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	03/25/2026

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure proper and effective Basic Life Support (BLS-the level of care provided to victims of life-threatening illnesses or injuries until full medical care is available, including recognition of cardiac arrest and activation of the emergency response system), that included cardiopulmonary resuscitation (CPR, an emergency procedure combining chest compressions and rescue breaths to circulate blood and oxygen when the heart stops or breathing ceases). The facility did not perform BLS for one of two sampled residents (Resident 1) identified full code (a resident who wants all possible life-saving measures used if their heart stops or they stop breathing, including CPR. When Resident 1 was found weak, with shallow breathing, no longer talking and became unresponsive and failed to ensure: 1. Registered Nurse Supervisor (RN) 1 and Licensed Vocational Nurse (LVN) 1 initiated CPR immediately when Resident 1 was found weak and unresponsive with an oxygen saturation (a measurement of the oxygen blood level) of 89% (blood oxygen level normal range 94-100%) without delay on [DATE], at 6:45PM. 2. RN 1 placed Resident 1 flat on the back on a firm, flat surface and use the head-tilt, chin-lift maneuver to open the airway while delivering oxygen (to ensure optimal oxygen flow and blood circulation during CPR) via simple mask (lightweight, clear plastic medical device that fits over a patient's nose and mouth, secured with an elastic strap, to deliver oxygen), but instead placed Resident 1 at a 70-90 degree angle while Resident 1 remained unresponsive. 3. RN 1, LVN 1 and LVN 2 performed continuous and uninterrupted CPR until emergency medical services (EMS- ambulance services or emergency services that provide treatment and stabilization for the patient) assumed care. 4. Immediate CPR was provided without delay due to the unavailability of an oxygen regulator that could deliver 15 L/min flow required to keep the Bag-valve-mask (BVM - a manual resuscitation technique that provides positive pressure ventilation to patients with inadequate or absent spontaneous breathing) fully inflated to deliver 100% oxygen. As a result of the deficient practice, paramedics arrived at the facility on [DATE] at 6:52 PM. According to the Emergency Medical Services (EMS) report, facility staff reported to EMS that the resident's (Resident 1) last known well (LKW) time (a time someone was last seen acting normally or without new symptoms) was approximately 30 minutes prior. The report also noted that no CPR was being performed by facility staff, and that Resident 1 was found with no measurable blood pressure, pulse rate, respirations, or oxygen saturation upon EMS arrival. A determination was made that the facility's noncompliance with one or more requirements of participation placed Resident 1 in immediate jeopardy, beginning [DATE]. On [DATE] at 4:42 PM, while onsite at the facility, the California Department of Public Health (CDPH) identified an immediate jeopardy situation (IJ, a situation in which the providers noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) regarding the failure to ensure CPR was immediately performed on Resident 1. The survey team notified Director of Nursing (DON), the administrator (ADM) of the IJ situation. After the IJ was removed, the surveyor verified that the facility's non-compliance remained at a lower scope of isolated (when one or a very limited number of residents are affected and/or one (continued on next page)

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
	056111	A. Building B. Wing	03/25/2026

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	or a very limited number of staff are involved) and lower severity of Level 3 (Actual Harm that is Not Immediate Jeopardy). On [DATE] at 4:45 PM, the IJ was removed in the presence of the ADM and the DON after the facility submitted an acceptable IJ Removal Plan (a plan that identifies all actions the facility will take to immediately address the noncompliance that has resulted in the IJ situation) and the surveyor verified/confirmed onsite the facility's implementation of the IJ Removal Plan and the IJ situation was no longer present. The IJ Removal Plan dated [DATE] at 4:45 PM, included the following: 1. The RN 1 last day worked at the facility was [DATE] and has resigned as of [DATE]. 2. On [DATE] staff involved LVN 1, LVN 2 were removed by the DON from direct patient care until competency was validated. 3. On [DATE] immediate re-education was reinforced by the DON for direct care staff on (immediate initiation of CPR, proper positioning on a firm, flat surface, continuous, uninterrupted CPR, crash cart (mobile cart with equipment used during CPR to ensure all necessary tools are organized and immediately available to save a patient's life) utilization including oxygen regulators that could deliver 15L/minute flow and backboards, using oxygen tanks and how to know if full or empty). 4. On [DATE] Crash cart was immediately checked by the DON and oxygen regulators were replaced to ensure 15 l/minute capability, BVM bag and oxygen delivery systems verified to be functional, oxygen tanks are full. 5. On [DATE] the Director of Nurses and the Director of Staff Developer (DSD) reviewed current certifications of all direct care staff and only staff with validated CPR certification are assigned to residents' care. 6. On [DATE] Medical Records Director (MRD) identified 60 residents were designated as full code. Facility staff are aware of where to find the code status in the residents' file paper medical records and the health record system. 7. On [DATE] DON initiated immediate in-service to Licensed Nurses (RNs and LVNs) and Certified Nurse Assistants (CNAs) 7AM-3 PM shift (first shift, day staff) and on [DATE] to 3PM to11 PM shift (second shift, evening staff) regarding the facility's policy and procedure (P&P) tilted Emergency Procedures Cardiopulmonary Resuscitation revised date 2/2018, with emphasis on the following: Calling code blue (a code called via hospital paging system when there is critical medical emergency within a hospital when a person is experiencing cardiac or respiratory arrest and requires immediate resuscitation) when a resident is found unresponsive. Able to locate the code status information (a medical order indicating the type of emergency treatment a person would not receive if their heart or breathing stopped) in the resident's medical record to ensure that CPR is immediately for a full code status resident found unresponsive. Placing a resident on a firm, flat surface while performing CPR by utilizing a backboard a rigid board inserted under a resident's back to create a firm surface, preventing soft surfaces [like mattresses] from absorbing compression force, thereby improving the depth and effectiveness of chest compressions) and use the head-tilt, chin-lift maneuver to open the airway while delivering oxygen (to ensure optimal oxygen flow and blood circulation during CPR) via simple mask, utilization of an oxygen regulator that could deliver 15 L/min flow required to keep the BVM bag fully inflated to deliver 100% oxygen. Performing continuous and uninterrupted CPR on the resident's bed until emergency medical services EMS assumed care. 8. On [DATE], a Code Blue drill was initiated and will continue weekly once per shift for 3 months and monthly thereafter for the purpose of Skills Check Validation through return demonstration of Licensed Nurses and CNAs response to Code Blue situations and providing effective Basic Life Support, including CPR. 9. On [DATE], the development of crash cart checklist was implemented by DON. The crash cart and oxygen equipment checklist was Implemented on [DATE] and shall be checked every shift by the lead licensed staff. 10. On [DATE] any room changes include residents' medical records to change reflecting new room assignment along with electronic health records and physical medical record will be completed during room changes. 11. On [DATE], a Certified CPR instructor came to the facility on 7-3 and 3-11 shift and provided mandatory re-education and training for all Licensed Nurses and CNAs which was also attended by the DON and DSD with return demonstration conducted. 12. Starting on [DATE], the DSD/Designee will validate that any newly hired Licensed Nurses and CNAs have a current valid CPR certification prior to scheduling the employee for direct resident care. No direct (continued on next page)

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	03/25/2026

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	care staff will be allowed to work with residents directly without a valid CPR certification. 13. On [DATE] DON had a 1:1 (one on one) in-service with LVN 1, and LVN 2 regarding Medical Emergency Response (immediate initiation of CPR, proper positioning on a firm, flat surface, continuous, uninterrupted CPR, crash cart utilization including oxygen regulators that could deliver 15L/minute flow and backboards, using oxygen tanks and how to know if full or empty). 14. On [DATE], the DSD updated all current direct care staff for CPR certification and will update monthly. The DSD shall audit and communicate with direct care staff if CPR certification expires. 15. The DON/Designee will provide a summary of findings for the monthly Quality Assurance Committee (QAC-a data driven proactive approach to improvement used to ensure services are meeting quality standards). During a review of Resident 1's admission Record dated [DATE] indicated that Resident 1 was admitted to the facility from another Skilled Nursing Facility (SNF) 2 on [DATE] for long term care. Resident 1's diagnoses included Diabetes Mellitus (DM-a disorder characterized by high blood sugar), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), dementia (a progressive state of decline in mental abilities), atrial fibrillation (A-Fib - a heart condition causing an irregular and rapid heart rate). A review of Resident 1's Physician's Orders for Life Sustaining Treatment (POLST - a record signed by the resident/representative and the physician that indicates the resident's medical treatment wishes so that emergency personnel know what treatments the resident wants during a medical emergency), dated [DATE] indicated resuscitation/CPR should be attempted and that Resident 1 had full treatment status. This information was known to facility staff and available for review by staff in the event of a code. During a review of Resident 1's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool) with assessment dated [DATE], indicated that Resident 1 had a severe cognitive (thought process or ability to think and reason) impairment. During a review of Resident 1's Physician Orders dated [DATE] indicated an order to administer oxygen 2-5 liters via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) as needed for shortness of breath or oxygen saturation below 92% as needed. During a review of Resident 1's Care Plan indicated Resident 1 was potential for cardiac distress related to A-Fib, heart failure, and atherosclerotic heart disease (buildup of fats, cholesterol and other substances in and on the artery walls) dated [DATE]. Resident 1's care plan indicated to monitor and observe for signs of elevated blood pressure (the force of your blood pushing against the walls of your arteries, dizziness (feeling lightheaded, unsteady), chest pain, dyspnea (difficulty breathing), shortness of breath, tachycardia (fast heart rate), edema (fluid retention) congestion, nausea, and vomiting. The care plan indicated to promptly contact the medical doctor if any symptoms occurred. During a review of Resident 1's Progress Notes dated [DATE] timed at 6:45 PM, indicated RN 1 was called to Resident 1's room by the Certified Nurse Assistant (CNA 2). RN 1 indicated that LVN 2 made him aware that Resident 1 was having difficulty breathing. RN1 indicated when he entered Resident 1's room and found the resident (Resident 1) sitting up in a 90-degree angle with the head tilted back, RN 1 proceeded to start taking vital signs (VS-measurement of the body temperature, blood pressure, respiratory rate, oxygen and pain level). RN1 indicated Resident 1 was not verbally responsive and made noises. RN1 then indicated he went to verify Resident 1's code status with LVN 1 and proceeded to grab the crash cart. Vital signs were obtained with a blood pressure measuring at 126/72 (normal ranges between 120/80 to 100/60), heart rate 71 (heart rate per minute, normal range is 60 to 100), respiratory rate 18 (number of breaths per minute normal range is between 12 to 20) and oxygen level of 98% (normal oxygen level in the blood-normal range 94-100%). RN1 indicated that he listened to Resident 1 lung sounds and were clear, eye pupils were normal at 3 millimeters (mm) (normal pupil size 2 to 4 mm) RN1 indicated Resident 1 had shallow breathing. RN1 indicated that on [DATE] at 6:54 PM oxygen level was rechecked but dropped to 96%, and at 7 PM Resident 1's oxygen level quickly dropped to 89%. RN1 indicated a 911 emergency call was initiated and he increased the resident's oxygen to 2-5 liters via mask. RN1 indicated that vital signs were obtained and the resident (continued on next page)

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	03/25/2026

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was still breathing. RN1 indicated that the paramedics arrived and started CPR. CPR included chest compressions, the use of mechanical breathing [a device used to help someone breathe]) for approximately 20 minutes and at 7:25 PM Resident 1 was pronounced dead by the paramedics. RN 1 indicated the paramedics arrived and started CPR. CPR included chest compressions and breathing help. After about 20 minutes, at 7:25 PM, the paramedics pronounced Resident 1 dead. During a review of Resident 1's Emergency Medical Services (EMS) report dated [DATE] at 6:52 PM, the paramedics dispatched time 6:46 PM and arrived at the facility at 6:52 PM. EMS was at Resident 1's bedside at 6:55 PM found Resident 1 lying supine (lying on one's back with face upward) n bed with the complaint of cardiac arrest and no CPR being done by the facility staff. Paramedics found Resident 1 in asystole (heart completely stops beating) at 6:55 paramedics-initiated CPR at 6:57 PM Resident 1 was found to have no blood pressure, no pulse, no respiratory rate, and no pulse oximeter. At 7:07 PM the paramedics report indicated Resident 1 had fixed and dilated (enlarge) pupils and pale skin. At 7:29 after 34 minutes of continuous CPR efforts by paramedics Resident 1 was pronounced dead. During an observation and concurrent interview on [DATE] at 3:50 PM with RN 1, RN 1 was unable to determine that the oxygen tank on the crash cart was empty. RN 1 could not demonstrate the proper procedure to connect the suction tube to the suction machine. During the interview, RN 1 stated he did not know how to determine whether the oxygen tank was empty or how to properly connect the suction machine. Upon inspection of the first drawer of the crash cart, an oxygen valve regulator with a maximum output of only 8 liters per minute was found and verified by RN 1. RN1 stated he did not know how to check if the oxygen tank was empty or how to connect the suction machine. During an interview on [DATE] at 4:28 PM with LVN 2, LVN 2 stated that on [DATE] Resident 1 was stable throughout the day and ate 100% of dinner. LVN 2 stated, on [DATE] at 6:54 PM, CNA 1 and CNA 2 asked her to come see Resident 1 who was unresponsive. LVN 2 stated she attempted to take Resident 1's VS but the VS was not documented in the resident's clinical record. LVN 2 stated at 7PM a 911 was called and the paramedics arrived at approximately 7:05 PM who placed Resident 1 on a bag valve mask (BVM), started chest compression and respiratory resuscitation. During an interview on [DATE] at 4:55 PM with CNA 1, CNA 1 stated, on [DATE] before dinner time, Resident 1 was talking and wanted to make a phone call to her Family Member (FM 1). CNA 1 stated after dinner CNA 1 and CNA 2 assisted Resident 1 to reposition in bed to keep the resident comfortable. CNA 1 stated as soon as CNA 2 stepped out of the room, CNA1 noticed Resident 1's eyes rolled back and became unresponsive, so she immediately called CNA 2 to go get help. CNA 1 stated RN1 came into the room and looked at Resident 1 and immediately left to go to the nursing station. CNA 1 reported that LVN 1 entered the room with the crash cart; however, no CPR was initiated by facility staff. CNA 1 stated that when paramedics arrived, Resident 1 was pulseless, and the paramedics began chest compressions and provided respiratory resuscitation. During an interview on [DATE] at 1:40 PM with RN1, RN 1 stated on [DATE] at 6:45 PM, he was called by CNA 2 to go check on Resident 1 who did not look good. RN 1 stated that Resident 1 was unresponsive, and he proceeded to obtain the resident's vital signs. According to RN 1, the initial pulse oximetry reading was 96%, but when he repeated the reading, it had decreased to 89%. He instructed staff to place Resident 1 on oxygen via a simple mask. RN 1 reported that he touched Resident 1's ear, and the resident responded by making a noise. RN 1 stated he did not initiate CPR because the resident demonstrated responsiveness to pain. He reported administering 2-5 liters of oxygen by simple mask when the oxygen saturation dropped to 89%; however, he did not reassess the oxygen saturation after applying the oxygen. RN 1 also stated that the vital signs were obtained but were not documented. During a continued interview on [DATE] at 1:40 PM, RN 1 stated that Resident 1 was becoming weak, exhibited shallow breathing, and was not talking. RN 1 reported that Resident 1 remained in a seated position at an angle of approximately 70-90 degrees while unresponsive. RN 1 further stated that he did not attempt to place the resident in a supine position to open the airway using a head-tilt chin-lift maneuver because the resident made a noise in response to pain when he touched the resident's ear. RN 1 also stated that staff did not (continued on next page)

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	03/25/2026

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	initiate chest compressions while Resident 1 remained unresponsive with shallow breathing. During an interview on [DATE] at 5:15 PM, the Director of Nurses (DON) stated that several oxygen regulators in the facility only provide up to 8 liters per minute; however, the facility also has regulators capable of delivering up to 15 liters per minute. The DON stated she was unsure why the crash cart did not contain a regulator capable of delivering up to 15 liters per minute. During an interview on [DATE] at 8:30 AM, the Paramedic Captain (PC) who responded to the 911 call stated the department received a report of an unresponsive resident with CPR in progress. The PC stated that upon arrival to the facility, no CPR was being performed to the residents by facility staff. The resident (Resident 1) was found unresponsive, pulseless, and apneic. The PC immediately requested a backboard (a CPR backboard is a rigid, flat board designed to be placed underneath a patient to provide a firm surface for effective chest compressions) and was informed by RN1 that the facility did not have one. The PC stated that the crash cart contained only one bagˆvalve mask (BVM), and the oxygen tank valve being used delivered a maximum of 8 liters of oxygen per minute. The PC reported that he had to search through every drawer of the crash cart to locate a valve capable of increasing the oxygen flow to 15 liters per minute. The PC further stated that a BVM must be connected to oxygen at 15 liters per minute to keep the reservoir bag fully inflated and deliver 100 percent oxygen. The paramedics used the available BVM; however, it could not be used appropriately during the code due to the inability to increase the oxygen flow beyond 8 liters per minute. According to the PC, the crash cart did not contain the necessary equipment to adequately respond to a code. During a continued interview with the PC on [DATE] at 8:30 AM the code blue on [DATE], the oxygen regulator connected to Resident 1's oxygen tank was limited to a maximum of 8 liters per minute which could not deliver 100% oxygen. The paramedics were unable to use the BVM appropriately during the Code Blue because the oxygen flow could not be increased beyond 8 liters/minute. PC found another regulator inside the crash cart that only increased to 8 liters/minute. PC stated he had to switch to their own oxygen valve regulator to be able to increase it to 15 liters to be able to deliver 100% oxygen. The PC stated, This resulted in delayed delivery of 100% oxygen that is needed during resuscitation. During an interview on [DATE] at 9:14 AM, LVN 1 stated that CNA 2 called him to Resident 1's room because staff needed assistance with the resident, who had become unresponsive. LVN 1 reported that Resident 1 was on oxygen via nasal cannula and was breathing, but he observed two to three long breaths and recognized that the breathing pattern was not normal. LVN 1 stated that he knew 911 needed to be called. LVN 1 reported that when he attempted to turn on the oxygen tank on the crash cart, it made a loud noise as if oxygen was leaking. He stated that he went to the oxygen room to obtain a valve capable of delivering 15 liters per minute for use with a nonˆrebreather mask (a non-rebreather mask is an oxygen mask that delivers high concentrations of oxygen). According to LVN 1, as he returned from the oxygen room, he saw paramedics entering the facility and immediately applying oxygen, followed by chest compressions, and initiating intravenous fluids. During an interview on [DATE] at 2:19 PM, Resident 1's Medical Doctor (MD) stated that he received a call from the facility reporting that Resident 1 was experiencing breathing difficulties. The MD stated that he did not recall all the details of the telephone conversation; however, if the resident was a full code and had gone into cardiac arrest, he would have expected facility staff to initiate CP. During an interview on [DATE] at 12:28 PM with LVN 2 stated that on [DATE] at approximately 6:45 PM, Resident 1 was having shortness of breath because Resident 1 was breathing slow and stated that Resident 1 was not aware that you could provide ventilation when a resident is unresponsive and breathing slow. LVN 2 also stated that the progress notes documentation times are inaccurate in her documentation stating, I don't know why it mark those times. During a facility's policy and procedure (P&P) titled Oxygen Administration revised 10/2010, indicated that while resident is receiving oxygen therapy the following symptoms should be assess for: restlessness, confusion, shallow breathing, vital signs, and oxygen saturation. During a facility's policy and procedure (P&P) titled Emergency Procedure - Cardiopulmonary Resuscitation revised on 2/2018, indicated that sudden cardiac arrest is (continued on next page)

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	03/25/2026

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a loss of heart function due to abnormal heart rhythms (arrhythmias) victims of cardiac arrest may initially have gasping respirations and chances of survival increase if CPR is initiated immediately upon collapse. The P&P indicated that if an individual is found unresponsive and not breathing normally a licensed staff member certified in CPR shall initiate CPR unless there is a Do Not Resuscitate (DNR) order. If the resident status is unclear, CPR will be initiated until it is determined that there is a DNR order. During a review of Basic Life Support Provider Manual by American Heart Association, dated 2020, indicated: High-quality CPR (proper hand position and depth of chest compression) with minimal interruptions and early defibrillation (administering a controlled electric shock to allow restoration of the normal rhythm.) are the actions most closely related to good resuscitation outcomes.

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	03/25/2026

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure three of three licensed nursing staff (LVN 1, LVN 2, RN 1) had the competent skills sets to provide care in accordance with the facility's policy and procedure (P&P) titled Staffing, Sufficient and Competent Nursing) and resident assessment for one of two sampled resident (Resident 1) who was unresponsive with difficulty breathing and required cardiopulmonary resuscitation (CPR - an emergency procedure combining chest compressions and rescue breaths to circulate blood and oxygen when the heart stops or breathing ceases). These deficient practices resulted in delayed provisions of emergency care for Resident 1 and other potential residents with full code status treatment (full support which includes CPR if the patient has no heartbeat and is not breathing) in a life-threatening situation. Findings: During a review of Resident 1's Physician Orders for Life Sustaining Treatment (POLST - a record signed by the resident/representative and the physician indicated the resident's medical treatment wishes so that emergency personnel know what treatments the resident wants during medical emergency) dated [DATE] indicated attempt resuscitation/CPR and full treatment status that was known to the facility staffs and available to the staffs for review in an event of a code. During a review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] for long term care with diagnoses that included Diabetes Mellitus (DM-a disorder characterized by high blood sugar), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), dementia (a progressive state of decline in mental abilities), atrial fibrillation (AFib - a heart condition causing an irregular and rapid heart rate). During a review of Resident 1's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool) with assessment dated [DATE], indicated the resident had a severe cognitive (thought process or ability to think and reason) impairment and was dependent on staff for oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene. During a review of Resident 1's Physician Orders dated [DATE] indicated an order to administer oxygen 2-5 liters via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) as needed for shortness of breath or oxygen saturation below 92% as needed. During a review of Resident 1's Care Plan indicated Resident 1 has potential for cardiac distress related to A-Fib, heart failure, and atherosclerotic heart disease (buildup of fats, cholesterol and other substances in and on the artery walls). dated [DATE] indicated to monitor and observe for signs of elevated blood pressure (the force of your blood pushing against the walls of your arteries, dizziness (feeling lightheaded, unsteady), chest pain, dyspnea (difficulty breathing), shortness of breath, tachycardia (fast heart rate), edema (fluid retention) congestion, nausea, and vomiting. The care plan indicated to promptly contact the medical doctor if any symptoms occurred. During an observation and concurrent interview on [DATE] at 3: 50 PM with RN 1, RN 1 was unable to determine that the oxygen tank on the crash cart was empty. RN 1 could not demonstrate the proper procedure to connect the suction tube to the suction machine (a device that uses vacuum pressure to remove fluids from airway or body) RN1 stated he did not know how to check if the oxygen tank was empty or how to connect the suction machine. During an interview on [DATE] at 4:10 PM with RN 1, RN 1 couldn't verbalize that a backboard was needed during CPR. During an interview on [DATE] at 4:28 with the Licensed Vocational Nurse (LVN 2) stated that Resident 1 was stable in the morning shift of [DATE] and ate 100% of her dinner. LVN 2 stated that around 6:54 PM on [DATE] the Certified Nurse Assistants (CNA 1 & CNA 2) called for help for Resident 1 who was weak, breathing slow. LVN 2 stated he attempted to take Resident 1's VS but he was not able to document the results. LVN 2 stated that as soon as the paramedics arrived, they started CPR. During a review of the undated Licensed Nurse Core Clinical Competencies for RN (continued on next page)

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	03/25/2026

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1indicated RN 1 did not have a skills and competency evaluation for the use of a suction machine, vital signs and emergency response. During an interview on [DATE] at 5:30 PM with the Director of Nurses (DON), the DON stated that RN1 experiences a language barrier. The DON explained that RN1 demonstrates better understanding of information when it is communicated in written form, such as notes on a piece of paper. The DON stated that she deliberately pairs the RN Supervisor with experienced Licensed Vocational Nurses (LVNs), taking into consideration RN1's comprehension of the English language and communication needs. During an interview on [DATE] at 8:30 AM the Paramedic Captain (PC) who responded to the 911 call on [DATE], stated that upon arrival to the facility the facility staff were not performing CPR, the backboard was not placed on Resident 1's back and the oxygen valve regulator connected to the oxygen tank only delivered up to 8 liters/minute. During an interview on [DATE] at 12:28 PM with LVN 2 stated that Resident 1 was having shortness of breath because she was breathing slow and stated that she was not aware that ventilation could be provided when a resident was unresponsive and breathing slow. LVN 2 also indicated that her documentation times are inaccurate in the documentation stated, I don't know why it mark those times. During a facility's policy and procedure (P&P) titled Oxygen Administration revised 10/2010, indicated that while resident is receiving oxygen therapy the following symptoms should be assess for: restlessness, confusion, shallow breathing, vital signs, and oxygen saturation. During a review of the facility's policy and procedure (P&P) titled Emergency Procedure - Cardiopulmonary Resuscitation revised on 2/2018, indicated that sudden cardiac arrest is a loss of heart function due to abnormal heart rhythms (arrhythmias) victims of cardiac arrest may initially have gasping respirations and chances of survival increase if CPR is initiated immediately upon collapse. The P&P indicated that if an individual is found unresponsive and not breathing normally a licensed staff member certified in CPR shall initiate CPR unless there is a Do Not Resuscitate (DNR) order. If the resident status is unclear, CPR will be initiated until it is determined that there is a DNR order. During a review of the facility's policy and procedure (P&P) titled Charting and Documentation dated 7/2017, indicated that documentation of procedures and treatments will include care-specific details, including the date and time the treatment and procedure was provided, the name and title of the individual that provided the care, the assessment data and any unusual findings during the procedure/treatment, notification of family, physician or other staff, if indicated. During a review of the facility's policy and procedure (P&P) titled Staffing, Sufficient and Competent Nursing) revised [DATE] indicated that the facility provides sufficient numbers of nursing staff with appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment.