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 _____	**06/02/2020**

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 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **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 two sampled residents (Resident 1) was free from physical abuse by failing to prevent Certified Nurse Assistant 1 (CNA1) from slapping/smacking on Resident's face after the resident hit her with a lap buddy (wedge pillow) during care. This deficient practice had a potential to cause the resident's discomfort, decreased sense of safety and overall well-being. Findings: A review of Resident 1's Face Sheet (admission record) indicated Resident 1 was admitted to the facility on [DATE], and re admitted on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set ((MDS), a resident assessment and care screening tool), dated [DATE], indicated severely impaired cognition (refers to mental abilities or processes). The MDS indicated that Resident 1 did not have disorganized thinking and altered level of consciousness or exhibit abnormal physical and verbal behavioral symptoms directed towards others such as hitting, screaming, kicking, abusing others sexually, disrobing or threatening others. The MDS indicated Resident 1 required extensive assistance (resident performed part of the activity; staff provided support with weight bearing, at times full staff performance of activity) with one person physical assist for the following activities of daily living (ADL): bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed), transfer (how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position), and toilet use (how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; and adjust clothes). A review of Resident 1's care plan, titled, Behavioral Symptoms dated 8/3/18, identified Resident 1 with episodes and recurrence of physically aggressive behavior. One of the care plan goal was to support the resident 1's overall comfort, safety, and sense of well-being. The staff approaches/interventions included understanding the resident, looking for the underlying cause of the behavior, avoiding confrontation, cueing the resident prior to care delivery, ensuring all staff understand and follow the individualized best practice for the resident. A review of the facility's investigative records regarding the allegation of physical abuse, dated 10/27/18 timed at 12:30 p.m., indicated that Resident 1 verbalized that he hit CNA 1 with the lap buddy (wedge pillow). The report indicated that CNA 1 Reacted by slapping Resident 1 on his left cheek. CNA 1's handwritten statement signed on 10/27/18, indicated My reaction without thinking was to place my hand on his (resident) left side of the face . all in the presence of CNA 2. CNA 2's handwritten statement signed on 10/27/18, indicated that CNA 1 avoided being hit by Resident 1 and responded 'quickly' and 'smack' the resident's face. A review of Resident 1's SBAR (situation, background, appearance, and review) Communication Form dated 10/27/18, indicated the licensed nurses' evaluation of Resident 1's physical aggression and emotional distress secondary to CNA 1 and Resident 1's physical abuse allegation. The form indicated that Resident 1 did not sustain any physical injury, redness, and/or emotional distress as a result of the alleged physical abuse. During an interview, on 11/1[DATE]8 at 3:25 p.m., CNA 2 stated that she assisted CNA 1 in transferring Resident 1 from the bed to the wheelchair, and they were standing on Resident 1's left and right side. CNA 2 stated I don't think that Resident 1 meant to hurt CNA 1. Resident 1 looked like he was fooling around. CNA 1 was never happy, always frustrated. CNA 2 stated she was surprised to witness CNA 1 used her opened hand and give Resident 1 a 'hard hit' in the cheek. CNA 2 stated that she told CNA 1 to report the incident to the supervisor immediately because CNA 2 would not cover for CNA 1. CNA 2 stated that CNA 1's response to Resident 1's action was not appropriate. During an interview, on 11/1[DATE]8 at 3:35 p.m., Registered Nurse 1 (RN 1) stated that on 10/27/18, CNA 1 called her attention to Resident 1's room. RN 1 stated that CNA 2 was there with Resident 1. RN 1 stated that CNA 1 informed her of what had happened and CNA 1's first reaction to hit Resident 1 in the face, by his left cheek. RN 1 stated that Resident 1 looked 'indifferent,' no fail expression, and not in pain. RN 1 stated that CNA 1 should not reacted impulsively to the situation and understand that the facility had more residents like Resident 1 with psychological issues. During an observation and interview, on 11/1[DATE]8 at 3:50 p.m., Resident 1 demonstrated how CNA 1 slapped him in the cheek. Resident 1 was sitting in his wheelchair with a lap buddy (wedge pillow) attached to his wheelchair. Resident 1 attempted to pull the lap buddy out of his wheelchair and chuckled. Resident 1 stated he did not get hurt. CNA 1 was no longer in the facility and could not be reached for an interview. A review of the facility's policy and procedures titled, Abuse Prevention/Prohibition, dated November 2018 indicated, the facility does not condone any form of abuse and develops facility policies, procedures, training programs, and systems in order to promote an environment free from abuse and mistreatment. The policy indicated 'physical abuse' was defined as hitting, slapping, pinching and/or kicking.

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

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.