STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056111	A. BUILDING _____ B. WING _____	**09/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRIFFITH PARK HEALTHCARE CENTER	**201 ALLEN AVE. GLENDALE, CA 91201**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide staff supervision in the smoking patio area to prevent a resident to resident altercation for two of six sampled residents (Residents 6 and 7) reviewed for altercations in the facility. There was no staff supervision in the smoking patio area when Resident 6 was hit three times in the face by Resident 7. This deficient practice had the potential for the residents to sustain an injury. Findings: A review of Resident 6's Face Sheet indicated the resident was admitted to the facility on [DATE], with admitting [DIAGNOSES REDACTED]. A review of Resident 6's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 8/14/20, indicated the resident understands and had the ability to express ideas and wants. Resident 1 required extensive assistance from staff for walking in the facility corridors. A review of Resident 7's Face Sheet indicated the resident was admitted to the facility on [DATE], with admitting [DIAGNOSES REDACTED]. A review of Resident 7's MDS dated [DATE], indicated the resident had no cognitive impairment (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and required limited assistance from staff for walking in the facility corridors. A review of Resident 7's Smoking assessment dated [DATE], indicated Resident 7 required supervision for smoking. A review of Resident Incident Report dated 6/10/20, at 4:30 p.m., indicated there was a non-witnessed, commotion in the smoking patio, a loud altercation between Resident 6 and 7. Staff went to the patio and separated the two residents. On 8/21/20, at 10:21 a.m., during an interview, Resident 6 stated, there was no staff in the smoking patio when the incident happen with Resident 7. Resident 6 further stated by the time staff arrived she got hit in the face by Resident 7 three times. On 9/2/20, at 9:17 a.m., during an interview with the Director of Nursing (DON), she verified the facility's policy was to provide staff supervision to the residents while in the smoking patio. The DON stated, on the day of the incident between Resident 6 and 7 there was no staff supervision in the patio. A review of the facility's undated policy and procedure titled, Smoking by Residents, indicated residents that require monitoring for smoking safety are not allowed to be in the smoking patio unsupervised.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 ensure the use of Personal Protective Equipment (PPE refers to protective clothing, helmets, gloves, face shields, goggles, facemasks and/or respirators or other equipment designed to protect the wearer from injury or the spread of infection or illness) and infection control practices for hand hygiene were followed, as indicated in the facility's Mitigation Plan (plan to mitigate the impact of a potential outbreak of COVID 19 ([MEDICAL CONDITION] 2019, a contagious virus that causes mild to severe upper respiratory infection) in the facility). These deficient practice had the potential to result in the transmission of COVID 19 to the residents, staff and visitors. Findings: On 8/21/20, at 7:07 a.m., during an observation of the facility's entrance, Laboratory Staff 1 (LS 1) entered the facility with a facemask that was positioned under her chin, which left her nose and mouth uncovered. LS 1 was ask about her facemask. LS 1 without responding placed the facemask over her nose and mouth and kept on walking. On 8/21/20, at 7:45 a.m., during an observation and concurrent interview, with Registered Nurse 1 (RN 1), in the yellow zone (area for the following residents: those who have been in close contact with known cases of COVID-19; newly admitted or readmitted residents; [MEDICAL TREATMENT] patients; those who have symptoms of possible COVID-19 pending test results; and for residents with indeterminate tests) Certified Nursing Assistant 1 (CNA 1) was exiting room [ROOM NUMBER] after providing care to the resident. CNA 1 had no gloves and was not wearing any isolation gown. RN 1 stated, CNA 1 should had worn a gown and gloves when going into resident's room in the yellow zone. On 8/21/20, at 8 a.m., during an observation and concurrent interview, CNA 2 was entering room [ROOM NUMBER]. CNA 2 donned PPEs with no hand hygiene prior to donning gloves. There was no alcohol based dispenser available within reach. The alcohol based dispenser was on the opposite end of the hallway to room [ROOM NUMBER]. On 8/21/20, at 8:30 a.m., during and observation and concurrent interview, with RN 1, she verified there was only one alcohol hand sanitizer dispenser for Station 1 hallway's that covered eight resident rooms. On 8/21/20, at 10 a.m., during an observation and concurrent interview, with the Infection Preventionist (IP, nurse who helps prevent and identify the spread of infectious agents like bacteria [MEDICAL CONDITION] in a healthcare environment), she verified there was no signs posted for hand hygiene and PPEs at the room doorways to remind staff of the infection prevention practices. A review of the facility's Mitigation Plan dated 6/18/20, indicated the following: - All staff should wear a facemask while in the facility, staff would adhere to infection control procedures. - Signs are posted immediately outside of resident rooms indicating appropriate infection control and preventions and required PPEs needed to enter room. - Staff in the yellow zone should wear a complete set of PPEs (surgical facemask, eye goggles or face shield, disposable gown and gloves). - All staff shall wash hands or use alcohol-based sanitizer before and after care. - Make sure that hand hygiene supplies, such as soap and water and alcohol-based hand sanitizer, are readily accessible in resident areas.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE