STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555605	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenhaven Healthcare	212 West Chevy Chase Drive Glendale, CA 91204

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 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 prevent and immediately report and/or no later than two hours the alleged allegation of abuse (an action that intetionally cause harm to another person) that involves verbal and physical abuse altercation of two of two sampled residents (Resident 2 and Resident 3) on 6/5/2025 before 10 AM when Resident 2 kicked Resident 3 ' s wheelchair and both residents had a verbal altercation. Resident 2 with history of abusive behavior hit License Vocational Nurse (LVN) 1 on the cheek on 6/2/2025 around 9 PM (prior medication pass) and was not supervised and monitored for his abusive behavior to prevent recurrent abuse as indicated in the facility's policy and procedure. This deficient practice resulted in Resident 2 hitting Resident 1 on the cheek while in the activity room on 6/5/2025 around 2:30 PM (four and a half hours after the first alleged abuse incident) during an altercation. Findings: A review of Resident 1 ' s admission record indicated the resident was admitted to the facility on [DATE] with diagnoses that included depressive episodes (persistent feeling of sadness and loss of interest), dementia (a decline in mental ability, severe enough to interfere with daily life), mood disturbance (a mental health condition that primarily affects your emotional state), and anxiety (a feeling of fear, dread, and uneasiness). A review of Resident 1 ' s History and Physical Examination (HPE), dated 2/15/2025, indicated Resident 1 has the capacity to understand and make decisions. A review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment screening tool), dated 5/21/2025, indicated the Resident 1 ' s cognitively status (ability to think, remember, and reason) moderately impaired. The MDS indicated Resident 1 was independent (resident completes the activity by themselves with no assistance with helper) with eating, toileting, dressing, personal hygeine, and required Setup and clean-up assistance (helper sets up and cleans up; resident completes activity) with bathing. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 2 ' s admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations (sensory experiences that appear real but are not, meaning someone might see, hear, feel, smell, or taste something that isn't actually there) and delusions (a false belief or judgment about external reality) and mood disorder symptoms, such as depression, mania), bipolar disorder (a mental health condition that causes extreme mood swings), and anxiety disorder. A review of Resident 2 ' s HPE, dated 3/6/2025, indicated Resident 2 does not have the capacity to understand and make decisions. A review of Resident 2 ' s MDS, dated [DATE], indicated the Resident 2 ' s cognitively status was moderately impaired. The MDS indicated Resident 2 required Setup and clean-up assistance with eating, personal hygeine, bathing, dressing and required supervision or touching assistance (Helper provides verbal cues and or touching steadying) with toileting. A review of Resident 3 ' s admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia, psychotic disturbance (a condition where a person experiences a significant loss of contact with reality), and anxiety. A review of Resident 3 ' s HPE, dated 1/23/2025, indicated Resident 3 was cooperative, appropriate affect, and normal judgment. A review of Resident 3 ' s MDS, dated [DATE], indicated the Resident 3 ' s cognitively status was moderately impaired. The MDS indicated Resident 3 required supervision or touching assistance with eating, personal hygeine, required partial/moderate assistance (helper does less than half the effort) with toileting and dressing, and substantial/maximal assistance (helper does more than half the effort) with bathing. A review of an SBAR (Situation, Background, Assessment, and Recommendation, a communication framework used to structure conversations, especially in healthcare, to ensure clear and concise information exchange, particularly in urgent situations) Communication Form and progress note dated 6/2/2025 timed at 9:25 PM, indicated Resident 2 punched LVN 1 on her right jaw in Resident 2 ' s room prior to medication administration. A review of SBAR Communication Form and progress note dated 6/5/2025 timed at 10AM, indicated Resident 2 had a physical and verbal aggressiveness towards a Resident (Resident 3) and was noted to have kicked Resident 3 ' s (while in his wheelchair) wheelchair in the hallway. A review of Resident 2 ' s facility document titled, SBAR Communication Form and progress note dated 6/5/2025 timed at 2:50 PM, indicated while playing BINGO in the activity room Resident 2 punched the other Resident (Resident 1) on the right side of the face. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 2 ' s care plan (CP) for diagnosis of schizophrenia manifested by outburst of anger, revised on 6/5/2025, indicated Resident 2 had episode physical aggression towards staff on 6/2/2025, kicking wheelchair of another resident on 6/5/2025, and hitting another resident unprovoked on 6/5/2025. The CP did not have any intervention how resiudent will be supervised and monitored for aggressive behavior. During an interview on 6/16/2025 at 9:45 AM with Activity Staff (AS) (Witness of Resident-to-Resident abuse between Resident 1and Resident 2). AS stated, on 6/5/2025 in the afternoon, while in the activity room during a game of BINGO, Resident 1 was reaching for Resident 2 ' s chips (small disc use as currency), Resident 2 then hit Resident 1 on the chin. During an interview on 6/16/2025 at 9:50 AM with Activity Director (AD), AD stated the altercation between Resident 1 and Resident 2 happened on 6/5/2025 around 2 PM. AD stated, AS reported to her that Resident 2 hit Resident 1 on the chin during a BINGO game, and she reported it immediately to the DON (Director of Nurses). AD stated, Resident 2 was not on 1 to 1 monitoring (one staff monitoring one resident) or on frequent monitoring prior to the incident. During an interview on 6/16/2025 at 10:00 AM with the DON, DON stated the incident between Resident 1 and Resident 2 happened on 6/5/2025 around 2 PM, both residents were separated, and Resident 2 was transferred to General Acute Care Hospital (GACH) 1 for evaluation. DON stated, Resident 2 was not placed on frequent monitoring, or 1 to 1 sitter prior to the abuse incident with Resident 1. During an interview on 6/16/2025 at 10:50 AM with the LVN 1 (LVN whom Resident 2 hit on the chin on 6/2/2025), LVN 1 stated, the incident happened on 6/2/2025 around 9 PM. LVN 1 stated, Resident 2 approached her for his medication while she was passing medications for another resident, she then told Resident 2 she could go to his room to give his medication. LVN 1 stated, when she went to Resident 2's room and about to turn on the overhead light to give him his medication, Resident 2 turned around and punched her on her right jaw. During a concurrent interview and record review on 6/16/2025 at 10:55 AM with the DON, facility document titled SBAR Communication Form and progress note (PN), dated 6/5/2025 timed at 10:00 AM was reviewed. The document indicated, Resident 2 was noted to have kicked a Residents wheelchair in the hallway. DON stated, the incident happened on 6/5/2025 before 10:00 AM, Resident 2 kicked Resident 3 ' s wheelchair and had a verbal altercation as they passed by each other in the hallway. During an interview on 6/16/2025 at 11 AM with the Director of Rehab (DOR), and MDS Nurse (MDSN) (Witnesses of alleged physical and verbal altercation between Resident 2 and Resident 3 on 6/5/2025 before 10 AM). DOR stated, the incident happened on 6/5/2025 before 10 AM. DOR stated, she was taking Resident 2 to the rehab room, Resident 2 was ahead of her in the hallway, when she turned around because MDSN called her, she heard a loud sound and observed Resident 2 and Resident 3 was having a loud verbal altercation. DOR stated, Resident 2 told her he kicked Resident 3 ' s wheelchair. MDSN stated, he with DOR intervened to prevent further altercation. DOR and MDSN both stated, they both reported the incident to the DON and ADM right away. DOR and MDSN both stated, the policy for alleged abuse was no report the incident immediately within 2 hours to the Ombudsman, Police, and California Department of Public Health (CDPH), MDSN stated, they should have followed up with the DON and the ADM, if it was reported to the proper agencies because they mandated reporter. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/16/2025 at 11:23 AM with LVN 2, LVN 2 stated she was the primary nurse for Resident 2 on 6/5/2025. LVN 2 stated, she learned about the incident between Resident 2 and Resident 3 ' s physical and verbal altercation from the DON, DOR and MDSN in the morning. LVN 2 stated, she was not aware that the incident was not reported timely within 2 hours to the proper agencies. LVN 2 stated, incident of alleged abuse allegation needs to be reported immediately to have an intervention and to prevent reoccurrence of aggression, its policy. During an interview on 6/16/2025 at 12:10 PM with the DON, DON stated, the physical and verbal altercation between Resident 2 and Resident 3 that happened on 6/5/2025 before 10 AM was reported to him. DON stated, there was no physical injury, that ' s why he did not report the incident to the appropriate agencies. DON stated, looking back he should have reported the incident to the proper agencies within two hours, to protect other residents and staff in the facility by more frequent monitoring of Resident 2 ' s behavior. DON stated, not reporting the physical and verbal altercation between Resident 2 and Resident 3 timely within 2 hours had the potential for reoccurrence of Resident 2 abusive behavior that could affect other residents ' and staff safety and potentially could have prevented the resident-to-resident abuse between Resident 2 and Resident 1. A review of the facility ' s policy and procedure (P&P) titled, Abuse and Neglect Prohibition Policy, dated 06/2022, the P&P indicated: a)the facillity policy prohibit abuse, mistreatment through; prevention of occurrence, identification of possible incidents or allegations, reporting of incidents and protection of residents, b) the facility staff are doing that is within their control to prevent occurrence of abuse and mistreatment, and c) under reporting of incidents; upon receiving information concerning a report of suspected or alleged abuse and mistreatment the administrator or designee will report all alleged violations -immediately but no later than 2 hours if alleged violation involves abuse.