| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056111 | A. Building<br>B. Wing | 01/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Griffith Park Healthcare Center | 201 Allen Ave.<br>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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**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 to three of three (Resident 1, 2 and 3) who needed assistance with ADL (activities of daily living) by not answering the call lights (a button or touch pad device that residents use to communicate assistance from the nursing staff) in a timely manner in accordance with the facility's policy and procedure by failing to assist: 1.Resident 1 and Resident 2 reported it took the facility one (1) to two (2) hours to respond to their call light when their adult briefs needed to be changed. 2.Resident 3 reported he waited about one (1) hour in the bathroom for a nurse to assist in cleaning him after having a messy bowel movement. As a result of this deficient practice, the residents were placed at risk for infection, skin breakdown and discomfort. Findings: 1.During a review of Resident 1 admission Record (AR), the facility admitted Resident 1 on 7/23/2025 with diagnoses that included encephalopathy (any disease, damage, or malfunction that may cause altered brain function), epilepsy (an abnormal burst of electrical activity in the brain that causes changes in behavior, movement, awareness, or sensation), and hypertension (high blood pressure). During a review of Resident 1's History and Physical (HP), dated 7/25/2025, the HP indicated Resident 1 did not have the capacity to understand and make decisions and the surrogate decision maker was Family Member (FM) 1. The HP indicated Resident 1 was bed bound and had a decrease tone and no movement on the right side of his body. During a review of Resident 1's Minimal Data Set (MDS- a resident assessment and care planning tool), dated 10/28/2025, the MDS indicated Resident 1's cognitive (a resident's thought process) skills were severely impaired. The MDS indicated Resident 1 required substantial assistance (helper does more than half the effort) with ADLs such as toileting hygiene (ability to maintain perineal hygiene before and after urinating or having a bowel movement), showering, and dressing himself. The MDS indicated Resident 1 required moderate assistance (helper does less than half the help) when repositioning himself in bed but required substantial assistance when transferring from a lying to sitting position and when transferring from chair/bed to chair transfer. The MDS indicated Resident 1 was always incontinent (loss of control of bladder and bowel movement) of urine and bowel. During a review of Resident 1's care plan (CP), revised 9/30/2025, Resident 1's CP indicated he had an ADL deficient related to ambulation, toileting, and personal hygiene. The CP's goal, revised on 1/26/206, indicated Resident 1's ADL needs will be met for 90 days. The CP's interventions, initiated on 9/30/2025, included monitoring and assisting Resident 1 with his ADL needs, keeping him clean and dry and changing [his adult briefs] as needed, having the call light within reach and the staff to answer call lights promptly. During an interview on 1/9/2026 at 9:15 AM with FM 1, FM 1 stated on 1/6/2025, Resident 1 had to wait over an hour for his adult briefs to be changed. FM 1 stated, when she visits Resident 1, all I hear are the bells going off all the time. During a concurrent observation and interview on 1/9/2026 at 11:50 PM with Resident 1 in Resident 1's room, Resident 1 was observed lying on his back in bed, with the head of bed<br><br>(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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | at 90 degrees and call light within reach. Resident 1 stated that he will call the nurses for assistance with the call light when his adult briefs need to be changed. Resident 1 stated, it will take one (1) hour for the call light to be answered, and he had to wait in his wet and soiled adult briefs, which was uncomfortable. 2.During a review of Resident 2's AR, the facility admitted the resident on 10/23/2024 with diagnoses that included benign prostatic hyperplasia (BPH-enlarged prostate), polyneuropathy (multiple peripheral nerve damage), spondylosis of the lumbar region (degeneration of the bones and disk in the lower back) and bilateral osteoarthritis (progressive disorder of the joints, caused by a gradual loss of cartilage) of the knee. During a review of Resident 2's MDS, dated [DATE], the MDS indicated that Resident 2's cognitive skills were moderately impaired that required supervision with toileting hygiene, oral hygiene, and dressing, transferring from a sitting to lying position and transferring from the chair/bed to chair. The MDS indicated Resident 2 was frequently incontinent (no control of bowel and bladder) with urine and stool. During a review of Resident 2's CP, revised 5/18/2025, the CP indicated Resident 2 had an ADL deficient related to his bilateral knee osteoarthritis and polyneuropathy. The CP's goal, revised on 12/9/2025, indicated Resident 2's ADL needs will be met daily for 90 days. The CP's interventions included monitoring and assisting Resident 2 with his ADL needs, keeping him clean and dry, and changing him as needed, and having the call light within reach and the staff to answer call lights promptly. During a concurrent observation and interview on 1/9/2026 at 1 PM with Resident 2 in Resident 2's room, Resident 2 was observed sitting in his wheelchair next to the bed with the call light on top of the bed. Resident 2 stated that he calls the nurses for assistance with the call light. Resident 2, he used the urinal (a portable container used to collect urine) when he urinates, but he used an adult brief when he needed to have a bowel movement. Resident 2 stated that he would have to wait one (1) to two (2) hours to have his adult brief changed after pressing the call light. Resident 2 stated, sometimes it takes a while for [the nurses] to come, and that's why I feel bad. 3. During a review of Resident 3's AR, the facility admitted Resident 3 on 2/13/2023 and readmitted Resident 3 on 11/27/2024 with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (generalized weakness on one side of the body) following cerebral infraction (stroke, loss of blood flow to a part of the break) affecting the left non-dominant side, osteoarthritis of the right and left shoulder, and glaucoma (damage to the optic nerve in the eye). During a review of Resident 3's HP, dated 11/10/2025, the HP indicated that Resident 3 had the capacity to understand and make decisions. During a review of Resident 3's MDS, dated [DATE], indicated Resident 3's cognitive skills were intact. The MDS indicated Resident 3 required substantial assistance with performing toileting hygiene and substantial assistance with repositioning himself in bed and with chair/bed to chair transferring. The MDs indicated Resident 3 was frequently incontinent with urine and occasionally incontinent of bowel. The MDS indicated Resident 3 was on a toileting program for his bowel continence. During a review of Resident 3's CP, dated 4/20/2025, the CP indicated Resident 3's bowel and bladder function. The CP's interventions included assisting Resident 3 with toileting as needed and keeping the call light within reach and use for assistance. During a review of Resident 3's CP, dated 12/4/2024, the CP indicated Resident 3 had an ADL self-care performance deficit related to his activity intolerance, hemiplegia, impaired balance, and osteoarthritis. The CP's interventions indicated Resident 3 required limited to extensive assistant by 1 staff with personal hygiene, oral care, and toileting and Resident 3 required extensive assistance by 1 staff member during toileting schedule. During an interview on 1/9/2026 at 1:42 PM with Restorative Nurse Assistant (RNA) 1, RNA 1 stated, the resident's call light should be within reach of the resident. RNA 1 stated, residents used the call<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | light to communicate their needs with the nursing staff and to ask for assistance such as adult brief changes or assistance to the bathroom. During an interview on 1/9/2026 at 2:15 PM with Licensed Vocational Nurse (LVN) 1 , LVN 1 stated, residents used the call light to communicate assistance from the nurses. LVN 1 stated that the call light should be within reach of the resident and answered timely for the resident's safety and needs. During a concurrent observation and interview on 1/9/2026 at 3:54 PM in Resident 3's room, Resident 3 was sitting in his wheelchair in front of his bed and the call light was on top of the bed. Resident 3 stated he would pressed the call light when he needed assistance from the nurses such as going to the bathroom to urinate or to have a bowel movement. Resident 3 stated, he used the call light in the bathroom to alert the nurses he needed assistance to be cleaned especially after a bowel movement because it can be very messy. Resident 3 stated that he would have to wait at least one (1) hour before someone came into his room. During an interview on 1/9/2026 at 4:15 PM with the Director of Staff Development (DSD), the DSD stated, call lights were used as a means of communication by the residents to ask for assistance from the nursing staff. The DSD stated, call lights were answered promptly by the nursing staffing, which would be no more than 15 minutes. The DSD stated that a resident should not be waiting one (1) hour for their call light be answered because it was important for the resident's needs to be attended timely, especially for an adult brief changed or assistance in the bathroom, to prevent skin breakdown and for the safety of the resident. During an interview on 1/9/2026 at 4:30 PM with the Administrator (ADM), the ADM stated that call lights should be answered promptly to address the resident's needs. The ADM stated that one (1) hour might be too long for the call light to be answered. During a review of the facility's policies and procedures (P&P) titled Activities of Daily Living (ADL), Supporting, dated March 2018, the P&P indicated that the appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including the appropriate support and assistance with hygiene (bathing, dressing, grooming and oral care), mobility (transfer and ambulation), elimination (toileting), dining, and communication. During a review of the facility's P&P titled Call System, Residents, dated September 2022, the P&P indicated that the residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. The P&P indicated that calls for assistance are answered as soon as possible, but no later than 5 minutes. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>Based on observation, interview, and record review, the facility failed to provide Orajel 2X Toothache & Gum Mouth/Throat Gel 20-0.26% (Orajel cream, topical cream applied to gums to relieve pain and discomfort) as for three days that was ordered by the physician to manage and relieve pain for one of three sample residents (Resident 1) who complained of upper left jaw toothache (pain around the tooth). As a result of this deficient practice Resident 1 reported experiencing consistent pain at 8 of 10 pain on the numerical number scale (a way of rating pain intensity, ranging from 0 - no pain to 10 - worst pain felt) and difficulty eating from 12/27/2025 to 12/29/2025 which could lead to weigh loss and/or prevents the resident to prevent in participation in activities of daily living that affects the quality of life. Findings: During a review of Resident 1 admission Record (AR), the facility admitted Resident 1 on 7/23/2025 with diagnoses that included encephalopathy (any disease, damage, or malfunction that may cause altered brain function), epilepsy (an abnormal burst of electrical activity in the brain that causes changes in behavior, movement, awareness, or sensation), and hypertension (high blood pressure). During a review of Resident 1's History and Physical (HP), dated 7/25/2025, the HP indicated Resident 1 did not have the capacity to understand and make decisions and the surrogate decision maker was Family Member (FM) 1. The HP indicated Resident 1 was bed bound (stays in bed most of the time) and had a decrease tone and no movement on the right side of his body. During a review of Resident 1's Minimal Data Set (MDS-a resident assessment and care planning tool), dated 10/28/2025, the MDS indicated Resident 1's cognitive (a resident's thought process) skills were severely impaired and required substantial assistance (helper does more than half the effort) with ADLs such as toileting hygiene (ability to maintain perineal hygiene before and after urinating or having a bowel movement), showering, and dressing himself. The MDS indicated Resident 1 required moderate assistance (helper does less than half the help) when repositioning himself in bed but required substantial assistance when transferring from a lying to sitting position and when transferring from chair/bed to chair transfer. The MDS indicated Resident 1 was not receiving a pain management regimen and denied pain. The MDS indicated the staff assessment for pain was blank. During a review of Resident 1's Order Summary Report, dated 8/26/2025, the physician order indicated to monitor Resident 1's pain level every shift using the pain scale (0 = no pain, 1 - 3 = mild pain, 4 - 7 = moderate pain, 8 - 10 = severe pain. During a review of Resident 1's Order Summary Report, an order dated 7/23/2025, the physician order indicated Resident 1 was to received Acetaminophen (Tylenol, pain and fever reducer medication) oral (by mouth) tablet 325 milligrams (mg, unit of weight) with the instructions to give two (2) tablets by mouth every 4 hours as needed for moderate pain (pain scale 4 -7) management. During a review of Resident 1's Care Plan (CP), revised on 11/25/2025, the CP indicated Resident 1 had dental health problems related to poor oral hygiene and missing teeth. The CP's interventions, dated 11/4/2025, indicated to monitor, document, and report any signs and symptoms of oral or dental pain such as pain (in the gums, toothache, palate), missing teeth, or ulcers in the mouth. During a review of Resident 1's Change of Condition (CoC) evaluation, dated 12/27/2025, the CoC indicated Resident 1 had mild swelling of the lymph nodes (lumps of tissue that filter fluid in the body and fights infection) and left cheek. The CoC indicated Resident 1 had a pain level of 5 out of 10 on the upper left jaw tooth ache on his face. During a review of Resident 1's Order Summary Recap Report, an order dated 12/27/2025, the order indicated the physician ordered Resident 1 to receive Orajel 2X Toothache & Gum Mouth/ Throat Gel 20 - 0.26% with instructions to give 1 application by mouth every 6 hours as needed for toothache for 7 days. During a review of Resident 1's Medication Administration Record (MAR) for the month of December 2025, the MAR indicated from 12/27/2025 to 12/31/2025,<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident 1 denied pain. During a review of Resident 1's MAR for the month of December 2025, there was no documented evidence Resident 1 received Acetaminophen Oral Tablet for pain from 12/27/2025 to 12/29/2025. During a review of Resident 1's MAR for the month of December 2025, there was no documented evidence Resident 1 received Orajel cream for his toothache from 12/27/2025 to 12/29/025. During a review of Resident 1's CP, dated 1/3/2026, the CP indicated Resident 1 had acute pain related to lymph node swelling as evidence by facial swelling and tenderness. The CP's interventions, dated 1/3/2026, included assessing Resident 1's pain level, swelling size, and tenderness every shift and administering pain medications as needed. During an interview on 1/9/2026 at 8:55 AM with Family Member (FM) 1, FM 1 stated Resident 1 complained of a toothache and was prescribed Orajel cream on 12/27/2025. FM 1 stated that the Orajel cream was not delivered until 12/30/2025. During a concurrent observation and interview on 1/9/2025 at 11:50 AM with Resident 1 and FM 2 in Resident 1's room, Resident 1 was observed lying on his back in bed, with the head of bed at 90 degrees, eating from the lunch tray placed in front of him on the overbed table (a rolling, adjustable table that slides over the bed to provide a portable surface). Resident 1 pointed to the upper left side of his jaw and stated he experienced frequent 8 out of 10 pain severity in this area a couple weeks ago. Resident 1 stated, when he received the cream for his toothache, the pain level decreased to 2 out of 10 pain severity and was able to eat more comfortably. During the same concurrent observation and interview on 1/9/2025 at 11:55 AM with Resident 1 and FM 2 in Resident 1's room, Resident 1 was observed pointing to his upper right jaw area. FM 2 stated, Resident 1 had a hard time eating for three days because it was difficult for him to chew with the left side of his mouth. FM 2 stated, Resident 1 had to move the food to the right side of his mouth and chew slowly. During the same concurrent observation and interview on 1/9/2025 at 12 PM, FAM 1 and FM 2 were in in Resident 1's room. FM 2 stated, during those 3 days, 12/27/2025 to 12/29/2025, FM 1 and FM 2 frequently told the nursing staff that Resident 1 was having pain and discomfort in his mouth. FM 1 stated the nursing staff kept saying the medication had not arrived from the pharmacy yet. FAM 1 stated she even offered to pick up the medication from the pharmacy but she was informed by the facility that the facility will follow up with the pharmacy staff.FM 1 stated, nothing was done until Tuesday [12/30/2025]. During an interview on 1/9/2025 at 2:30 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, she was aware Resident 1 had an infection in his mouth. LVN 1 stated, she was aware Resident 1 had an order for Orajel cream in December 2025, but it was not reported to me that Resident 1 had mouth pain. During a concurrent interview and record review on 1/19/2025 at 4:10 PM with the Director of Staff Development (DSD), Resident 1's Order Recap Report and December 2025 MAR were reviewed. The DSD stated, Resident 1's Orajel cream was ordered on 12/27/2025 but the first dose was given on 12/30/2025. The DSD stated, he did not know why it took three (3) days before the first dose was given. During the same interview and record review on 1/19/2025, at 4:35 PM with the DSD, Resident 1's December 2025 MAR was reviewed. The DSD stated, from 12/27/2025 to 12/29/2025, there was no documented evidence Resident 1 received Orajel cream or Tylenol for Resident 1's complain of toothache. The DSD stated, from 12/27/2025 to 12/29/2025, the MAR indicated Resident 1 denied having pain. The DSD stated, Resident 1's family members were very involved and vocal about ensuring all of Resident 1's needs were met. The DSD stated, if Resident 1's family members informed the nurses of Resident 1's toothache, there should have been a thorough pain assessment completed. The DSD stated there was no documented evidence of a thorough pain assessment, including pain level, location, frequency, and description from 12/27/2025 to 12/29/2025. During the same concurrent interview and record review on 1/19/2025 at 4:45 PM with the DSD, Resident 1's December 2025 was reviewed. The DSD stated, the MAR indicated from 12/27/2025 to 12/29/2025<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident 1 denied pain. The DSD stated that pain assessment for 12/27/2025 to 12/29/2025 did not make sense if Resident 1's family members were informing the nurses of Resident 1's mouth pain and if there was an order for an Orajel cream. The DSD stated, if Resident 1 did not have mouth pain on 12/27/2025, there would be no order for Orajel cream. During a review of the facility's policies and procedures (P&P) titled Pain - Clinical Protocol, dated March 2018, the P&P indicated that the nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. The P&P indicated that the staff and physician will identify characteristics of pain such as location, intensity, frequency, pattern, and severity. The P&P indicated that the nursing staff will identify any situation or intervention where an increase in the resident's pain may be anticipated. During a review of the same facility's P&P titled Pain - Clinical Protocol, dated March 2018, the P&P indicated that the staff will reassess the individual's pain and related consequences at regular intervals and should include a frequency, duration, intensity of pain, and the ability to perform ADLs. |