risk of developing illnesses such as pneumonia and could be hospitalized. During a review of the facility's P&P titled Pneumococcal Vaccine dated October 2019, the P&P indicated that prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within 30 days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. The P&P further indicated assessments of pneumococcal vaccination status will be conducted within five working days of admission if not conducted prior to admission.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Provide the COVID -19 vaccine as required and appropriate for one of five residents sampled for immunizations (Resident 66) when Resident 66 consented to receive the COVID-19 vaccine but was not administered the vaccine. 2. Failed to maintain documentation related to staff COVID-19 vaccination status when the newly hired Infection Preventionist (IP) was not endorsed a list of staff members immunized or consented for the COVID-19 vaccine. This deficient practice had the potential to result in the facility's staff and residents contracting, transmitting, and experiencing complications related to COVID-19 such as difficulty breathing, persistent pain or pressure in the chest, or diarrhea. Findings: During a review of Resident 66's admission Record, the record indicated Resident 66 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities) and kidney failure. During a review of Resident 66's Vaccine Consent Form dated 12/5/2025, the consent form indicated Resident 66 was consented to receive the COVID-19 vaccine. During a review of Resident 66's CAIR2, the CAIR2 indicated Resident 66 had not been administered the COVID-19 vaccine for 2025-2026. During an interview with the IP on 12/11/2025 at 2:59 PM, the IP stated she was newly hired into the facility with no proper endorsement of immunization surveillance and tracking from the previous IP, therefore she had to start a new log for tracking. The IP further stated that residents who are admitted to the facility should be assessed for vaccine eligibility, consented, and administered the vaccine per the facility's policy. During an interview with the IP on 12/12/2025 at 10:18 AM, the IP stated she did not have a list of staff members who consented to receive, or had been administered, the COVID-19 vaccine for 2025 - 2026 because she was not endorsed a list from the facility's previous IP. The IP further stated that the previous IP should have been maintaining an updated list of vaccination records for staff so that staff and residents were protected from contracting or spreading the coronavirus. During a review of the facility's policy and procedure (P&P) titled Coronavirus Disease (COVID-19) - Vaccination of Residents dated June 2022, the P&P indicated COVID-19 vaccine education, documentation, and reporting are overseen by the infection preventionist and coordinated by his or her designee. The P&P further indicated that each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident has already been immunized.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one out of three residents (Resident 64) who were sampled for self-administering medications was determined by the facility to safely self-administer medications when Resident 64 was observed in the resident's room with 3 bottles of medications at the bedside table. This failure had the potential to expose Resident 64, who was self-administering medications, to side effects and adverse effects of these medications that could go unmonitored by facility staff. Findings: During a review of Resident 64's admission Record indicated the resident was admitted on [DATE] with diagnoses that included depression (a mood disorder causing persistent sadness and loss of interest, a person's capacity to feel, think, and handle daily activities), hypertension (prolonged elevated blood pressure), atrial fibrillation (irregular heartbeat, causing irregular and rapid pulse), and obesity (a disease characterized by having too much body fat). During a review of Resident 64's History and Physical (H&P), dated 5/12/2025, indicated that the resident has the capacity to understand and make decisions. During a review of Resident 64's Minimum Data Set (a resident assessment tool), dated (11/13/2025), indicated the resident has intact cognition (the ability to process thoughts and emotions). The MDS indicated that Resident 64 was assessed requiring substantial assistance (helper does more than half the effort) on activities such as toileting, putting on clothing, and changing position from lying to sitting. The MDS also indicated that the resident requires moderate assistance (helper does less than half the effort) on activities such as performing personal hygiene, rolling in bed from left to right, and changing position front sitting to lying. During a review of Resident 64's assessment note titled, Self-Administration of Medication, dated 11/13/2025, the note indicated that Resident 64 was not capable of self-administering eye and ear drops. The Assessment also indicated that Resident 64 requires assistance to store medications in a secure location, open and close medication containers, and self-administer oral medications. The Assessment ultimately concluded that Resident 64 is not approved for self-administration of medications and that the resident may not keep medications at bedside. During a review of Resident 64's current physician's orders, dated 12/12/2025, the orders did not include orders to permit Resident 64 to self-administer medications. During a review of Resident 64's entire care plans, from date of admission to 12/12/2025, the care plans did not include a care plan for Resident 64 to self-administer medications. During a concurrent observation and interview on 12/9/2025 at 9:33 AM inside Resident 64's room, Resident 64's bedside table was observed with 3 bottles of medications and one unlabeled medication cup that contained white powder. Resident 64 stated the 3 bottles of medications are medications for pain, sleep, and allergies. Resident 64 stated she did not know the contents of the white powder that is in the unlabeled medication cup. Resident 64 added the white powder was given by the nurse last night. During a concurrent observation and interview on 12/9/2025 at 9:40 AM inside Resident 64's room with Licensed Nurse (LN) 4, LN 4 stated Resident 64's bedside table contains 3 bottles of medications and one unlabeled medication cup containing white powder. LN 4 stated the 3 medication bottles are diphenhydramine HCl 50mg (an oral medication used to relieve allergy symptoms), acetaminophen 500mg (an oral medication to control pain), and oxymetazoline HCl 0.05% nasal spray (a medication that is sprayed into the nose and is used to relieve allergy symptoms). LN 4 stated she did not know the contents of the medication that is in the unlabeled medication cup. LN 4 emphasized that residents are not allowed to keep medications at the bedside. During a record review of Resident 64's clinical record from date of admission on [DATE] at 11:06 AM with LN 4, indicated no documented evidence that Resident 64 had a physician's order or that care plans were developed permitting the resident to self-administer medications. LN 4 added that the physician's orders do not include the 3 medications that were on Resident 64's bedside table. During the same concurrent interview and record review on 12/9/2025 at 11:06 with LN 4, Resident 64's assessment note titled, (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Self-Administration of Medication, dated 11/13/2025, was reviewed. LN 4 stated the assessment indicated that Resident 64 is not approved for self-administration of medications. LN 4 further added that the assessment indicated that Resident 64 may not keep medication at the bedside. During an interview on 12/12/2025 at 4:52 PM with the Director of Nursing (DON), the DON stated that residents are evaluated prior to permitting residents the opportunity to self-administer medications. The DON added that when a resident is permitted to self-administer medications, the resident must be monitored for potential side effects when the resident self-administers the medications. The DON stated that if a resident self-administers medications without the knowledge of the nurses, the resident could potentially suffer from adverse reactions that could go unmonitored. The DON also added that even when residents are permitted to self-administer medications, the medications must be stored in a secure location where other residents may not have access to them. During a review of the facility's policy and procedures (P&P) titled, Self-Administration of Medications, revised 12/2016, the P&P indicated that residents have the right to self-administer medications if the interdisciplinary team had determined that it is clinically appropriate and safe for the residents to do so. The P&P indicated that if the facility determines that a resident cannot safely self-administer medications, the nursing staff will administer the resident's medications. The P&P indicated that self-administered medications must be stored in a safe and secure place, which is not accessible by other residents.		

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NAME OF PROVIDER OR SUPPLIER Griffith Park Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interviews and record reviews, the facility failed to ensure completion of the Advance Directive Acknowledgment (ADA- a document where a person confirms they have received information about their right to create an advance directive and understand their options for future medical decisions) and documentation of the resident's exercise of rights regarding advance directives, for 1 of 4 sampled residents reviewed (Resident 77) for Advance Directives. This failure has the potential to result in more than minimal harm because incomplete ADA documentation may prevent staff from being aware of and honoring the resident's treatment preferences in an emergency. Findings: During a review of Resident 77's admission Record (AR), the AR indicated the facility admitted Resident 77 on 11/22/2025 with diagnoses that included End Stage Renal Disease (ESRD- irreversible kidney failure), atherosclerotic heart disease (a heart disease caused by thickening or hardening of the arteries), and hypertension (high blood pressure). During a review of Resident 77's Minimum Data Set (MDS, a assessment tool), dated 11/28/2025, the MDS indicated Resident 77 had moderately impaired cognition (ability to understand and make decisions) and memory. The MDS also indicated that Resident 77 required partial/moderate assistance (helper does less than half the effort) on eating, oral hygiene, and walk 10 feet. During a review of Resident 77's ADA form dated 11/22/2025, it was noted that the form was incomplete. Specifically, the section requiring initials from the resident or their Responsible Party (RP) was not completed for the following statements: - I have been given written material and informed about my right to accept or refuse medical treatment. - I have been informed of my rights to formulate Advance Directives. - I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility. - I understand that the terms of any Advance Directives that I executed will be followed by the health care facility and my caregivers to the extent permitted by law. During the same review of Resident 77's ADA form dated 11/22/2025, it was noted that the section requiring the resident or Responsible Party (RP) to indicate whether they decline to execute an Advance Directive or wish to execute an Advance Directive was left blank. No check mark was placed in either option. During a concurrent interview and record review on 12/10/2025 at 11:15 AM with the Social Service Director (SSD), Resident 77's ADA form dated 11/22/2025 was reviewed. The SSD stated that she and her designee were responsible for explaining and assisting residents with their Advance Directives (AD). The SSD acknowledged that she believed the ADA form had been completed; however, upon review, she confirmed that the ADA form in the resident's medical record was incomplete. The SSD further stated that it was important to complete ADA forms in their entirety and to inform residents and their Responsible Parties (RP) about their rights to formulate an Advance Directive. She emphasized that completing the ADA form ensures facility staff can follow the resident's wishes in the event of an emergency. During a review of the facility's policies and procedures (P&P) titled Advance Directives, dated 12/2016, the P&P indicated the following: 1. Prior to or upon admission of a resident, the Social Service Director or designee will inquire of the resident, his/her family member and/or his/her legal representative, about the existence of any written advance directive. 2. Information about whether or not the resident has executed an advance directive is displayed prominently in the medical record. 3. If the resident indicates that he or she has not established advance directive, the facility staff will offer assistance in establishing advance directives. The P&P further indicated that the resident will be given the options to accept or decline the assistance, and care will not be contingent on either decision. Nursing staff will document in the medical record the offer to assist and the residents decision to accept or decline assistance.		

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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. **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 (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 incident on 7/13/25 between Resident 45 and Resident 46. During a review of Resident 46's Change in Condition Evaluation (known as COC) dated 7/1/2025 to 10/31/2025, the COC did not indicate any documentation of any resident-to-resident altercation between Resident 46 and Resident 45. 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 and 6 AM LN 2 recalled there was an incident 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 went to Resident 45's room saw that Resident 45 and Resident 46 looked upset. Resident 46 stated to LN 2 that Resident 45 hit her first. LN 2 stated LN 2 and LN 7 separated the Residents 45 and 46 immediately and brought Resident 46 to another room. LN 2 stated that the administrator (ADM) came in early the morning of 7/13/25, and LN 2 reported this incident involving Resident 45 and Resident 46 to the ADM, in which the ADM stated he would take care of everything. LN 2 stated this incident occurred close to morning shift change on 7/13/2025. LN 2 stated since ADM said he would take care of it, so LN 2 left once the shift was over and did not call police to report the incident according to the facility P&P. LN 2 stated Resident 45 or Resident 46's responsible parties or physicians were not notified of the resident to resident altercation. LN 2 stated that the ADM did not interview LN 2 further about the incident involving Resident 45 and Resident 46. LN 2 also stated he did not check back following the incident and he did not know that there was no care plans but there should have been developed for Resident 45 and 46 about altercation on 7/13/2025. During an interview on 12/15/2025 at 1:30 PM with the ADM, the ADM stated he could not find documented evidence of reporting the incident of Resident 45 and 46 on 7/13/2025. The ADM stated he could not remember anything about the incident. The ADM stated he could not explain why this incident was not documented in the resident's clinical record on 7/13/2025. The ADM stated that any abuse allegation including injury of unknown source is reportable to all appropriate agencies and should have had facility investigation. During a phone interview on 12/16/2025 at 8:55 AM with LN 7, LN 7 stated he worked on 7/12/2025 during the night shift as a charge nurse. LN 7 stated on 7/13/2025 early morning between 5 to 5:30 AM, LN 7 responded to a noise coming from Resident 45's room. LN 7 stated he saw Resident 45 upset sitting at edge of his bed, while Resident 46 sitting approximately five to ten feet from Resident 45 looking agitated. LN 7 stated LN 2 and LN 7 separated the residents immediately. LN 7 stated Resident 45 could not tell LN 7 what happened but he noticed a red mark on Resident 45's between left frontal and temporal area (upper left portion of the forehead). LN 7 stated he could not recall why he did not document the incident in the Resident 45's records, LN 7 could not remember if he called Resident 45 and 46's responsible parties. LN 7 could not explain why he did not complete the form COC form dated 7/13/2025 in Resident 45's records. LN 7 stated the ADM came in that morning and told LN 7 and LN 2 that they could go home because the ADM is the abuse coordinator and that he would take care of it. LN 7 stated he was not interviewed by the ADM following the incident. LN 7 also stated that he did not further develop a care plan for Resident 45 and 46 but there should have been one with interventions to protect the residents. During a review of the facility's P&P, titled Abuse Prevention/Prohibition undated, the P&P indicated the facility does not condone any form of resident abuse, neglect, misappropriation of resident property, exploitation and/or mistreatment. The Administrator as Abuse Prevention Coordinator (APC) is responsible for the coordination and implementation of the facility's abuse prevention policies and training. The P&P further indicated that (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as part of Staff Training the facility would implement the following as part of the abuse P&P: 1. Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation. 2. Identifying what constitutes abuse, neglect, exploitation and misappropriation of resident's property. 3. Recognizing signs of abuse, neglect, exploitation and misappropriation of resident property, such as physical or psychosocial indicators. 4. Reporting abuse, neglect, exploitation and misappropriations of resident property, including injuries of unknown sources, and to whom and when staff and others must report their knowledge related to any alleged violation without fear of reprisal; During a review of the facility's P&P, titled Abuse Reporting and Investigation dated 5/2025, the P&P indicated the following: 1. The Facility will report ALL allegations of abuse, unless indicated below, as required by law and regulations to the appropriate agencies within 2 (two) hours. The facility promptly and thoroughly investigates reports of resident abuse, mistreatment, neglect, exploitation, misappropriation of resident property, or injuries of an unknown source when appropriate. 2. When the Abuse Prevention Coordinator (APC) receives a report of an incident or suspected incident of resident abuse, mistreatment, neglect, exploitation or injuries of an unknown source, the APC will initiate an investigation immediately. 3. The APC conducting the investigation will interview individuals who may have information relevant to the allegation. Individuals who may have information relevant to the incident are the resident, witnesses to said incident, other residents under the care of the staff member involved, roommates, family, visitors, etc. ^		

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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. **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 (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 it, so LN 2 left after her shift was over and did not call police to report the incident according to the facility P&P. LN 2 stated Resident 45 or Resident 46's responsible parties or physicians were not notified of the resident to resident altercation. LN 2 stated that the ADM did not interview LN 2 further about the incident. During an interview on 12/15/2025 at 1:30 PM with the ADM, the ADM stated he could not find documented evidence of reporting the alleged resident to resident altercation between Resident 45 and 46 on 7/13/2025. The ADM stated he could not remember anything about the incident. The ADM stated he could not explain why this incident was not documented in the resident's clinical record on 7/13/2025. The ADM stated that any abuse allegation including injury of unknown source was reportable to all appropriate agencies and should have had facility investigation. During a telephone interview on 12/16/2025 at 8:55 AM with LN 7, LN 7 stated he worked on 7/12/2025 during the night shift as a charge nurse. LN 7 stated on 7/13/2025 at around 5 AM to 5:30 AM, LN 7 responded to a noise coming from Resident 45's room. LN 7 stated when he arrived in Resident 45's room, he saw Resident 45 upset and seated at the edge of his bed, while Resident 46 was seated approximately five to ten feet from Resident 45, and appeared agitated. LN 7 stated LN 2 and LN 7 separated Resident 45 and Resident 46 immediately. LN 7 stated Resident 45 could not state what occurred to LN 7, but LN 7 stated Resident 45 had a red mark in between the upper left portion of the forehead. LN 7 stated he had not documented the incident in Resident 45's medical record and could not recall if Resident 45 and Resident 46's responsible parties were notified. LN 7 stated a COC was not completed for both residents on 7/13/25 after the incident, and that when the ADM came in the morning of 7/13/25, the ADM stated since he was the abuse coordinator, he would take care of it. LN 7 stated a follow up interview was not conducted by the ADM after the incident between Resident 45 and Resident 43 on 7/13/25. During a review of the facility's P&P, titled Abuse Reporting and Investigation dated 5/2025, indicated The Facility will report ALL allegations of abuse, unless indicated below, as required by law and regulations to the appropriate agencies within 2 (two) hours. The Facility promptly and thoroughly investigates reports of resident abuse, mistreatment, neglect, exploitation, misappropriation of resident property, or injuries of an unknown source when appropriate. The P&P indicated when the Abuse Prevention Coordinator (APC) receives a report of an incident or suspected incident of resident abuse, mistreatment, neglect, exploitation or injuries of an unknown source, the APC will initiate an investigation immediately. The P&P indicated The APC will immediately, or as soon as practicable, notify by telephone the Ombudsman, or law enforcement, and the APC will send a written SOC 341 report to the Ombudsman or Law Enforcement and CDPH Licensing and Certification within 24 hours of the initial report.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** ^Based on interviews and record review, the facility failed to complete a Pre-admission Screening and Resident Review Level II (PASRR II)-a follow-up assessment that ensures residents with mental disabilities receive appropriate care-after the initial PASRR Level I assessment was completed for one (1) of three (3) sampled residents (Resident 26), in accordance with the facility's policy and procedure (P&P) titled PASRR Completion Policy. This deficient practice had the potential to put Resident 26 at risk of not receiving appropriate mental health care and placement to appropriate facility.^ Findings:^^ During a review of the facility's P&P titled, Pre admission Screening and Resident Review (Level II) (PASRR) dated 10/2018 indicated that the facility will coordinate the recommendations from the Level II PASRR determination and the PASRR evaluation report with the resident's assessment, care planning and transition of care; if the PASRR level II evaluation is not available within five (5) days admission coordinator should follow up the status of PASRR II evaluation and response will be filed in the clinical record; in the absence of the admission coordinator/ designee, the director of nursing (DON) will review the PASRR portal for new admission and Level II determination. During a review of Resident 26's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs).^ During a review of Resident 26's Notice of PASRR Level I Screening Results dated 5/30/2025, indicated that Resident 26 required a serious mental illness (SMI) level II mental health evaluation. During a review of Resident 26's Notice of Attempted Evaluation Unable to Complete Level II Evaluation for Serious Mental Illness (SMI) dated 6/3/2025, the noticed indicated that a SMI Level II Mental Health Evaluation was not scheduled for the following reason: Facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level I Screening. During a review of Resident 27's Minimum Data Set (MDS, a care assessment and screening tool) dated 9/2/2025, the MDS indicated the resident was cognitively severely impaired (never/rarely made decisions). ^^ During a concurrent interview and record review on 12/10/2025 at 10:10 AM with the Director of Nursing (DON), Resident 26's PASRR I Screening and notice of Unable to Complete Level II Evaluation for Serious Mental Illness (SMI) were reviewed. The DON stated that Resident 26 was admitted on [DATE] and she did not see SMI or PASRR II evaluation report in Resident 26's clinical file. The DON stated that Resident 26 should have received a PASRR II shortly after admitted to the facility. The DON stated she could not explain the reason indicated in this Notice of Attempted Evaluation.^The DON stated that the PASRR was an assessment completed to ensure residents were provided correct care for residents with mental disabilities and if it was not completed the residents might not receive appropriate care and placement to appropriate facility.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the musculoskeletal care plan was updated to reflect the current nursing interventions for one out of five residents (Resident 8) who were sampled for unnecessary medications. This deficient practice had the potential to cause Resident 8 to not receive services and nursing care to address the resident's musculoskeletal issues. Findings: During a review of Resident 8's admission Record indicated the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included metabolic encephalopathy (brain dysfunction from a chemical imbalance, often from systemic illnesses like liver/kidney failure, diabetes, infections, or toxins, causing confusion, memory issues, personality changes, fatigue, or even coma), epilepsy (a brain condition that causes recurring seizures or uncontrolled and involuntary movement), and low back pain. During a review of Resident 8's History and Physical (H&P), dated 11/13/2025, the H&P did not indicate if the resident has the capacity to understand and make decisions. The H&P indicated a resident plan to control the resident's pain. During a review of Resident 8's Minimum Data Set (a resident assessment tool), dated 10/2/2025, the MDS indicated that the resident has moderately impaired cognition. During a review of Resident 8's pain assessment note, dated 10/2/2025, timed at 5:55 PM, the note indicated that received pain medication in the last 5 days from the time of the assessment. The note indicated Resident 8 experienced pain frequently during the last 5 days. The note indicated that over the past 5 days, the pain frequently disrupted the resident's sleep at night. The note also indicated that over the past 5 days, the pain occasionally limited the resident's day-to-day activities. The note also indicated that the resident's pain is alleviated by taking medications. During a review of Resident 8's care plan for risk for musculoskeletal system care plan, initiated on 2/20/2025, and revised on 3/1/2025, the care plan indicated that Resident 8 has an alteration in musculoskeletal system related to pain, decreased strength, and left sided weakness. The care plan included a goal for Resident 8's pain to be resolved within 1 hour of interventions, revised on 11/7/2025. The care plan also included an intervention for the resident to receive tizanidine HCl (a medication used to relieve muscle spasms and discomfort) oral tablet 2 MG (milligram, a unit used to measure weight), give 1 tablet by mouth every 6 hours as needed for spasms, initiated on 2/20/2025. During a review of Resident 8's physician's orders for 12/2025, the orders did not include an order for tizanidine HCl oral tablet 2 MG. During a concurrent interview and record review on 12/12/2025 at 2:15 PM with Licensed Nurse (LN) 4, Resident 8's medical records were reviewed, including the resident's physician's orders and care plans. LN 4 stated Resident 8's physician's orders does not include an order for tizanidine HCl. LN 4 stated that Resident 8's care musculoskeletal care plan has not been updated, because Resident 8 no longer has an order for tizanidine HCl. LN 4 stated that Resident 8's care plan should have been updated when tizanidine HCl was discontinued. During an interview on 12/12/2025 at 4:52 PM with the Director of Nursing (DON), the DON stated that care plans are used by nurses as a guide to provide care for the residents. The DON also stated that the care plan is used by the nurses to monitor and track which interventions work for the resident's problems. The DON added that the nurses would not know which interventions work if the care plans are not updated. The DON further indicated that the care plans must be updated whenever there are changes to the resident's care, such as when a change in condition occurs or when medications are discontinued. During a review of the facility's policy and procedures (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 12/2016, the P&P indicated that a comprehensive, person-centered care plan is developed and implemented for each resident. The P&P indicated that the care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The P&P also indicated that the interdisciplinary team must review and update the care plan when the (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	desired outcome is not met and when the resident has been readmitted to the facility from a hospital stay. The P&P further indicated that care plans are revised as information about the residents and the resident's conditions change.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one of five sampled residents for unnecessary medications (Resident 8) had physician orders for PRN (as needed) analgesics (pain reliever) that were clear, specific, and non-conflicting. The physician orders contained overlapping administration parameters, which created a risk for significant medication errors and did not comply with professional standards of quality. This deficient practice placed Resident 8 at risk for potential adverse effects associated with ambiguous pain medication parameters, including inconsistent medication administration, duplicate therapy, or failure to follow physician orders. Findings: During a review of Resident 8's admission Record indicated the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included metabolic encephalopathy (brain dysfunction from a chemical imbalance, often from systemic illnesses like liver/kidney failure, diabetes, infections, or toxins, causing confusion, memory issues, personality changes, fatigue, or even coma), epilepsy (a brain condition that causes recurring seizures or uncontrolled and involuntary movement), and low back pain. During a review of Resident 8's History and Physical (H&P), dated 11/13/2025, the H&P did not indicate if the resident has the capacity to understand and make decisions. The H&P indicated a resident plan to control the resident's pain. During a review of Resident 8's Minimum Data Set (a resident assessment tool), dated 10/2/2025, the MDS indicated that the resident has moderately impaired cognition. The MDS indicated Resident 8 had no pain during the MDS assessment reference period. During a review of Resident 8's pain assessment note, dated 10/2/2025, timed at 5:55 PM, the note indicated that the resident received pain medication in the last 5 days from the time of the assessment. The note indicated Resident 8 experienced pain frequently during the last 5 days. The note indicated that over the past 5 days, the pain frequently disrupted the resident's sleep at night. The note also indicated that over the past 5 days, the pain occasionally limited the resident's day-to-day activities. The note also indicated that the resident's pain is alleviated by taking medications. During a review of Resident 8's physician's orders for 12/2025, the orders included the following orders: 1. Acetaminophen (a medication to control pain) Oral tablet 325 MG (milligram, a unit used to measure weight), give 2 tablets by mouth every 6 hours as needed for moderate to severe pain (4-10), ordered on 11/13/2025. 2. Hydrocodone-Acetaminophen (an opioid drug combination that helps to control pain) oral tablet 10-325 MG, give 1 tablet by mouth every 6 hours as needed for severe pain (8-10), ordered on 11/13/2025. During a review of Resident 8's care plan for risk for pain, initiated on 2/20/2025, the care plan included interventions to administer medications for pain as ordered by the physician. The care plan also indicated for staff to evaluate the effectiveness of interventions and to review the medication's dosing schedules. During a review of Resident 8's care plan for the resident's risk of adverse reaction related to polypharmacy (use of 5 or more medications at the same time), initiated on 11/13/2025, the care plan included interventions for staff to review the resident's medications for duplicate medications, proper dosing, timing and frequency of administration. The care plan included a goal for Resident 8 to be free of adverse drug reactions. During a concurrent interview and record review on 12/12/2025 at 2:15 PM with Licensed Nurse (LN) 4, Resident 8's medical records were reviewed, including the resident's physician's orders. LN 4 stated that Acetaminophen is ordered for pain that ranges from 4 to 10 and Hydrocodone-Acetaminophen is ordered for pain that ranges from 8 to 10. LN 4 stated Resident 8's physician's orders include pain medications Acetaminophen and Hydrocodone-Acetaminophen that have overlapping parameters. LN 4 stated the nurses could get confused on which pain medication to administer because if the resident states a pain of 8 out of 10 or greater, the nurses have options to administer either medication. LN 4 stated the orders should be specific and must be changed. During a concurrent interview and record review on 12/12/2025 at 4:52 PM with the Director of Nursing (DON), the DON stated that physician's orders for pain medications, (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	such as Acetaminophen and Hydrocodone-Acetaminophen, should indicate specifically when they should be administered. The DON stated the pain medication orders for Resident 8 should be clarified and changed. The DON further stated that if the orders are not clear and specific, the facility could mismanage the resident's pain. The DON added ensuring that each medication has the proper indication is important in identifying unnecessary medications. During a review of the facility's policy and procedures (P&P) titled, Adverse Consequences and Medication Errors, revised 2/2023, the P&P indicated that the interdisciplinary team monitors medication usage in order to prevent and detect medication-related problems such as adverse drug reactions (ADRs) and side effects. The P&P indicated that staff strive minimize adverse consequences by defining appropriate indications for the medication's use.		

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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 observation, interview, and record review, the facility failed to provide care and services in accordance with the resident's care plan and professional standards of practice for one of three residents sampled for quality of care (Resident 54) when: 1. Certified Nursing Assistant (CNA) 4 failed to turn Resident 54, who was bed bound, every two hours or as needed as stated in the resident's care plan. 2. Licensed Nurse (LN) 1 failed to inspect and ensure that Resident 54 had a dressing on her gastric tube (g-tube: a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) site as written in her care plan and ordered by the physician. 3. Licensed nurses failed to reconcile Resident 54's order for an abdominal binder (a stretchy support belt worn around the stomach to help protect a g-tube site by covering it securely and preventing the resident from pulling or dislodging the tube) after Resident 54 was readmitted to the facility from a hospital. These deficient practices had the potential to result in skin breakdown, infection, and inconsistent care for Resident 54. Cross Reference F880 Findings: During a review of Resident 54's admission Record, the record indicated Resident 54 was originally admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), dysphagia (difficulty swallowing), and failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 54's Minimum Data Set (MDS- a resident assessment tool) dated 12/5/2025, the MDS indicated Resident 54 had severely impaired cognition (profound decline in mental abilities-such as memory, attention, and reasoning-that results in full dependence on others for basic daily activities). The MDS also indicated Resident 54 was fully dependent on staff (helper does all of the effort) for all cares such as personal hygiene, toileting hygiene, and turning in bed. During a review of Resident 54's Interdisciplinary Team Conference Record (IDT: a group of healthcare professionals who collaborate to develop and implement a comprehensive, patient-centered care plan that addresses medical, psychosocial, and functional needs) dated 12/3/2025, the IDT record indicated Resident 54 was readmitted to the facility from the general acute care hospital (GACH) on 12/2/2025 after a g-tube reinsertion. The IDT record further indicated to continue with the current plan of care. During a review of Resident 54's care plan titled Risk for skin Breakdown Care Plan, dated 2/4/2025, the care plan indicated Resident 54 was at risk for breakdown related to failure to thrive, moderate protein-calorie malnutrition, diabetes (DM: a disorder characterized by difficulty in blood sugar control and poor wound healing), low albumin (a protein in the blood that helps keep fluid balance), poor activities of daily living (ADL) functioning, incontinence (inability to control) of bowel and bladder, weight loss, and being bed bound. The care plan further indicated interventions for staff to reposition Resident 54 at least every two hours. The care plan did not indicate that Resident 54 had a preference of being positioned on her right side. During a review of Resident 54's care plan titled G-tube Feeding Care Plan, dated 12/4/2025, the care plan indicated a goal for the resident's insertion site to be free of signs and symptoms of infection. The care plan further indicated interventions for g-tube stoma site (a surgically created opening on the body's surface) cleanse with NS (Normal Saline: a sterile, salt water solution used to help clean wounds), pat dry, apply T-drain sponge (a type of dressing) initiated on 1/28/2025. During a review of Resident 54's Order Summary Report (OSR: a list of instructions from a licensed medical provider that authorize specific treatments, tests, medications, or services for a resident, serving as the legal and clinical basis for delivering care) dated 12/11/2025, the report indicated an order for g-tube stoma site cleanse with NS, pat dry, apply vitamin A and D ointment (a skin protectant used to help heal minor cuts, burns, and dry or irritated skin) and gauze around tubing below bumper then T-drain sponge every day shift ordered on 12/3/2025. The OSR also indicated an order for Enhanced Barrier Precautions (EBP: infection control measure that require the use of gowns (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that all orders were complete to maintain continuity of care. Regarding repositioning, the DON stated bed bound residents were dependent on staff assistance for ADLs and therefore Resident 54 should have been repositioned every two hours or more as needed to prevent skin breakdown, as written in her care plan. The DON stated that failing to turn Resident 54 was a quality-of-care issue that could compromise her skin integrity, diminish her quality of life, and cause pain. During a review of the facility's policy and procedure (P&P) titled Gastrostomy/Jejunostomy Site Care, dated October 2011, the P&P indicated to assess the stoma site for signs of redness, pain or soreness, or drainage and the purposes of this procedure are to promote cleanliness and to protect the gastrostomy. site from irritation, breakdown, and infection. During a review of the facility's (P&P) titled Prevention of Pressure Injuries dated April 2020, the P&P indicated to reposition the resident as indicated on the care plan During a review of the facility's job description for Nurse Supervisors, the job description indicated the nurse supervisors assist with the admission of new residents in compliance with facility policy and procedure and review charts for accuracy and completeness in response to admission assessments.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to ensure that one of three sampled residents (Resident 92), who had an indwelling Foley catheter, and was reviewed for infections, received appropriate monitoring and documentation of intake and output (I&O) and assessment of urine characteristics as required by the physician's order, the resident's care plan, and facility policy. Specifically, staff did not document I&O from 12/1/2025 to 12/12/2025, did not record urine output in the Elimination section, and did not identify or report cloudy urine observed on 12/12/2025. This deficient practice resulted in the potential for undetected urinary tract infection (UTI-an infection in the bladder/urinary tract), catheter obstruction, or urinary retention, which could lead to complications such as sepsis or worsening of the resident's condition. Findings: During a review of the facility's Policy and Procedures (P&P) titled Catheter Care, Urinary, dated 9/2014, the P&P indicated that, to prevent catheter-associated urinary tract infections, the guidelines included the following: - Maintain an accurate record of the resident's daily output. - Observe the resident for complications associated with urinary catheters and check the urine for any unusual appearance (e.g., color, presence of blood, etc.). During a review of Resident 92's admission Record (AR), the AR indicated that Resident 92 was admitted on [DATE] with diagnoses including sepsis (a life-threatening blood infection), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and candidal cystitis (a fungal infection in the bladder) and urethritis (infection of tube that carries pee from the bladder out of the body [urethra]). During a review of Resident 92's Care Plan dated 12/5/2025, the Care Plan indicated that Resident 92 had a Foley catheter due to a pressure ulcer. The Care Plan identified the goal as: Resident 92's bladder will show no signs or symptoms (S/S) of urinary infection. The Care Plan also listed interventions, including monitoring and documenting intake and output, and monitoring, recording, and reporting to the doctor if urine appears cloudy or if there is no urine output (UOP). During a review of Resident 92's Physician Order dated 12/5/2025, the order directed staff to monitor every shift for signs and symptoms (S/S) of infection and document as follows: 0 = None 1 = Acute dysuria 2 = Fever (>100 F) 3 = Gross hematuria (visible blood in urine) 4 = Functional decline 5 = Purulent drainage (containing white blood cells or pus) around the catheter site and notify the doctor. During a review of Resident 92's Medication Administration Record from 12/1/2025 to 12/12/2025, there was no documented evidence of recording Resident 92's Intake and Output (I&O). During a review of Resident 92's Intake and Output and Elimination records for the same period, from 12/1/2025 to 12/12/2025, there was no documented evidence of recording Resident 26's Intake and Output. During a review of Resident 92's Minimal Data Sheet (MDS- a resident assessment tool) dated 12/12/2025, the MDS indicated that Resident 76's cognition was moderately impaired (short-term memory is more affected, significant difficulty with memory, reasoning, problem-solving, and daily tasks, including confusion, trouble following conversations, and challenges managing complex situations.) The MDS also indicated that Resident 92 was dependent (Helper does all of the effort) on toileting hygiene, shower/bathe self, and personal hygiene. During an observation on 12/12/2025 at 9:05 AM, Resident 92's Foley catheter drainage was noted to have cloudy yellow urine output (UOP). During a subsequent observation and concurrent interview on 12/12/2025 at 11:00 AM with CNA 9 and TXN 2 in Resident 92's room, the Foley catheter continued to show cloudy yellow urine output. CNA 9 acknowledged the cloudy urine and stated she would document UOP if instructed to do so. TXN 2 stated that the charge nurse should be responsible for assessing Resident 92 and being aware of the urine color. TXN 2 further stated that Resident 92 was a new admission with a catheter and, to her understanding, nurses were supposed to record intake and output (I&O) for the first 30 days. During an interview and concurrent record review on 12/12/2025 at 11:30 AM with Licensed Nurse (LN) 3, Resident 92's Medication Administration (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record (MAR) and CNA documentation under Eliminations were reviewed. LN 3 stated she could not find documentation of the resident's urinary output and was unsure whether Resident 92's intake and output (I&O) had been recorded. LN 3 stated she did not know the resident's I&O from the previous shift and had not noticed Resident 92's urine drainage during her assessment between 7:00 and 8:00 AM. LN 3 further stated that it is important to monitor the resident's urinary output and report any signs or symptoms of infection to the doctor. LN 3 acknowledged that without documentation, she would not be able to determine if the resident had adequate drainage. During an interview on 12/12/2025 at 2:00 PM with the Director of Nursing (DON), the DON stated that without an intake and output (I&O) record, she would not be able to determine whether the resident's catheter was unobstructed or if the bladder was retaining urine. The DON stated that it is the nursing staff's responsibility to monitor and identify signs and symptoms (S/S) of urinary tract infection (UTI) or urinary retention and to document any findings. The DON further stated that Resident 92 should have been closely monitored for urine output and unusual appearance, and an accurate record of daily output should have been maintained.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one out of one sampled resident (Resident 74) who had food preferences, was prepared a meal that honored the resident's dislikes when Resident 74's meal tray included green vegetables. This deficient practice had the potential to cause Resident 74 to lose his appetite, which could affect the resident's nutritional status. Findings: During a review of Resident 74's admission Record indicated the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included dysphagia (difficulty in swallowing), diabetes mellitus (DM, prolonged elevated blood sugar levels), and malnutrition (a serious condition from an imbalance (deficiency or excess) of nutrients, including not enough calories, protein, vitamins, or minerals). During a review of Resident 74's History and Physical (H&P), dated 11/10/2025, indicated the resident does have the capacity to understand and make decisions. The H&P indicated that Resident 74 is moderately at risk for malnutrition. During a review of Resident 74's Minimum Data Set (a resident assessment tool), dated 9/5/2025, indicated that the resident has intact cognition (the ability to process thoughts and emotions). The MDS also indicated that Resident 74 requires setup or clean-up assistance (helper sets up or cleans up) when eating. The MDS also indicated that Resident 74 requires a therapeutic diet (a diet that is prescribed by a physician for a resident) while in the care of the facility. During a review of Resident 74's physician's orders, dated 12/12/2025, the orders included a dietary order for CCHO (consistent carbohydrate, a diet that is low in carbohydrates that is often prescribed to people with DM), Regular texture, regular/thin consistency, dislikes green vegetable, ordered on 9/17/2025. During a review of Resident 74's Nutritional Screening note, dated 12/5/2025, the note indicated that Resident 74 dislikes green vegetables, fish, and shellfish. During a review of Resident 74's nutritional status care plan, initiated on 11/28/2024, and revised on 12/4/2024, the care plan included a goal regarding the resident's nutritional needs for staff to respect the resident's right to choose. The care plan also included an intervention for staff to honor the resident's food and drink preferences. During an observation and interview on 12/9/2025 at 12:37 PM, the Director of Staff Development (DSD) was observed inspecting the residents' meal trays in the meal cart A with Certified Nursing Assistant (CNA) 2. The DSD stated he is conducting his inspection to ensure residents received the diet that is prescribed by their physician. During another observation, interview, and concurrent record review of Resident 74's diet order on 12/9/2025 at 12:47 PM, the DSD stated that he inspected meal cart A, and that all meal trays contained in meal cart A had the correct diet order for each meal tray. The DSD instructed CNA 2 that the meal trays were ready to be passed to the residents. The DSD was asked to reinspect Resident 74's meal tray which contained broccoli and cilantro. The DSD confirmed Resident 74's diet order indicated the resident disliked green vegetables and that the meal tray needed to be sent back to the kitchen since the resident's diet preference was not honored. During an interview on 12/9/2025 at 12:50 PM with the Dietary Supervisor (DS), the DS stated that Resident 74's meal tray should not have contained any green vegetables, such as broccoli or cilantro. The DS stated Resident 74 dislikes green vegetables and the facility should have honored the resident's diet preferences. During an interview on 12/9/2025 at 12:52 PM with the DSD, the DSD stated that he made a mistake when he was inspecting the resident's meal tray. The DSD stated that he did not read Resident 74's the tray card in its entirety because it was covered by the plate in the meal tray. During an interview on 12/9/2025 at 2:11 PM with Kitchen Staff (KS) 1, KS 1 stated she made a mistake when she informed the Kitchen [NAME] (KC) 1 about Resident 74's meal. KS 1 stated that she forgot to read Resident 74's food preference to KC 1 because she felt overwhelmed. During an interview on 12/9/2025 at 2:17 PM with KC 1, KC 1 stated that he did not know that he prepares the residents' meal trays with the help of KS 1. KC 1 stated that he prepares the meal trays based on what KS 1 tells him. During an (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 12/11/2025 at 11:05 AM with Resident 74, Resident 74 stated that he hates green vegetables. Resident 74 stated that whenever he sees green vegetables, he gags and loses his appetite. Resident 74 added that he does not want to lose his appetite because he wants to eat and not lose weight. During an interview on 12/12/2025 at 4:52 PM with the Director of Nursing, the DON stated that the resident's meal preferences such as likes and dislikes must be honored. The DON stated that if the resident's meal preferences are not honored, the resident may not eat their food which could cause weight loss. The DON also added that not honoring the resident's meal preferences could cause the resident to become upset. During a review of the facility's policy and procedure (P&P) titled, Therapeutic Diets, revised 10/2017, the P&P indicated that diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. The P&P indicated that the diet will be determined in accordance with the resident's informed choices, preferences, treatment goals, and wishes.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records that are accurately documented for one of six residents sampled for accurate documentation (Resident 54). Specifically, Resident 54's treatment administration record indicated that wound care was provided at a time inconsistent with actual delivery of care. This deficient practice had the potential to compromise continuity of care by inadequately documenting tasks that were or were not completed. Findings: During a review of Resident 54's admission Record, the record indicated Resident 54 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), dysphagia (difficulty swallowing), and failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 54's Minimum Data Set (MDS- a resident assessment tool) dated 12/5/2025, the MDS indicated Resident 54 had severely impaired cognition (profound decline in mental abilities-such as memory, attention, and reasoning-that results in full dependence on others for basic daily activities). The MDS also indicated Resident 54 was fully dependent on staff (helper does all of the effort) for all cares such as personal hygiene, toileting hygiene, and dressing. During a review of Resident 54's Order Summary Report (OSR: a list of instructions from a licensed medical provider that authorize specific treatments, tests, medications, or services for a resident, serving as the legal and clinical basis for delivering care) dated 12/11/2025, the report indicated the following orders: 1. Low air loss mattress for skin/wound management, may adjust per resident's comfort settings. Monitor for accurate settings every shift; ordered on 12/3/2025. 2. Apply Heal Protector and monitor placement every shift for skin management; ordered on 12/3/2025. During a review of Resident 54's Treatment Administration Record (TAR) dated December 2025, the TAR indicated Treatment Nurse (TXN) 1 documented administration of treatments for: 1. Low air loss mattress: documented on 12/8/2025 for day shift and 12/9/2025 for day shift 2. Heel protector: documented on 12/8/2025 for day shift and 12/9/2025 for day shift During a review of Resident 54's Medication Admin Audit Report dated 12/10/2025, the audit report indicated the following documentation: 1. Low air loss mattress for skin/wound management: a) Scheduled date: 12/8/2025 at 7:00 AM. Administration time: 12/8/2025 at 7:42 PM documented by TXN 1. b) Scheduled date:12/9/2025 at 7:00 AM. Administration time: 12/9/2025 at 8:39 PM documented by TXN 1. 2. Heel protector monitoring: a) Scheduled date: 12/8/2025 at 7:00 AM. Administration time: 12/8/2025 at 7:42 PM documented by TXN 1. b) Scheduled date: 12/9/2025 at 7:00 AM. Administration time: 12/9/2025 at 8:39 PM documented by TXN 1. During an interview on 12/11/2025 at 2:13 PM with TXN 2, TXN 2 stated that day shift referred to 7:00 AM - 3:00 PM, evening shift referred to 3:00 PM - 11:00 PM, and night shift referred to 11:00 PM - 7:00 AM. TXN 2 also stated that documentation of treatments should be done after the treatment was done and further stated that documentation of treatments should indicate the accurate time the treatment was administered. During an interview on 12/11/2025 at 5:08 PM with TXN 1, TXN 1 stated that he was only scheduled to work in the evening shift (3:00 PM - 11:00 PM) when the facility could not find a treatment nurse to work during the day shift. TXN 1 further explained that he documented for the day shift treatments because he was covering for day shift and was documenting the treatments that were not done in the day shift that should have been done. During an interview on 12/12/2025 at 2:05 PM with the Director of Nursing (DON), the DON stated that medication and treatments should be documented on the same shift after administration. The DON further stated that TXN 1 should have documented administration of treatments for the evening shift to reflect the time that he administered Resident 54's treatments. During a review of the facility's policy and procedure (P&P) titled Charting and Documentation dated [DATE], the P&P indicated treatments or services performed is to be (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented in the resident medical record and will be objective (not opinionated or speculative), complete, and accurate.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to inspect and ensure that a dressing was in place on the gastric tube (g-tube: a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) of one of two residents (Resident 54) sampled for g-tube dressings. This failure placed Resident 54 at risk of developing an infection at her g-tube site and had the potential to cause the g-tube to become dislodged, further leading to hospitalization. Findings: During a review of Resident 54's admission Record, the record indicated Resident 54 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), dysphagia (difficulty swallowing), and failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 54's Minimum Data Set (MDS- a resident assessment tool) dated 12/5/2025, the MDS indicated Resident 54 had severely impaired cognition (profound decline in mental abilities-such as memory, attention, and reasoning-that results in full dependence on others for basic daily activities). The MDS also indicated Resident 54 was fully dependent on staff (helper does all of the effort) for all cares such as personal hygiene, toileting hygiene, and dressing. During a review of Resident 54's care plan titled G-tube Feeding Care Plan, dated 12/4/2025, the care plan indicated a goal for the resident's insertion site to be free of signs and symptoms of infection. The care plan further indicated interventions for g-tube stoma site (a surgically created opening on the body's surface) cleanse with NS (Normal Saline: a sterile, salt water solution used to help clean wounds), pat dry, apply T-drain sponge (a type of dressing) initiated on 1/28/2025. During a review of Resident 54's Order Summary Report (OSR: a list of instructions from a licensed medical provider that authorize specific treatments, tests, medications, or services for a resident, serving as the legal and clinical basis for delivering care) dated 12/11/2025, the report indicated an order for: 1. g-tube stoma site cleanse with NS, pat dry, apply vitamin A and D ointment (a skin protectant used to help heal minor cuts, burns, and dry or irritated skin) and gauze around tubing below bumper then T-drain sponge every day shift ordered on 12/3/2025. 2. Enhanced Barrier Precautions (EBP: precautions that require the use of gowns and gloves during high-contact care to prevent the spread of multidrug-resistant organisms [MDRO: bacteria or fungi resistant to multiple types of antimicrobial drugs, making them difficult to treat and often causing severe infections) due to indwelling medical device (a medical tool designed to stay inside the body for a period-either temporarily or long-term-to drain fluids, deliver medication, support a function, or monitor a condition, helping patients manage issues like urinary retention or provide IV access, though they require careful infection control): G-tube and wounds ordered on 12/10/2025. During an observation on 12/9/2025 at 2:55 PM in Resident 54's room, Resident 54's abdomen was observed to have an abdominal binder (a stretchy support belt worn around the stomach to help protect a g-tube site by covering it securely and preventing the resident from pulling or dislodging the tube). Underneath the abdominal binder, the g-tube site was observed without a dressing, and the abdominal binder was rubbing directly onto the stoma site. Resident 54's feed tubing (the plastic tube that connects the tube feeds to the resident's g-tube) was connected and infusing to the resident's g-tube. During an interview with Licensed Nurse (LN) 1 on 12/9/2025 at 3:00 PM, LN 1 stated that the treatment nurse (TXN) was responsible for changing g-tube dressings in the facility, however there was no treatment nurse available during the day. LN 1 stated she was not aware that Resident 54's g-tube site did not have a dressing and was unaware of how long the dressing was off since she had not assessed Resident 54's g-tube during her shift. During an interview with TXN 2 on 12/10/2025 at 9:15 am, TXN 2 stated that if there was no TXN available, the LN assigned to the resident was responsible for assessing and changing the g-tube dressing. TXN 2 stated it was important to ensure there was a dressing in place to prevent the site (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from becoming infected, further stating that the resident could develop sepsis (a life-threatening blood infection) and become hospitalized . During an interview with the Director of Nursing (DON) on 12/12/2025 at 2:05 PM, the DON stated LNs were expected to visually inspect the g-tube site every shift as part of their daily assessment. The DON stated that it was important to ensure the g-tube site was covered with a dressing to prevent the resident from developing an infection with an Multidrug-Resistant Organisms. The DON further stated Enhanced Barrier Precautions were ordered for residents with indwelling devices such as g-tubes specifically to prevent MDRO infections. During a review of the facility's policy and procedure (P&P) titled Gastrostomy/Jejunostomy Site Care, dated October 2011, the P&P indicated to assess the stoma site for signs of redness, pain or soreness, or drainage and the purposes of this procedure are to promote cleanliness and to protect the gastrostomy. site from irritation, breakdown, and infection.		

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident's bedrooms accommodated no more than four residents for five (5) of 36 rooms (Rooms 31, 32, 33, 34, and 35 with six beds in each room) in the facility in accordance with the facility's policies and procedures (P&P) titled Bedrooms, dated May 2017. This deficient practice had the potential to negatively affect the residents' privacy, safety, and quality of care due to inadequate space for quality nursing and emergency care services. Findings: During a review of the facility's request for an additional room waiver, dated 12/9/2025, the room waiver indicated Rooms 31, 32, 33, 34, and 35 have been occupied by more than four (4) residents in the past few years. The room waiver indicated the rooms were designed for adequate nursing care, and the comfort and privacy of the residents. The room waiver indicated the residents in mentioned rooms had the same required equipment and furniture as residents of the other room. The room waiver indicated there was no negative outcomes from the number of residents in each room. During a review of the Client Accommodation Analysis form, dated 12/9/2025, submitted by the facility on 12/9/2025, the form indicated the following rooms did not meet the federal requirement of no more than four beds per resident room in a multiple-resident room: From 12/9/2025 to 12/12/2025, the following were observed: 1. room [ROOM NUMBER] had six (6) beds with six (6) occupied beds 2. room [ROOM NUMBER] had six (6) beds with five (5) occupied beds 3. room [ROOM NUMBER] had six (6) beds with six (6) occupied beds 4. room [ROOM NUMBER] had six (6) beds with five (5) occupied beds 5. room [ROOM NUMBER] had six (6) beds with five (5) occupied beds During an interview on 12/10/2025 at 10:30 AM with the Administrator (ADM), the number of beds occupancy in Rooms 31, 32, 33, 34, and 35 remained the same. During the survey, multiple observations from 12/9/2025 to 12/9/2025 were conducted at random times from 7:30 AM to 5:00 PM. The residents in Rooms 31, 32, 33, 34, and 34 had enough space for individualized beds, bedside tables, overbed tables (an adjustable table with lockable wheels designed to roll over a bed or a chair and provide a flat and stable surface), and individualized resident care equipment. During a concurrent observation and interview on 12/11/2025 at 9:15 AM in Resident 1's room, there were six (6) available beds with six (6) occupied beds. Resident 1 stated that he liked his room and there was enough space in his room. During a concurrent observation and interview on 12/11/2025 at 9:33 AM in Resident room [ROOM NUMBER], there were six (6) available beds with five (5) occupied beds. Resident 8 stated that he had all his things such as his wheelchair, his laptop, his bedside table, and his clothes in his space and his closet. During a concurrent observation and interview on 12/11/2025 at 9:39 AM in Resident 19 room's, there were six (6) available beds with five (5) occupied beds. Resident 19 stated that he liked his room, and he had no issues with the space or his roommates. During an interview on 12/11/2025 at 9:43 AM with Licensed Nurse (LN) 6, LN 6 stated that she had residents in Rooms 31, 32, 33, 34, and 35. LN 6 stated, most of the residents were bedbound but some of the residents were ambulatory and had enough space to use their front wheel walkers (FWW, mobility aid with two wheels in the front) or their wheelchairs. LN 6 stated that there was enough space to do her work. During an interview on 12/11/2025 at 10:00 AM with Certified Nurse Assistant (CNA) 5, CNA 5 stated, she had residents in room [ROOM NUMBER] today. CNA 5 stated, there was enough space to do her work and use resident medical equipment such as wheelchairs, FWW, and Hoyer lift (a mechanical device used to safely lift and transfer residents with limited mobility) comfortably in the room. During a review of the facility's P&P titled Bedrooms, dated May 2017, the P&P indicated all residents are provided with clean, comfortable, and safe bedrooms that meet federal and state requirements. The P&P indicated bedrooms accommodate no more than two residents at a time.		

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/15/2025
NAME OF PROVIDER OR SUPPLIER Griffith Park Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident's bedrooms measured at least 80 square feet (sq.ft, unit of measure) per resident in five (5) of 36 rooms (Rooms 31, 32, 33, 34, and 35 with six beds in each room) in the facility in accordance with the facility's policies and procedures (P&P) titled Bedrooms, dated May 2017. This deficient practice had the potential to have a negative impact on the care and services of the facility's staff to provide safe nursing care and privacy to the residents. Findings: During a review of the facility's request for an additional room waiver, dated 12/9/2025, the room waiver indicated Resident Rooms 31, 32, 33, 34, and 35 were approximately 4378.56 sq.ft. The room waiver indicated the rooms were designed for adequate nursing care and the comfort and privacy of the resident. The room waiver indicated that the residents who occupy the rooms have the same required equipment and furniture as the rest of the residents within the facility. The room waiver indicated there was no negative outcomes from the number of residents in each room. During a review of the Client Accommodation Analysis form, dated 12/9/2025, submitted by the facility on 12/9/2025, the form indicated there were five (5) rooms that did not measure 80 sq. feet per resident as listed below: 1. room [ROOM NUMBER] - 437.56 sq ft with six (6) beds and six (6) occupied beds 2. room [ROOM NUMBER] - 437.56 sq ft with six (6) beds and five (5) occupied beds 3. room [ROOM NUMBER] - 437.56 sq ft with six (6) beds and six (6) occupied beds 4. room [ROOM NUMBER] - 437.56 sq ft with six (6) beds and five (5) occupied beds 5. room [ROOM NUMBER] - 437.56 sq ft with six (6) beds and five (5) occupied beds The required total sq.ft for Rooms 31 - 35 was 480 sq. ft. During the survey, multiple observations from 12/9/2025 to 12/12/2025 were conducted at random times from 7:30 AM to 5:00 PM. The residents in Rooms 31, 32, 33, 34, and 35 were observed to have adequate room for the operation and use of the wheelchairs (a chair fitted with wheels for use as a means of transport by a person who is unable to walk as a result of illness, injury, or disability), walkers (a device that provides additional support to maintain balance or stability while walking), or canes. The room variance did not affect the care and services provided to the residents when nursing staff were observed providing care for the residents. During an interview 12/10/2025 at 10:40 AM with the Administrator (ADM), the ADM stated there have been no complaints from the residents, resident's families, and facility staff about the room size of Rooms 31, 32, 33, 34, and 35. During a concurrent observation and interview on 12/11/2025 at 9:15 AM in Resident 1's room, there were six (6) available beds with six (6) occupied beds. Resident 1 stated that he liked his room and there was enough space in his room. During a concurrent observation and interview on 12/11/2025 at 9:33 AM in Resident 8's room, there were six (6) available beds with five (5) occupied beds. Resident 8 stated that he had all of his things such as his wheelchair, his laptop, his bedside table, and his clothes in his space and his closet. During a concurrent observation and interview on 12/11/2025 at 9:39 AM in Resident 19's room, there were six (6) available beds with five (5) occupied beds. Resident stated that he liked his room, and he had no issues with the space or his roommates. During an interview on 12/11/2025 at 9:43 AM with Licensed Nurse (LN) 6, LN 6 stated that she had residents assigned in Rooms 31, 32, 33, 34, and 35. LN 6 stated, most of the residents were bedbound but some of the residents were ambulatory and had enough space to use their front wheel walkers (FWW, mobility aid with two wheels in the front) or their wheelchairs. LN 6 stated, the staff will move equipment such as beds a little bit to make room for residents using a wheelchair to go out of the room and then the staff will move the bed back to its original position. During an interview on 12/11/2025 at 10:00 AM with Certified Nurse Assistant (CNA) 5, CNA 5 stated that she had residents in room [ROOM NUMBER]. CNA 5 stated that there was enough space to do her work and use resident medical equipment such as wheelchairs, FWW, and Hoyer lift (a mechanical device used to safely lift and transfer residents with limited mobility) without difficulty. During a review of (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	the facility's P&P titled Bedrooms, dated May 2017, the P&P indicated all residents are provided with clean, comfortable, and safe bedrooms that meet federal and state requirements. The P&P indicated bedrooms accommodate no more than two residents at a time.		