STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056111	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Griffith Park Healthcare Center	201 Allen Ave. Glendale, CA 91201

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to initiate a person-centered care plan for one of two sampled residents (Resident 1) with a diagnosis of dysphagia (difficulty swallowing). This deficient practice resulted in the potential for Resident 1 to not receive individualized care and services necessary to address his swallowing difficulties, thereby placing him at risk for adverse outcomes such as aspiration (the inhalation of a foreign substance into the airway), choking, or inadequate nutrition and hydration.FINDINGS:During a review of Resident 1's admission Record indicated the resident was admitted on [DATE] with diagnoses that included epilepsy (abnormal electrical activity in your brain that temporarily affects your consciousness, muscle control and behavior), malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets), encephalopathy (any disorder that affects brain function, leading to an altered mental state such as memory loss or personality changes), and narcolepsy (a chronic sleep disorder characterized by excessive daytime sleepiness and sudden sleep attacks that significantly impact daily life). During a review of Resident 1's History and Physical (H&P), dated 7/25/2025, the H&P indicated that Resident 1 does not have the capacity to understand and make decisions. The H&P also indicated that Resident 1 had diagnoses of muscle weakness and dysphagia. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 7/29/2025, indicated that Resident 1 has severely impaired cognition (the ability to process thoughts and emotions). The MDS also indicated that Resident 1 required substantial assistance (the helper does more than half the effort) in activities such as toileting, bathing, hygiene, moving while in bed, sitting up in bed, and transferring from the bed to a chair. The MDS also indicated that Resident 1 required supervision (the helper provides verbal cues and/or touching assistance as resident completes activity) on activities such as eating and oral hygiene. The MDS also indicated that Resident 1 required a mechanically altered diet (require change in texture of food or liquids such as pureed food and/or thickened liquids). During a review of Resident 1's Speech Therapy Notes (ST), dated 10/16/2025, the ST Notes indicated that Resident 1 required a pureed (medical diet of foods that have been blended, ground, or strained into a smooth, lump-free, pudding-like consistency) consistency diet. The ST also indicated that Resident 1 was on swallow precautions (a set of safety guidelines and techniques used to help individuals with dysphagia eat and drink without accidentally inhaling food, liquid, or saliva into their lungs [aspiration]). During a review of Resident 1's physician's orders for the month of 11/2025, the orders indicated an order for a No Added Salt (NAS) diet Pureed texture, Regular/Thin consistency, ordered on 9/17/2025. The physician's orders also included an order which indicated that staff may crush medications unless contraindicated, ordered on 7/23/2025. During a review of Resident 1's entire care plans, the care plans did not indicate any care plan for Resident 1's dysphagia and the need for a pureed consistency diet. During a telephone interview on 11/24/2025 at 12:22 PM with Resident 1's Family Member (FM), FM stated that Resident 1 required all medications to be crushed due to difficulty swallowing whole pills. FM also stated that Resident 1 could only eat pureed foods and was at risk of aspiration if given uncrushed medications or non-pureed foods. During a concurrent (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observation and interview on 11/25/2025 at 9:25 AM in Resident 1's room, Resident 1 was observed sitting up in bed. Resident 1 stated he was only able to eat pureed food and required all medications to be crushed, as he could not swallow whole pills. During an interview on 11/25/2025 at 9:56 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 required his medications to be crushed. LVN 1 added that Resident 1 is on a pureed consistency diet because of his difficulty in swallowing. During a concurrent interview and record review on 11/25/2025 at 12:41 PM with Registered Nurse (RN) 1, Resident 1's care plans were reviewed. RN 1 stated Resident 1's care plans did not indicate any care plan to address Resident 1's dysphagia. RN 1 stated Resident 1's dysphagia should have a care plan since care plans were used to monitor the resident's response to the interventions that were implemented by the facility staff. During a follow up interview on 11/25/2025 at 1:28 PM with RN 1, RN 1 stated Resident 1's care plan for swallowing difficulties must include interventions for licensed nurses (LN) to crush Resident 1's medication and must indicate a pureed consistency diet. RN 1 stated it was important to indicate Resident 1's specific needs on the care plan since the facility used the care plan to monitor and assess whether interventions were effective or not. 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 care plan is developed and implemented for each resident. The P&P indicated that comprehensive, person-centered care plan will include measurable objectives and timeframes. The P&P also indicated that the care plan will describe services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The P&P further indicated that care plans are revised as information about the residents and the residents' conditions change.