

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Griffith Park Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a comprehensive, resident centered care plan was developed for one of three sampled resident (Resident 1), who was legally blind to address and assist specific needs. This deficient practice resulted in Resident 1 not being provided with specific care and services required to maintain her independence. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the resident was originally admitted on [DATE], with a diagnosis of, but not limited to Blindness of left and right eye, respiratory failure(a serious condition where your lungs cannot get enough oxygen into your blood) , and diabetes(a condition where your body has trouble controlling sugar in your blood). During a review of Resident 1's History and Physical (H&P), dated 8/11/2025, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), indicated the resident is cognitively intact (fully alert, oriented, and able to make decisions and participate in care planning) requiring moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with oral hygiene, toileting hygiene, lower and upper body dressing and putting on / taking off foot ware. During an interview on 1/28/2026 at 10:30AM with Resident 1, Resident 1 stated that due to her blindness she was unable to visually identify her meals. Resident 1 stated that she used her hands to determine what she was eating by touching the texture of food and feeling the temperature. During an interview on 1/28/2026 at 11:45AM with Registered Nurse (RN) 1, RN1 stated that Resident 1 was blind in both eyes. RN1 stated that usually, assistance would be provided for meal set- up (including identifying food items and their location on the tray), as well as for transfers and toileting due to her visual impairment. During a concurrent interview and record review on 1/28/2026 at 2 PM with RN 2, Resident 1's Care Plans were reviewed. RN 2 stated there was no care plan initiated to address Resident 1's specific diagnosis for blindness. RN2 stated the care plan should have been initiated and should include measurable goals and address interventions for behaviors and needs to decrease stress and anxiety. During an interview on 1/29/2026 at 11:53AM with minimum data set nurse (MDSN) , MSDN stated there was no care plan initiated to address Resident 1's blindness. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person - Centered, revised December 2016, indicates a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional need is developed and implemented for each resident. A comprehensive, person-centered care plan is developed and implemented for each resident. A comprehensive, person -center care plan developed within seven (7) days after a significant change in status with care plan interventions chosen only after data gathering, proper sequencing of events, careful consideration between the resident's problem areas and their causes, and relevant clinical decision making. Assessments of residents are</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 056111	Facility ID: 056111 If continuation sheet Page 1 of 3

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ongoing, and care plans are revised as information about the residents' conditions change.

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview and record review, the facility failed to implement infection control practices in accordance with the facility's Policy and Procedure (P&P) titled Oxygen Administration and Departmental (Respiratory Therapy) for a one of two sampled residents (Resident 1) by failing to : Ensure Resident 1's oxygen tubing (a flexible plastic tube, often green, that delivers supplemental oxygen from a tank or concentrator to a patient via nasal prongs) was labeled with a date the oxygen tubing was last changed.Ensure Resident 1's breathing nebulizer (a device that converts liquid medication into a fine mist for inhalation) was changed within seven (7) days. The nebulizer was last dated 1/5/2026.Document oxygen set- up, which included the date and time the procedure was performed in Resident 1's medical record. These deficient practices had the potential to increase the risk and spread of infections. Findings: During a review of Residents 1's admission Record (AR), the AR indicated Resident 1 was admitted to facility on 08/08/2026, with a diagnosis of chronic respiratory failure (lungs can't get enough oxygen), obstructive pulmonary disease (blocked airways, hard to breathe out) and delusional disorders (false beliefs). During a review of Resident 1's History and Physical (H&P), dated 8/11/2026, the H&P indicated Resident 1 has the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 11/15/2025, indicated resident is cognitively intact (can understand, remember and make decisions appropriately) and requires moderate assistance (helper does less than half the effort) with Activities of Daily living (ADLS) such as personal and oral hygiene, and dressing. During a review of Resident 1' s Order Summary Report, the report indicated an order start date of 12/25/2025 for oxygen at 5 liters per minute(lpm) by nasal canula (small tub in the nose that gives extra oxygen) to be administered continuously (all the time) every shift. During an observation on 1/28/2026 at 10:30AM in Resident 1's room, Resident 1's oxygen tubing was observed without a date or time to indicate when the tubing was last changed and breathing nebulizer tubing was dated 1/5/2026. During a concurrent observation and interview on 1/28/2026 at 11 AM with Licensed Vocation Nurse (LVN) 1 in Resident 1's room, Resident 1's oxygen tubing and breathing nebulizer was observed. LVN 1 stated oxygen tubing must be dated to ensure staff know when to change the tubing next. During a concurrent observation and interview on 1/28/2026 at 11:45 AM with Registered Nurse (RN1), Resident 1's oxygen tubing and nebulizer was observed. RN 1 stated the oxygen tubing was not labeled and should be labeled weekly to ensure the tubing was changed to prevent infection. RN1 stated the nebulizer tubing was dated 1/5/2026 and that the tubing should have been changed since not changing the nebulizer tubing would increase the risk of infection. RN 1 stated there was no way to know when the tubing's were last changed since there was no date or documentation to indicate when Resident 1's oxygen tubing was changed. RN 1 stated that the nebulizer tubing was last changed on 1/5/2026, since that date was indicated on the label, and that the nebulizer tubing should have been changed every 7 days, which would have been last changed on 1/19/2026. During a review of the facility's policy and procedure (P&P) titled Oxygen Administration dated October 2010, indicated the purpose of the P&P is to provide guidelines for safe oxygen administration and documentation. The policy requires that, after completing oxygen se-up, the date and time the procedure was performed be documented in the resident's medical record. During a review of the facility's P&P titled Departmental (Respiratory Therapy)dated November 2011 indicated the purpose of the P&P is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators , among residents and staff. The P&P indicates to change the oxygen cannula and tubing every seven (7) days, or as needed and to document the following information in the resident's medical record, the date and time the respiratory therapy was performed.</p>		